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## *At the Bedside*

# Helping Patients to Achieve What They Find Most Meaningful in Life

*Edmund G. Howe*

### ABSTRACT

Patients' and families' greatest need is often to do what for them is most meaningful. This may be, for example, their religion, their family, or their doing good for others. This piece will explore ways in which care providers may help maximize these ends. Paradigms offered will include Jehovah's Witness patients needing kidney transplants, a transgender adolescent wanting his sperm preserved, care providers' deciding whether to disclose that a deceased organ donor had HIV, and care providers seeking to do good for children profoundly impaired and adults who feel shame for just existing.

In this issue of *The Journal of Clinical Ethics (JCE)*, three articles discuss aspects of life through which patients and their family members—or anyone—may find the most meaning: religion, family, and being able to do good. What gives meaning to our lives is of the most importance to all of us, including patients.<sup>1</sup> Thus, as clinicians, to the degree that we can, we should seek to determine what is most important to pa-

tients and assign it priority when we treat them. I will consider these three sources of meaning as examples and as paradigms for other values that patients and family members may find most meaningful, and I will consider how we might prioritize these values, as well.

In "Justice and Respect for Autonomy: Jehovah's Witness and Kidney Transplant," Paul J. Cummins and Federico Nicoli ask whether Jehovah's Witness patients should have equal access to kidney transplants.<sup>2</sup> Their article highlights religion and meaning. The authors state that although they discuss only kidney transplants, their arguments apply also to heart, liver, lung, pancreas, and stem-cell transplants. I would go further, and suggest that their arguments apply to all patients who have religious or cultural beliefs that are meaningful to them. I will suggest a response to an additional core question they raise, taking an altogether different tack than many have in the past.

In the second article that I will discuss, "Familial Discordance Regarding Fertility Preservation for a Transgender Teen: An Ethical Case Study," Gwendolyn P. Quinn, Amani Sampson, and Lisa Campo-Engelstein ask whether an adolescent, Kasey, who identifies as transgender, should be able to have her sperm frozen.<sup>3</sup> (Here, I will use "transgender" in place of "nonconforming gender.") Kasey's father opposes freezing Kasey's sperm, and also opposes her transitioning. This article involves family and meaning. I will discuss how clinicians may best ap-

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proach resolving such impasses regarding treatment for minors, doing it in a way that maximally benefits both transgender children, whether young or adult, and their parents. I will also discuss the age at which parents or transgender persons should make different decisions, and how clinicians—and we, as a society—might best respond when transgender persons request to freeze sperm or eggs. I will also discuss two articles published in the last issue of *JCE*. Both address what clinicians should do when they discover that a posthumous kidney donor had HIV. The specific questions the authors pursue are whether we should tell the donor's partner and family.

The third article in this issue of *JCE* that I will discuss is "To Give or Not to Give: The Challenge of Pharmaceutical Coupons," by Mihail Zilbermint and Louise Schiavone.<sup>4</sup> The authors ask whether clinicians should give patients free medication samples. The article involves clinicians who want to do good, and is a springboard for asking a host of additional far-reaching questions. For example: Can what some people find most meaningful in their lives harm others? How far should clinicians go to help patients who are worst-off? How may we most help patients find meaning in their lives?

Overall, I suggest that if we want to prioritize helping patients to find meaning in their lives, we have a way to go. We may need to ask our patients, early on, "What is most important to you?" and then listen. It might seem that there is not enough time for this, but that assumption may not be accurate. A series of studies report that patients' complete opening statements of their concerns took an average of 38 seconds, and none of the patients took longer than 150 seconds to fully elaborate their concerns.<sup>5</sup>

## RELIGION

Cummins and Nicoli state that Jehovah's Witness patients are sometimes denied equal access to kidney transplants because clinicians deem them to be at too much a greater risk because they do not accept blood and blood products.<sup>6</sup> A second concern that Cummins and Nicoli raise goes the opposite way: they note that these patients may refuse blood because they fear that if they accept it, they will be ostracized by their religious community. In regard to these decisions regarding the allocation of donated organs, I will first discuss what clinicians might

want to consider as they decide whether or not to treat these patients as they would other patients. In regard to the latter concern, I will propose that clinicians might want to take a different tack.

### Should These Patients Have Equal Access?

Cummins and Nicoli state that clinicians who do not give Jehovah's Witness patients' equal access to kidney transplants stems from an overreliance on the ethical principle of utility. They cite Robert Veatch in support of their view. Veatch is an acknowledged expert on ethics and specifically on the ethics of kidney transplant. He said, as these authors quote, that justice should generally be prioritized over utility, and that no allocation should be acceptable if it is driven solely by utility.<sup>7</sup> The United Network for Organ Sharing (UNOS) has shared this view. It gave the principle of equal access greater priority than previously was the case, for example, when it enacted new criteria for allocating kidneys in 2003.<sup>8</sup> It did this to reduce the disparity then present between African American and Caucasian kidney recipients.<sup>9</sup>

UNOS continues to strive to balance competing principles in the best possible way. All adult kidney candidates in the United States now receive an expected survival score based on age, time on dialysis, current diabetes status, and whether the candidate previously has had a solid organ transplant.<sup>10</sup> Even though UNOS uses a somewhat complex point system to determine which patients who need a kidney should be accorded the highest priority, it seeks to make this determination sufficiently transparent so that those who want to understand the point system can. Thus, transparency is an additional ethical criterion that was intentionally built into the scoring system, as it currently exists.<sup>11</sup> The difficulty, which is no doubt irresolvable, is that persons have differing views. Patients who need a kidney acquire points in this system, for example, if they are younger and have previously donated a kidney to another person. How much these considerations—much less other conditions—should weigh relative to each other is controversial.

None of the factors currently being considered work against Jehovah's Witness patients having equal access to kidney transplants. These patients may be turned down, not because of policy, but primarily because surgeons who

would perform the transplant don't want to do it without the option of giving the patients blood if they need it.<sup>12</sup> Surgeons may refuse to do this procedure because they feel that it would require them to act against their consciences. The right to follow one's own conscience has been equated to other ethically problematic medical procedures, such as termination of pregnancy and fertility treatment.<sup>13</sup> The right to follow one's own conscience includes policy makers who privately determine priorities and clinicians who carry out the policies. Many healthcare institutions allow administrators and clinicians to follow their consciences.<sup>14</sup>

These considerations could pertain to clinicians who have a role in determining the priority of organ recipients. The consideration that should come first is that Jehovah's Witness patients' refusal of blood and blood products, and any added risk their refusal could cause, are based on their religious beliefs. Our general respect in the U.S. for all people's religious beliefs is well-acknowledged. It is, in one sense, contradictory to respect Jehovah's Witnesses beliefs such that we allow them to die for their beliefs, but at the same time not respect their beliefs sufficiently to give them equal access to kidney transplants when they will not accept blood or blood products.

