

Edmund G. Howe, "Can Careproviders Still Bond with Patients after They Are Turned Down for a Treatment They Need?" *The Journal of Clinical Ethics* 32, no. 3 (Fall 2021): 185-94.

At the Bedside

Can Careproviders Still Bond with Patients after They Are Turned Down for a Treatment They Need?

Edmund G. Howe

ABSTRACT

After COVID-19 first began to spread in the United States, dentists developed new guidelines that limited whom they could treat under these emergency conditions. Patients who faced greater limits to accessing treatment included children. Using a case of a child who was not able to access treatment, I discuss how careproviders might best seek to maintain their emotional bonding with patients and their loved ones, even if they must turn them down for an intervention.

I also address whether and when to give patients and their loved ones warning that access to treatment could be limited, using illness caused by COVID-19 as an example of how careproviders may better anticipate patients' needs at all times.

Finally, I discuss careproviders' needs. I suggest that medical professionals' culture should make it as easy as possible for them to acknowledge their feelings of vulnerability, so that they may better determine, in times of disaster, whether they should treat or triage patients. Careproviders who triage may choose to share with patients and loved ones that they also feel pain when they deny patients an intervention.

Edmund G. Howe, MD, JD, is Professor of Psychiatry and Director of Programs in Medical Ethics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland; and Editor in Chief of *The Journal of Clinical Ethics*. Disclaimer: The opinions or assertions contained herein are the private views of the authors and are not necessarily those of USUHS or the Department of Defense. Conflicts of interest: none.

In this issue of *The Journal of Clinical Ethics (JCE)*, in "What Is Best for the Child? Pediatric Dental Care during COVID-19," Priyanshi Ritwik, Kimberly K. Patterson, and Elsa Alfonzo-Echeverri present four cases in which children needed emergency dental care just after the COVID-19 virus first emerged.¹ One patient went to a hospital emergency room (ER) to get a front tooth replanted after it had been knocked out in a bicycle accident. The dentists at the hospital believed they had to turn him down, in part due to new professional guidelines promulgated in response to the pandemic. Under normal conditions, they would have replanted the tooth. Ritwik, Patterson, and Alfonzo-Echeverri state, "The decision not to replant an avulsed permanent tooth is contrary to traditional dental training and practice."

Significantly, they note this new practice brought about by the pandemic could create "a sense of patient abandonment." The risk of feeling abandoned may also exist for loved ones when a patient is turned down. In theory, these feelings of loss are not inevitable. Plausibly, careproviders could try to prevent them. And when they succeed, they may be better off themselves. Ritwik, Patterson, and Alfonzo-Echeverri state, for example, that treating patients under such limited conditions was "a humbling and distressing realization," and their "angst and burn-out from this endeavor is palpable."

In this article I will explore how careproviders might seek to prevent patients and their loved ones from feeling abandoned when they are turned down by careproviders. This issue has been addressed when patients request treatments that are outside medical standards of care,² but these refusals are different than the cases that Ritwik, Patterson, and Alfonzo-Echeverri describe. I will explore how we might seek to prevent feelings of abandonment. First, I will discuss ways that patients and loved ones who experience feelings of abandonment may respond, particularly on how patients and loved ones may experience anger, and how careproviders may take preliminary steps to limit or prevent that response. I will discuss the pros and cons of warning patients and loved ones about the allocation of limited resources, when this may happen, and approaches to use when warning them. These approaches may even be helpful under more “normal” circumstances.

Second, I will discuss how careproviders themselves may fare better; their feelings are important in their own right, and if they fare better, so may their patients and loved ones.

Third, I will comment on how careproviders may most help patients and loved ones not feel abandoned—although the extent to which this is possible is not known. The approach I suggest goes against what many careproviders do and against what medical students are taught, for the most part: to show their emotions.

If careproviders who use these approaches are able to help even a small number of patients and loved ones avoid feeling abandoned, the efforts seem to be warranted. Patients, loved ones, and careproviders would feel better, and their relationships would remain intact. Which is probably what all of the parties would want.

PATIENTS

In one case related in the article by Ritwik, Patterson, and Alfonzo-Echeverri, a 15-year-old had a tooth knocked out, and he kept the tooth in cold milk to preserve it during the 40-minute trip to the hospital. The dentists there declined to replant it. This was in part “in accordance with the guidelines set forth by the International Association of Dental Traumatology.” Under normal (nonpandemic) conditions, these guidelines ensure the “long-term retention and favorable prognosis of traumatized teeth, particularly when they are permanent teeth.” But after

COVID-19 emerged, these guidelines prescribed emergency care only for “odontogenic swellings.” Thus, “replantation of avulsed teeth was not then to be performed” according to these guidelines. This decision, Ritwik, Patterson, and Alfonzo-Echeverri state, was “contrary to traditional dental training and practice.” It was, though, they report, typical of the changes that dentists made after COVID-19 emerged.

The Use of Professional Guidelines

In this case, the dentists did follow their profession’s latest guidelines. That they did this, raises an initial ethical question: to what extent, generally, should careproviders follow their professional guidelines? For example, they could adopt other criteria, like patients’ pain. Guidelines reflect the views of leading experts, and, when followed exclusively, may maximize justice. That is, when the guidelines are followed exclusively by all careproviders in making allocation decisions, there is less chance that they will choose different criteria as they exercise greater discretion. But this possible gain may also be a limitation: careproviders cannot then tailor interventions to most meet their patients’ individual needs.