I will focus next on the relative moral weight and priority that should be given to the principle of equity, as opposed to the principle of utility. Clinicians often have a preference for utility in making decisions because arguments based on utility may be easier to defend than those based on deontological principles. Arguments based on utility can be quantified; they support decisions that are based on what will mathematically provide the greatest good for the greatest number. Those responsible for making decisions may use reasoning based on utility to protect themselves, should their decisions be challenged. That they do this to protect themselves may be outside their conscious awareness. Thus, we should ask ourselves, when we are making these kinds of decisions, whether we should give greater moral weight to deontological values such as equity, even though they may be more difficult to defend.

Finally, reasonable people may differ regarding the question of who should decide which patients warrant the greatest priority. We might always want to ask whether a decision is the best one, but also who should make the deci-

sion. We often do this in ethics, for example, when we determine that parents should decide a child's outcome when the child is so ill that there is no valid way to decide what clinicians should do.

Again, Veatch here may lead us. He repeatedly has asked whether clinicians' medical expertise and experience gives them greater ethical expertise, or more enlightened ethical judgment than others, at least to the degree that some clinicians believe. Rebecca Dresser, JD, repeated this concern at a recent Office for Human Research Protections workshop, by asking who should decide what information research participants should receive when they enter a research protocol. This determination might, she noted, best be made by "ordinary" people, rather than by medical experts.<sup>15</sup>

I recall an instance that gives this concern added anecdotal support. After a research project was completed, researchers asked participants what information they wished they had been given before they agreed to participate in the research. Most reported they wished they had been given information that wasn't provided when they signed up: how painful it was to have blood taken from an artery rather than a vein. In the same way that "ordinary" people might decide that additional information should be included in recruiting packets for research protocols that medical experts would miss, ordinary people might offer differently weighted values regarding providing equal access to kidney transplants for Jehovah's Witness patients. Perhaps ordinary people would be more likely to share Cummins and Nicoli's views. Robert Klitzman, MD, an eminent ethicist, recently suggested that, in allocating points to determine who should receive a kidney, it might be better to progressively decrease the points allocated to potential kidney recipients as they get older, rather than allocating points based on age solely to recipients who are under the age of 18, as is currently the case.<sup>16</sup> Based on Klitzman's suggestion, we could ask: Do the existing hearing and consensus panels that set policy on the allocation of organs capture alternative views that should be on the table?

The core questions may be what limits, if any, should be placed on clinicians' being able to exercise their moral consciences, and who should decide on those limits as conditions, like the success of bloodless surgery, continue to change. When there is inequity, as is in this case,

the importance of our asking these questions increases.

An additional consideration, warranting no small ethical weight, is the possible consequence of excluding Jehovah's Witness patients: if they do not have equal access to kidney transplants, they may die. This serious outcome makes a strong case for increasing the consideration of equity in ranking these patients. Similar serious consequences in other contexts have resulted in distinctive policies and practices; for example, when patients can't afford emergency care, they must still be admitted to emergency rooms. Ignoring the possible consequences in these cases assaults the dignity of the patients as people.

Liver transplant could be used as a paradigm.<sup>17</sup> Even though patients who have liver failure due to excessive drinking may resume excessive drinking after they receive a liver transplant, they are given access to transplants notwithstanding this increased risk to the organ.<sup>18</sup> What kind of difference might this make for those making kidney allocation decisions? Even if the effect of these considerations is slight, the outcome for some Jehovah's Witness patients may be life, rather than death. For example, for those who make allocation decisions, these considerations may shift the burden from having to prove that these patients *should* have equal access, to having to prove that they *shouldn't*. I use the word "burden" as it is used in the law, not as in everyday conversation. I do not mean "a heavy load." In the sense I use it, "burden" may be illustrated most clearly by the assumption in U.S. criminal law that an alleged offender is innocent until proven guilty. The prosecution has the burden of proving guilt. If the prosecution does not prove guilt, and the alleged offender may have committed a capital crime, the offender may live. If the defense has this burden, the offender might die.

### Clinicians' Options

We can take steps in advance to assist Jehovah's Witness patients that could be lifesaving. For example, we could identify surgeons ahead of time who are willing to operate on them without blood. Some hospitals already do this.<sup>19</sup> This requires that hospitals poll surgeons who have admitting privileges in advance to discern who, if any, would be willing to operate on Jehovah's Witness patients without using blood. The ef-

fort could go further. If there are not enough surgeons at a hospital who are willing to operate under these conditions, the hospital could poll surgeons in the wider community. It could continue its outreach further and further until enough surgeons are found to ensure that the hospital is prepared as adequately as possible—even though a Jehovah's Witness patient may have never previously come for surgery.

Similarly, hospitals could seek in advance to identify persons such as elders in the Jehovah's Witness faith who have special knowledge regarding the most effective clinical use of blood substitutes.<sup>20</sup> In the past, clinicians and hospital authorities may have been reluctant to call in these experts. They may have feared that if they called in experts, the experts would encourage patients to refuse blood. This might happen. But how likely it is that it would determine patients' outcomes is open to question. On the other hand, if the experts have knowledge that clinicians lack, the experts' extensive knowledge might save patients' lives.

Jehovah's Witness patients who are hospitalized may refuse blood not because they want to, but because they fear being socially ostracized by members of their church if they accept blood. Their families may arrange for relatives and friends to be with them in their hospital room 24/7, to try to insure that a staff member can't come in while the patients are alone and try to persuade them to accept blood.

In such situations, staff may respond in two ways. Initially they may wait, hoping that family and friends will leave. If they do leave, staff will go to the patients and do what family and friends feared. The other option is for staff to remove family and friends by force. For instance, they may tell family and friends that they simply must leave, that they have no choice. Staff may say, perhaps in an attempt to soften their demand, that it is hospital policy. The policy may not be formal or written, but it may be an informal policy. Staff may understand that they will do this, based on past experience, if such an impasse comes about. They may explain that they must do this to insure that what patients say is what patients truly want. These interventions have an obvious downside. They may destroy the alliance between families and clinicians. If a patient dies, the family may need the clinician's support more than ever. Yet, while the death may be heart-wrenching, the family's religious faith may sustain them.

What might clinicians do instead? Let us assume, hypothetically, that some patients and families believe that if blood is transfused, this will eliminate any hope patients have for eternal life. Of course some Jehovah's Witness individuals may have different beliefs, which is not unusual when individuals share one basic faith. Based on this assumption, we may choose to ally ourselves with patients' family members. We can invite patients and families to meet with us and talk with them about what they all feel. We could, for example, express our own regret and sadness. We could express our understanding of why the patient and family feel they must make the choice they are making. (Ethically, we should still say that the patient can accept blood, but this would be clear from the conversation.) We might say that we wish the patient was young enough that we could transfuse her or him over her or his objections, because then the patient would have had no control over the decision to receive blood, and so would not be held accountable or ostracized. But saying this may risk losing the support of the patient and family.

A last question to be considered is who should carry on these discussions. Many of us, from just knowing that a patient could lose his or her life (and in our view, lose it needlessly), will find such conversations emotionally wrenching. We may be less able to effectively establish an alliance with the patient and family. Paradoxically, staff members who are least emotionally affected may be best equipped to lead these discussions.<sup>21</sup>

## FAMILY

Many people would willingly die for a family member. Such a preference may be expressed, for instance, when pregnant women say that they are willing to undergo a surgery that is needed by their fetus, with no consideration of the danger it may pose to them. Consequently, surgeons may agonize over whether they should proceed with surgery.

In this section on family and meaning, I will discuss the core dilemma considered by Quinn and colleagues in their article about Kasey and her father, who disagree about Kasey's trisomy and about freezing her sperm.<sup>22</sup> I follow this with other important questions raised by the case, involving the age at which transgender persons transition and about preserving their sperm and eggs.

In a subsection, I will present and discuss whether we should tell a posthumous kidney donor's family that the donor had HIV. This case raises the question of how we can best respect the special meaning that members of a family find in each other.

## The Transgender Adolescent

Quinn, Sampson, and Campo-Engelstein's article about Kasey, a transgender adolescent, and her father brings up for discussion the frequency of tragic outcomes for transgender individuals. As many as 40 to 60 percent may attempt suicide at some time in their life.<sup>23</sup> Parents' support of their child may greatly prevent this tragic outcome. Thus I will describe a way that we may try to help parents offer their child maximal support.

### *The Importance of Parents' Support*

Parents' support of their transgender child is likely to be critical to the child, at any age. With this support, the child may fare much better, regardless of the many other stresses faced.<sup>24</sup> Experts in treating transgender persons report that parents can fully give their child their support even when the parents continue to have doubts.<sup>25</sup> This should not be surprising. Clinicians who know this may be much more helpful to these children than they might imagine. That is, the transgender child, whether adolescent or adult, may know substantial uncertainty remains in this field regarding when and whether transgender persons should make the changes that will alter their gender identity. Clinicians in the Netherlands, for example, tend to believe, based on research performed there, that transgender persons may change their views regarding their gender more often than transgender persons in the U.S. say they do.<sup>26</sup> There may be various reasons for this. It may be, for example, that the persons studied in the Netherlands who identify themselves as transgender are a different population, with less strong convictions regarding their gender, than those seen by clinicians specializing in treating these patients in the U.S.

Children in the U.S. may know that their parents could still have doubts, even though their parents support them. As a result, the children may feel all the more certain that their parents, supporting them regardless, love them, and, for

that matter, love them unconditionally. The children may conclude, likewise, that their parents will put their child's needs first. But even parents who fully support their child may not know the many ways in which they can unknowingly give or not give their support. Thus, clinicians should alert parents to resources available to them, so that they can help their child as much as they can.<sup>27</sup>

Given these considerations, how can clinicians who, presumably, do not have adversarial beliefs, help parents like Kasey's father, who opposed his child's transgender identity? There are three steps clinicians should consider. First, we can ask parents why they feel as they do, and try to support them. There always will be some validity to the parents' views, and acknowledging this may connote, quite rightly, that we value their views and concerns. By "some validity," I mean that there will be something of concern that can or ought to be recognized, considered, and discussed openly and compassionately—even feelings of hate.

If, for example, parents say that they feel as they do because they fear their child's changes will be irreversible, we can say that we appreciate this, using the example of a teenager who wants to get a tattoo. "Many parents may fear this for the same reason," we can say. We could commend the parents for being so concerned for, and committed to, their child: "You clearly and greatly love your child." We could go on to say that children are often able to forgive a parent who has abused them, knowing the abuser was sick, but they but may not forgive as easily the parent who remained passive but who could have intervened to prevent the abuse.

We could add the horrendous statistics regarding suicide rates in transgender persons. We could say to parents that if they wish to help their child to the greatest extent possible, they need to support their child, and that they can do this, regardless of what they feel about transitioning. We can explain that each day their child lives as a member of the "wrong gender," it may be a living hell for the child. Further, the negative effect may be cumulative. The longer such daily hell continues, the worse chance the child may later be able to enjoy an emotionally rich and fulfilling quality of life.

In seeking to support parents, we may find our countertransference feelings to be most difficult. We may feel angry at the parents because we side with the child, and, as a result, our tone

and nonverbal behavior may refute and even offset what we say. Thus, we must at all cost avoid feeling such anger, or, if we can't, to pass this task on to another person who can. It may help us to feel more compassion for the parents if we continually remind ourselves that they may love their child just as much as parents who support their child, and also that what is best for these children still remains significantly open to controversy.

#### *At What Age Should Changes Be Made?*

For the best ages at which gender-related changes should generally be made, there are guidelines. Patients' needs and contexts may vary greatly. Thus, serious clinical questions remain—and always will, I suspect—in regard to what we should best do for persons who want to make gender-related changes.<sup>28</sup> I will discuss, then, just a few of the more critical clinical questions we may confront regarding the best age to transition. The first is the singular importance to a child of any age of being able to "fit in" as seamlessly as possible with peers. Not fitting in, its negative short- and long-range effects, may outweigh most other concerns in regard to what is best for the child.

There may be standards, some of which are legal, regarding the age at which individuals have the requisite capacity to make such decisions. Ideally, children might be accorded capacity requirements that are geared to the different kinds of decisions they may make, for example, taking medicines to prevent changes due to puberty to better fit in, or later taking medicines to bring about gender-appearance changes, so that they can better fit in. The hardest question for parents may be the age at which they allow their child to socially change. At a very young age, children may not yet be able to express themselves well verbally. But they may, some believe, be able to express themselves by such behaviors as the toys they prefer to play with.<sup>29</sup>

On the other hand, some parents so strongly fear that they may, even unwittingly, influence their child to adopt one gender or another that they scrupulously seek to avoid giving any cues that the child could read as a hint. The parents thus raise the child as gender-neutrally as they can. Even so, they may have to decide at some time, in some way, the social gender they believe their child feels he or she is.

### *Freezing Sperm and Eggs*

The third and last ethical issue I discuss in this first section involving family is whether Kasey, in the case presented by Quinn and colleagues, should have her sperm frozen. This would apply to the preservation of eggs as well.<sup>30</sup> First, we should recognize how important preserving sperm and eggs is to some people. They may, for instance, see the sole ultimate meaning in life as being able to pass on their genes to biologically related offspring.

Clinicians who miss this may respond to patients who make such a request in a way that, connotatively at least, is demeaning. Clinicians may do this because they see their own view as based on impeccable logic. That is, they may reason—quite rightly—that parents can be as happy, or possibly even happier, with a child they adopt. And *vice versa*: adopted children may be as happy, if not happier, than they would be with a biologically related parent.<sup>31</sup> Thus, clinicians may say, “But you can adopt.”

Patients who have requested assistance in having a biologically related child may find this insensitive. They may see the clinician as not being concerned with what they want. Patients may also see this as clinicians’ imposing their own views, and, worse, attempting to make patients feel shame for not wanting to adopt.<sup>32</sup> Clinicians may be more prone to offer their views with transgender persons who are younger, like Kasey in the case Quinn and colleagues present. Younger patients may need their clinicians to be optimally sensitive to their felt needs. They are more vulnerable due to their young age, and because they may anticipate that their clinicians will feel more free to offer their own opinions.

At present there are great uncertainties about the effect of the hormones transgender persons may take on their sperm and eggs. We do know that the effects may be substantial.<sup>33</sup> Consequently, freezing sperm and eggs may be necessary. That transgender people want to give birth to biologically related children presents new challenges. This should be considered because the needs of transgender persons, although less common, should be equally addressed as other persons’ needs, and, if possible, should be met. Some transgender men may, for example, want to deliver their child.<sup>34</sup> They may want to be able to breast-feed their infant. In this past year, transgender men have done so. Concerns for the infants still make this practice controversial.<sup>35</sup>

### **Informing Family Members that a Deceased Kidney Donor Had HIV**

Two articles in the fall 2018 issue of *JCE* addressed whether clinicians should tell family members that a deceased kidney donor had HIV. In “Positive HIV Tests from Deceased Organ Donors: Should We Disclose to Next of Kin?” Anne L. Dalle Ave and David M. Shaw highlighted the medical gains that clinicians may provide by sharing this information.<sup>36</sup> In “Posthumous HIV Disclosure and Relational Rupture,” Laura K. Guidry-Grimes and D. Micah Hester focused on some of the possibly harmful emotional effects of a disclosure.<sup>37</sup> I will discuss primarily the latter effects, because they illustrate the importance of clinicians attending to what patients find most meaningful, and then making this a priority. The psychological effects that Guidry-Grimes and Hester unearthed are examples of family members’ concerns to which clinicians should attend.

The source of the harms for family members of deceased, HIV-positive organ donors, as is often the case for transgender persons, is stigma. Stigma is still associated with people who have HIV. Examples continue to abound. For example, a couple chose to have their embryo frozen. They learned that the container that stored their embryo included an embryo from a parent who had HIV. They strongly objected to their embryo’s sharing a container with the other embryo. As a result, the other embryo was placed in a separate container, even though, as one clinician put it, even if HIV was present, the virus cannot fly.<sup>38</sup> I will now consider the specific issues that Guidry-Grimes and Hester most insightfully raised.

### *Finding Meaning in Remembering*

A first concern Guidry-Grimes and Hester raised was whether a donor who had HIV would want family members to know this. Key possibilities include: (1) what may have been most important to the donor was his or her legacy with family members and their memory of him or her; (2) while alive, the donor might have cringed at the thought of family knowing the donor had HIV; (3) the donor might have feared this knowledge would damage the beauty of the family’s memories of the donor; (4) family might treasure their memories of the late donor, and their knowledge that the donor had HIV might harm their memories (as irrational as that might seem).

Dalle Ave and Shaw pointed out that disclosing the donor's HIV status, at least to a marital partner, might enable the partner to discern that he or she has HIV and get earlier treatment. This might allow the partner to avoid passing HIV on to another person. Should this possible medical gain outweigh the gain of allowing the deceased donor to preserve her or his legacy, and allow family members to remember the donor as the donor may have wished? This question is readers' to resolve, but these questions should at least be on the table.<sup>39</sup>

#### *Not Having an Opportunity to Ask Why*

Guidry-Grimes and Hester raised a second potential harm of informing members of a deceased donor's family that the donor was HIV positive. If the donor was married, and the donor's partner was informed of the donor's HIV status, the partner would not be able to ask the donor why. For example, why did the donor "stray" from monogamy (if he or she did)? Guidry-Grimes and Hester seem to presuppose that if a donor's partner could discuss this with the donor, it would help. But would it? The question is germane to this specific example, but is also germane in similar situations, when both partners are alive. The partners who are informed may seek out a mental health provider, or may choose instead to share their distress with a primary care provider they already know.

There are many possible variations of this kind of situation, and I will provide a few points regarding what clinicians may best do.<sup>40</sup> For example, the conflict need not be sexual. Perhaps one partner has had intimate conversations over the internet with a person he or she has never met. He or she may say, and believe, that this is nothing. We could inform him or her that this absolutely isn't the case; what bothers the other partner must dictate. Perhaps the "wronged" partner responds in new and irrational ways, again and again, such as calling the partner at work every hour to reassure him- or herself that the partner is not with the other person. The offending partner may well "squawk" at this. We may be able to clarify for him or her, that such repeated calling may be necessary, at least initially, for the wronged partner, and the relationship, to heal. The offending partner should accept this. But what can we do if the offending partner has died, as in the case of the HIV-positive organ donor? We may point out

that, yes, the donor may have erred. Yet, although the donor may have done this, many such people still deeply love their partner.

The surviving partner may, as Guidry-Grimes and Hester noted, become more troubled, and wonder why the deceased partner didn't share this information. With a sudden, devastating awareness, the surviving partner might wonder whether the deceased partner wholly trusted him or her. The surviving partner may wonder whether the deceased partner saw him or her as untrustworthy, as too judgmental. Perhaps there was nothing to their relationship at all? Perhaps it was wholly empty and a sham?

Should a possible, devastating awareness like this play out, we can point out what the surviving partner may not have fully considered: the deceased partner may have not shared this information because he or she loved the surviving partner too much. The deceased may have loved the surviving partner so much that he or she feared that if he or she shared this, the surviving partner would reject him or her.

This kind of intervention may well be beyond what many of us would feel confident and comfortable doing, based on our limited experience and/or training. We might prefer to refer such cases to another. Alternatively, we might not refer, but, although well-intentioned, respond in a way that is mismanaged or misunderstood. We may do this out of an understandable and praiseworthy desire to do good, but this may end up doing harm. I present this, regardless, to illustrate two critical points. First, it is always possible to benefit patients by alerting them to relevant perspectives that they may be missing. But it is preferable when doing to first ask, "Would you be comfortable with my sharing with you an additional perspective? I might be all wrong, but it's up to you. What would you prefer?"

Making this point could restore the surviving partner. In all cases, we should dare to take such initiatives. We should share with our patients alternative meanings that they may have missed. This is particularly the case when an event such as this has damaged the core source of meaning in the patients' lives.

#### **DOING GOOD**

In their article in this issue of *JCE*, Zilbermint and Schiavone ask whether clinicians should give patients free samples of medications. Cli-

nicians may especially want to do this when patients can't afford their medications. We want to do this because we want to do good.<sup>41</sup> Zilbermint and Schiavone point out there can be downsides to such generosity. For example, some authors have describe the plight of parents who were given samples of an expensive baby formula for their young infant, only to learn later that the infant greatly preferred the formula, but the parents couldn't afford to buy it.<sup>42</sup>

On the other hand, we can consider the effect that giving out samples may have on bonding with our patients. This bonding could outweigh all other considerations, because these relationships may be necessary to bring about many other positive outcomes. Such relationships may be lifelines for some patients, that enable them to keep going, rather than choose to die.

Regarding the moral weight we should place on bonding between patients and clinicians, throughout the remainder of this last section I will explore the pros and cons of clinicians doing other kinds of "good." First I will look at an example in which we may do a good we believe in, only to miss what may be a much better way to go. Then I will look at the other extreme, in which we may "do good" in a way that is literally lifesaving.

### **Placing the Good Above What Is Better**

In a particularly heated set of articles published in 2015 in *JCE*, authors wrangled over whether a pediatrician or neonatologist should attend the delivery of a pregnant woman who wanted home delivery attended by a midwife, even though the woman and her husband knew that their infant might experience exceptional difficulties after birth.<sup>43</sup> The authors considered whether the pediatrician should attend the delivery to assist the infant. Or, the authors ask, would the pediatrician benefit the infant more by refusing to go to the parents' home for the delivery, which might force the parents to instead go to the hospital for the delivery?

We could ask decisive, empirical questions, such as how likely it would be that the pediatrician's not going to the parents' home would move the parents to change their minds about home birth. But, when confronted, these parents "dig in" and stay with their plan for a home birth. This is a clinically profound truth: we all have an oppositional part of our mind

that, when confronted, tends to dig in.<sup>44</sup> We can keep this in mind when we consider how we may be quite wrong when we believe we are only doing good.

For example, a newborn who is doing quite badly in the hospital, medically speaking, because she needs artificial respiration and tube feeding, which cannot ever be removed. Parents in these kinds of situations may be devastated and engage in unruly behavior. The catastrophe may only increase. The staff may focus on the child's outcome and may see, rightly, that the infant may do well, if loved throughout her lifetime, even though she is never able to breathe or eat on her own. Given the staff's focus, if the parents seem insufficiently loving, don't visit enough, don't hold the child when they could, or, worse, deny their child's needs and want to take her home without the technologies that sustain her life, the staff's intent to do good for the child may be stirred. The staff may instruct the parents, with ever increasing force, that the child has the difficulties that she has, needs what she needs, and the parents better shape up. The staff may even surreptitiously contact the hospital legal team to see what they must do if the parents go further and try to take the child home. The staff may envision, even at this early time, the possibility that they will need (with help) to divert the child to an institution or, preferably, to a foster home, to do this child good. The writing on the wall then may become more obvious. The oppositional brains of the parents may be triggered, and it is more possible that the child will be separated from her parents.

An alternative route that the staff can follow is to be indirect. They can put most of their nonmedical efforts into recognizing the parents' pain and responding to it. Then, if the staff can support the parents adequately, the child may go home with the parents, who still feel supported enough to be able to carry out the needed medical caring at home. As this example illustrates, the staff's desire to do what they find most meaningful may mislead them—in the same way, Zilbermint and Schiavone might contend, that giving out free samples can mislead.

There are other ways to do good that focus on building parents' alliance with their children. A first approach is preventative: we can recognize, early on, that some parents are at higher risk. When this is the case, we can come by to see the parents, not to check on them, but to support them.<sup>45</sup> Rather than come by and ask,

“How are you?” we could say something like, “I can’t even come close to imagining how much you may feel devastated.”

Perhaps surprisingly, a second approach would be to attend to clinicians’ needs. The rationale for this is simple: if to any degree parents are distressed, clinicians also will be distressed. This innovative approach involves what informally might be called “the eyeball test.” If clinicians roll their eyes when discussing parents or their interactions with parents, we might infer that they feel stressed. We can then do all that we can to try to reduce their stress, for example by giving them an opportunity to debrief.

Ethicists who do regular consults can assess when families appear to be exceptionally distressed. As they seek to address the families’ concerns, ethicists can put equal effort into helping clinicians relieve their stress, as well. The underlying assumption here is that the stress of both parties may be triggering each other. Thus, helping both may better help all.

Ethics consultants who know this can welcome the opportunity to help, in advance. Consultants may routinely come to rounds, and, while rounding, can ask clinicians whether parents are having trouble, and thus prepare the clinicians for possible later consultations. The success of such enhanced interventions, intentionally focused on how clinicians hurt, is ultimately dependent on the relational skills of the ethicists and their bonding with clinicians. Ethicists who have prior bonding with clinicians can empathize with their frustration and reframe for them what may be going on that they may be missing—and point out that these things can be easy to miss.<sup>46</sup> For example, in the case of the infant above, ethicists can note that the way the parents are acting is normal: they are devastated. The parents did not expect to have a future with a child on a respirator and a feeding tube. Ethicists can note that such parents can, with sufficient time and support, come to love their child and their life with them, just as much as any other set of parents would.

A third approach to building alliances is the use of a sharing model, if clinicians and parents are stymied as they try to decide together what to do. One highly innovative approach is to ask what the baby would want. In one way, this makes little sense. What could a baby know about what he or she wants? The clinician who came up with this approach says that while the answers that parents and clinicians imagine to-

gether may be instructive, this approach, on the other hand, can also be self-interested. It allows parents and clinicians to reduce the guilt they feel, as it allows them to place some imaginary responsibility for what they decide on the child, as well as on themselves.<sup>47</sup> In discussing this question, regardless, the parents and the clinicians are allied. This may be the essential springboard for the child to later do well.

### **Patients’ Gains from Clinicians Helping Them Find Meaning**

Clinicians who treat patients with cancers know how these patients hurt. Most clinicians who enter this field anticipate and willingly accept making extra efforts for their patients. The clinicians know that they themselves will suffer exceptional emotional pain. An example that needs no explanation is sharing bad news. The predictable aspects of this practice were recently documented in a study of 22 medical oncologists.<sup>48</sup> One internist said in regard to the need to be accessible, “It hurts sometimes but you have to be available.”<sup>49</sup> Many of those studied said that their interest in working with profound emotions brought them to this specialty.<sup>50</sup> One said that the especially demanding emotions they are likely to feel are crucial to their sense of themselves. These emotions reflect, this clinician said, “the meaningfulness of our work and the role we play.”<sup>51</sup> This kind of increased availability is exceptionally beneficial to patients.

Turning back to pediatrics for an example, I recall talking with parents who had a child who could neither talk nor walk, and never would, and who needed around-the-clock care. The parents, as a result, hadn’t taken a day’s vacation away from the child for more than 10 years, although they had other children with whom they would have loved to go away, “as other children could.” The parents began to see a new pediatrician. On learning of their situation, the pediatrician said that she would be happy to find a nurse who would stay with their son, and she would make herself available throughout their time away, 24/7. The parents and the other children then did go to the beach, loved it, and have spoken of this pediatrician, gratefully, ever since.

Clinicians who find it meaningful to be especially available, like this pediatrician, may meet their patients’ needs more than is evident. This often is the case in psychiatry. Here patients

may experience sudden, meltdown turmoil. One patient called me at home at 4 a.m. She was falling apart because a past assault had been retriggered. Within a half hour of our talking, she was calm. It continues to amaze me how a person who is wholly disheveled emotionally can rally in response to a trusted other in so little time. As Elvin Semrad, a much renowned psychiatrist at Harvard said, even patients who appeared to be very psychotic became, in their contacts with him, understandable human beings.<sup>52</sup>

I end this section with an extreme example that is meant to illustrate how far clinicians may go in their choice to do what is most meaningful to themselves. The kind of patients considered here are rare, perhaps, although they may exist more commonly than any of us recognize. These are patients whom one psychiatrist described as feeling shame just for existing. The psychiatrist describes one patient using the patient's words: "My presence, my being is a burden on those around me, on humanity, on the world."<sup>53</sup> As this psychiatrist describes it, the shame of existing, as opposed to other forms of intense shame, is not shame felt for an aspect of who or how the patients feel they are, but pertains to their merely existing. Whereas shame is usually characterized by the urge to hide and conceal, the shame of existing impels the subject to wish to disappear or dissolve.<sup>54</sup>

These patients feel empty inside. They may dread the nighttime, when they wake up and then can't return to sleep, only to dread more when they awake in the morning. Every day, every minute, they may wish they were dead. How might they come to be this way? One possibility is as follows. A mother chose not to look at her newborn for days after he was born. She told him when he was older that she wished she had never had him.<sup>55</sup>

How might a psychiatrist who is wholly devoted to such a patient intervene? An example is the psychiatrist Frieda Fromm Reichmann. She, it is said, would return time again and again for sessions with a withdrawn and uncooperative patient who would not talk to her until the patient could bear it no more and would then open up to her.<sup>56</sup> However, as is evident from this example, more than the usual approach may be required. Some psychiatrists who do this work have said that, for these patients, clinicians must radically depart from standard practice.<sup>57</sup> This may involve, for example, abandoning their traditional hierarchical place for one that is

equal. For example, in response to a patient's asking, "How old are you?" rather than ask, "Why do you ask?" they may respond, "I'll tell you, if first you tell me why you ask."

## CONCLUSION

I have reviewed three core sources of meaning in life: religion, family, and doing good. I have suggested in regard to religion and specifically Jehovah's Witnesses that clinician may ally themselves with patients, even when this means accepting the patients' death. I have suggested that clinicians who meet with parents regarding a transgender child first validate the parents' views, then celebrate who and how they are, and then tell the parents what they must do if they love their child.

I have given examples of how clinicians who prioritize what is the most meaningful to them, such as doing good, may have both bad and good results. They may give priority to their own principles, and not see that forming relationships with patients may be the only way they can achieve what they want. To reach and help patients who are the worst-off, like patients who feel shame for existing, they may have to abandon the usual tenets of their practice.

Our own reason for living, presuming we have one, may be paramount in our life, although it may be out of our awareness, or around the corner. We must never forget the importance of meaning in life when we treat our patients.

An excellent example of such meaning is presented by Arthur Miller in his play *The Crucible*.<sup>58</sup> The lead character, John Proctor, is a loving husband and father who is caught up in the hysteria of 17th century witch trials in colonial Massachusetts. At the end of the play, a court determines that Proctor must either confess to being a witch—which will result in punishment, but not death—or deny he is a witch, for which he will be hanged as a liar, as the court has determined this would be a lie. Proctor's wife tells him he must do what he determines to be right. He writes a confession to save his life, but then tells the truth, and is hanged. For this character, like Jehovah's Witnesses, the price of death for doing what is meaningful is not too high.

## NOTES

I would like to thank Norman Quist for his most insightful comments on this article.

1. C.E. Hill et al., "Meaning in Life in Psychotherapy: The Perspective of Experienced Psychotherapists," *Psychotherapy Research* 27, no. 4 (July 2017): 381-396.

2. P.J. Cummins and F. Nicoli, "Justice and Respect for Autonomy: Jehovah's Witnesses and Kidney Transplant," in this issue of *The Journal of Clinical Ethics*, volume 29, number 4 (Winter 2018).

3. G.P. Quinn, A. Sampson, and L. Campo-Engelstein, "Familial Discordance Regarding Fertility Preservation for a Transgender Teen: An Ethical Case Study," in this issue of *The Journal of Clinical Ethics*, volume 29, number 4, (Winter 2018).

4. M. Zilbermint and L. Schiavone, "To Give or Not to Give: The Challenge of Pharmaceutical Coupons," in this issue of *The Journal of Clinical Ethics*, volume 29, number 4, (Winter 2018).

5. R.M. Frankel and H.B. Beckman, "Accuracy of the Medical History: A Review of Current Concepts and Research," chap. 45, in *The Medical Interview*, ed. M. Lipkin, Jr., S.M. Putnam, and A. Lazare (New York:Springer, 1995), 218, 511-24.

6. Cummins and Nicoli, "Justice and Respect for Autonomy," see note 2 above.

7. Veatch has advocated the priority of deontological over consequential values in other contexts. I recall, for example, decades ago, at an annual course on bioethics at the Kennedy Institute of Ethics in Washington, D.C., that an attendee asked him the ethical grounds, if any, on which he thought it might be permissible to override the advance directive of a patient in a persistent vegetative state who had indicated that she wanted to be kept alive. This was when it was presumed that such patients could not at all recover. Veatch's answer was "justice."

8. E.C. Hall et al., "Effect of Eliminating Priority Points for HLA-B Matching on Racial Disparities in Kidney Transplant Rates," *American Journal of Kidney Diseases* 58, no. 5 (November 2011): 813-6.

9. Veatch, when teaching this, would ask learners rhetorically who would get all the kidneys if utility was the only principle used. "All white middle-class males," he would respond, depicting in his voice and expression the wrongness of this outcome.

10. "The New Kidney Allocation System (KAS): Frequently Asked Questions," 4 December 2014, [https://optn.transplant.hrsa.gov/media/1235/kas\\_faqs.pdf](https://optn.transplant.hrsa.gov/media/1235/kas_faqs.pdf).

11. P.A. Mayer, D. McElfresh, and G. Schnickel, "'OK Google—Who Should Get this Kidney?' Artificial Intelligence and Transplant Algorithms," presentation at the 20th ASBH 2018 Annual Meeting, 18 October 2018, Anaheim, Calif.

12. Ibid.

13. R. Trzcinski et al., "Surgery in Jehovah's Witnesses—Our Experience," *Przegląd Gastroenterologiczny* 10, no. 1 (2015): 33-40.

14. Ibid.

15. R. Dresser, "Laying the groundwork for meaningful informed consent," presentation at the OHRP

Exploratory Workshop: Meeting New Challenges in Informed Consent in Clinical Research, 7 September 2018, in Rockville, Md., <https://www.hhs.gov/ohrp/education-and-outreach/upcoming-educational-events/ohrp-exploratory-workshop-tentative-agenda-09072018/index.html>.

16. Mayer, McElfresh, and Schnickel, "OK Google," see note 11 above.

17. T. Wu et al., "Controversies in Early Liver Transplantation for Severe Alcoholic Hepatitis," *Annals of Hepatology* 17, no. 5 (24 August 2018): 759-68.

18. Ibid.

19. M. Reitar, "Relational Autonomy, Care, and Jehovah's Witnesses in Germany," *Bioethics* 32, no. 3 (2018): 184-92.

20. Ibid. All Jehovah's Witnesses may not have the same views, especially in regard to storing and then using their own blood.

21. There has been much discussion of practice with Jehovah's Witness patients over past decades. See, e.g., J.L. Dixon and M.G. Smalley, "Jehovah's Witnesses: The Surgical/Ethical Challenge," *Journal of the American Medical Association* 246, no. 21 (1981): 2471-2.

22. Quinn, Sampson, and Campo-Engelstein, "Familial Discordance," see note 3 above.

23. A. Antommara, Z. Goldstein, H. Mabel, and E. Reis, "Looking to the Past, Understanding the Present, and Imagining the Future of Bioethics and Medical Humanities: Engagement with Transgender Health," presentation at the 20th ASBH 2018 Annual Meeting, 19 October 2018, Anaheim, Calif.

24. E. Nealy, *Transgender Children and Youth* (New York: Norton, 2017).

25. C. Ryan, "All in the Family: Changing the Paradigm for Wellness, Prevention and Care for LGBT Children and Youth," presentation at the 143rd Spring 2018 Meeting of the Group for Advancement of Psychiatry, 13 April 2018, White Plains, N.Y.

26. Antommara, Goldstein, Mabel, and Reis, "Looking to the Past," see note 23 above.

27. Nealy, "Transgender Children and Youth," see note 24 above, p. 345. Free and confidential peer-support hotline numbers for GLBT individuals are 1(888)843-4564, 1(800)246-7743, and 1(877)565-8860.

28. Clinicians may have to strictly adhere to present standards of care, as those of the World Professional Association for Transgender Health, for medical insurance companies to pay for transgender persons' treatment.

29. J. Brooks, "Is Three Too Young for Children to Know They're a Different," *KQED Science*, 26 August 2018. This story links to a radio interview Jack Drescher did in May 2018, <https://www.kqed.org/futureofyou/440851/can-you-really-know-that-a-3-year-old-is-transgender>. Parents such as Kasey's father may ask, "What if she later changes her mind?" We could respond, "The more worrisome question is, what if she doesn't?"

30. E.K. Johnson et al., "Fertility Preservation for Pediatric Patients: Current State and Future Possibilities," *Journal of Urology* 198, no. 1 (July 2017): 186-94. Additional concerns that Quinn, Sampson, and Campo-Engelstein raise are: Who should pay? How? They cite approximate costs. This raises a question of justice, which, in this case, is especially warranted, since bearing biologically related children may be to some people so singularly meaningful. Transgender persons may be harmed by stigma within society. Based on this harm, the public's support for sperm and egg preservation for persons in this group might be considered, based on the principle of compensatory justice. Quinn, Sampson, and Campo-Engelstein, "Familial Discordance," see note 3 above.

31. A possible reason that adopted children and their parents may be happier, howsoever construed, is that these parents wanted these children and jumped hurdles to be able to adopt them.

32. This example exemplifies the risk that clinicians may take on, should they assume that what patients will feel is what seems logical to the clinicians.

33. Antommaria, Goldstein, Mabel, and Reis, "Looking to the Past," see note 23 above.

34. They may prefer having a midwife deliver their baby at home. A transgender man gives this reason: "I knew early on that I really wanted to have a midwife. The idea to me of walking into a hospital, in labor, and trying to explain to every single person I met who I am, was very scary to me." J.C. Valente, "The Midwives Who Help Trans and Non-Binary Parents Give Birth," *Kveller*, 7 July 2017, <https://www.kveller.com/the-midwives-who-help-trans-non-binary-parents-give-birth/>.

35. Even research to determine whether the medicinal means to bring this about are harmful may be ethically impermissible: "Given that there is a safe alternative to feeding infants whose mothers cannot or will not breast-feed, namely, bottle-feeding, how could a clinical trial to determine the safety and nutritional value of breast milk from induced lactation be justified?" B. Steinbock, "Breastfeeding and Transgender Women," *Hastings Bioethics Forum*, 21 February 2018, <https://www.thehastingscenter.org/breast-feeding-transgender-women/>.

36. A.L. Dalle Ave and D.M. Shaw, "Positive HIV Test Results from Deceased Organ Donors: Should We Disclose to Next of Kin?" *The Journal of Clinical Ethics* 29, no. 3 (Fall 2018): 191-6.

37. L.K. Guidry-Grimes and D.M. Hester, "Posthumous HIV Disclosure and Relational Rupture," *The Journal of Clinical Ethics* 29, no. 3 (Fall 2018): 196-201.

38. Ethics Committee of the American Society for Reproductive Medicine, "Human Immunodeficiency Virus (HIV) and Infertility Treatment: A Committee Opinion," *Fertility and Sterility* 104, no. 1 (July 2015): e1-8.

39. We now have better treatments for HIV. This raises the question whether ethically this answer is

different today than when HIV first appeared and there were no effective treatments.

40. I offer these comments in response to questions raised by Guidry-Grimes and Hester, to show how we might salvage the meaning that patients and families have for each other, when they are alive and after one has died. Guidry-Grimes and Hester, "Posthumous HIV Disclosure," see note 37 above.

41. The concept of doing good is open to question philosophically and psychologically. Philosophically, it is debated whether all altruism is self-interested. For a recent review of how altruistic behavior may be complex, see A. Tusche et al., "Decoding the Charitable Brain: Empathy, Perspective Taking, and Attention Shifts Differentially Predict Altruistic Giving," *Journal of Neuroscience* 36, no. 17 (27 April 2016): 4719-32. Helping patients achieve what is meaningful to them may be meaningful to clinicians. See in this regard, A.L. Suchman, W.T. Branch, and D.A. Matthews, "The Role of the Medical Interview in the Physician's Search for Meaning," chap. 30, in *The Medical Interview*, ed. M. Lipkin, Jr., S.M. Putman, and A. Lazare (New York: Springer, 1995), 368-75.

42. K.A. Katz, E.E. Reid, and M.M. Chren, "The Good, the Bad, and the Ugly of Free Drug Samples," *JAMA Dermatology* 150, no. 11 (November 2014): 1238.

43. J. Jankowski and P. Burcher, "Home Birth of Infants with Congenital Anomalies: A Case Study and Ethical Analysis of Careproviders' Obligations," *The Journal of Clinical Ethics* 26, no. 1 (Spring 2015): 27-35; M. Cheyney, "Of Missing Voices and the Obstetric Imaginary: Commentary on Jankowski and Burcher," *The Journal of Clinical Ethics* 26, no. 1 (Spring 2016): 36-9; E.G. Howe, "Professionalism: One Size Does Not Fit All," *The Journal of Clinical Ethics* 26, no. 1 (Spring 2016): 3-15.

44. See, e.g., F.A. Chervenak et al., "Neural Mechanisms Underlying Individual Differences in Control-Averse Behavior," *Journal of Neuroscience* 38, no. 22 (2018): 5196-208.

45. C. Collura, J.A. Krick, M. Arnolds, and D.M. Feltman, "Can You Hear Me Now? Amplifying the Voices of Parent Stakeholders," presentation at the 20th ASBH 2018 Annual Meeting, 19 October 2018, Anaheim, Calif. Family members who are at high risk who may trigger a preventive interaction may include parents who fight, parents who lack critical understanding even after multiple briefings, and family members who have difficulty understanding due to speaking a different language.

46. *Ibid.*

47. *Ibid.* Parents and clinicians who are aware that they may use this imaginary exercise for their own needs may reduce this possibility. For both parties to ask this imaginary question together may contribute to their bonding, especially over time. See, i.e., M. Rossigna-Milon and E.T. Higgins, "Epistemic Companions: Shared Reality Development in Close Relationships," *Current Opinion in Psychology* 23 (11

January 2018): 66-71.

48. W.T. Wong, A. Broom, E. Kirby, and Z. Lwin, "What Lies Beneath? Experiencing Emotions and Caring in Oncology," *Health*, 24 September 2018, 1-18. (Nine patients in the study were women; 13 were men.)

49. *Ibid.*, 15.

50. *Ibid.*, 12.

51. *Ibid.*, 8.

52. M. Good, "Elvin V. Semrad (1909-1976): Experiencing the Heart and Core of Psychotherapy Training," *American Journal of Psychotherapy* 63, no. 2 (2009): 183-205, 186.

53. R. Wille, "The Shame of Existing: An Extreme Form of Shame," *International Journal of Psychoanalysis* 95, no. 4 (2014): 695-717, 695.

54. *Ibid.*

55. *Ibid.*, 706.

56. J. Maltzberger, "Treating the Suicidal Patient/Basic Principles," *Annals of the New York Academy of Sciences* 92, no. 1 (2001): 158-68, 161.

57. "One of the principal characteristics of the real relationship must be that the therapist will love the patient and not conceal this fact." Maltzberger, *ibid.*

58. A. Miller, *The Crucible* (New York: Dramatists Play Service, 1953).

Of this play, Miller wrote, "The witch-hunt was a way of saying, 'You must gather to us in the church since we alone stand between you and the Devils overwhelming the world.' Beneath high moral dudgeon, then as now, lay our old friend power, and the lust for it. When several hundred thousand people had been executed in Europe for witchcraft, it was hardly wisdom to say that the cause was merely imaginary." A. Miller, *Timebends: A Life* (New York: Grove Press, 1987).