David T. Ozar, in his response to Ritwik, Patterson, and Alfonzo-Echeverri, “Learning about Professional Ethics from Inter-Professional Dialogue,” addresses especially the pluses that guidelines offer.³ As an example, he describes how principal outcomes help dentists to prioritize practice values to optimize their patients’ care. Earlier, in a separate article, Ozar asserted that those who write guidelines are experts in their fields, and have a “special kind of expertise.”⁴ But this special expertise is not necessarily in ethics. The late Robert M. Veatch, an eminent medical ethicist, wrote: “Most critically, physicians have to understand that patients also bring moral views to the relation that the patient considers authoritative. Ideally, a moral meeting of the minds will occur so that lay person and professional can share common moral world views. These shared norms may be incompatible with morality coming from professional sources.”⁵ In sum, Veatch argued that even when those who write guidelines have the best intentions, they may still impose their medical biases on patients.

Ozar speaks in the earlier article of the special authority that the larger society grants professions.⁶ The moral weight this point warrants

may vary, depending on the moral stature of the larger society. Its stature might depend, for instance, on its inclusiveness of minority groups and on how it treats its worst-off. Kimberlé W. Crenshaw's "intersectional approach" is an example of such a problem. She proposed decades ago that people who are subjected to discrimination due to their race, gender, or class may not be the most vulnerable, because they may be more easily identified. Those who are likely to be at greater risk, she contended, suffer less from any single source of discrimination, but suffer more over all, because they are members of more than one of these groups.⁷

The strongest arguments against relying exclusively on guidelines are, most generally, at the outer margins of cases to which the guidelines apply. The following examples are illustrative. A first example is when careproviders report child abuse or neglect. Some parents may spank with excessive force, and some would argue that even spanking is abuse. Careproviders may or may not believe this is abuse that they must report. Some careproviders believe that, in spite of professional guidelines that state abuse should be reported, they don't need to report it, because they believe that these families, and especially the children, may do better if they treat rather than report them. This particularly may be the case when careproviders know the family and have the parents' trust. If careproviders do report, it may end the relationship they have with parents and may be worse for the patient and the family.

A second example is a conflict that careproviders experienced in the past. At one time it was thought that careproviders who treated patients who were suicidal should ask them to sign an antisuicide contract. Some careproviders disagreed with this, as they feared that if they made this request, it could undermine patients' trust. Thus, some would not ask, and some of those who did ask explained to their patients that they thought asking was wrong, and why.⁸

A third example is careproviders who refuse to sign out a patient from an ER or hospital against medical advice (AMA). They may fear that if they sign the AMA form, it may jeopardize their positive relationship with the patient. Optimal care for these patients should include follow up,⁹ but if the patient-careprovider bond is severed, that may have suboptimal results.

This last example may require exceptional courage, especially when other staff members

strongly disagree.¹⁰ The line between having courage and having too much courage—that is, an action that may cause harm to a patient—may be difficult to draw, and this question may arise whenever careproviders consider departing substantially from guidelines. This question may arise in many situations; for example, a careprovider may request a discounted cost for transportation, such as a bus, to help a patient access treatment, or a careprovider may go to court to support a patient who faces legal action, even if this only means that the careprovider will sit by the patient. Some may see the examples given above as careproviders' going beyond prescribed professional boundaries.

Thinking through, Initially, the Reasons

The principle of justice usually pervades professional guidelines. Careproviders may hope that patients and loved ones, disappointed about being turned down for a treatment, will see the fairness underlying the decision and accept it. Thus, when experts design algorithms to determine how to distribute limited resources, such as kidneys for transplantation, they try to make the schemes understandable to the general public.

During a disaster, however, it is common for decisions regarding the allocation of limited resources to rely mostly or completely on the ethical principle of utility. In this context, utility means promoting the greatest good for the greatest number, in some way. When the criterion of utility is used exclusively to allocate resources, it effects the justice of these decisions, because the priority of all patients is determined by this one criterion. Careproviders who are tasked with the triage of patients, during and after a natural disaster, may use this criterion alone, and reflexively. The use of this criterion alone may be easier to defend, because all of the judgements made, based on utility, are (at least in theory) quantifiable, and one quantitative outcome can be weighed against every other.

But translating benefits and risks into competing net numbers that can be compared and weighed against each other is less objective than might be imagined. A core ethical question is, whose quantitative judgment should apply? Patients who currently receive kidney dialysis, for example, may see its quantitative value far differently than people who are healthy. This difference is particularly important because people who are better-off or who make up any majority

may underestimate the needs of those who are worse-off.¹¹

Careproviders who make allocation decisions, including emergency dental care, may want to consider other, additional values beyond guidelines that are not quantifiable. Two examples of the use of other values to make allocation decisions can be found in the stories of patients, loved ones, and careproviders who were stranded for days in the flooded Memorial Hospital in New Orleans, after Hurricane Katrina, in high temperatures, without power for ventilators or air conditioning. One example of the use of different values was the decision that, when rescue efforts became possible, priority would be given to the rescue of all members of a family at the same time, to avoid the possibility that some might be left behind.¹²

A second example concerned a pregnant visitor who was stranded at the hospital.¹³ Before Hurricane Katrina hit, hospital staff had set aside food and water, so they could continue to care for patients if they became isolated. When food and water became scarce, the staff wondered whether they should offer to share their food and water with the pregnant woman. The supply of food and water was limited, and sharing it would violate, in its simplest sense, the principle of utility.¹⁴

Sharing the Reasons Why

Careproviders may opt to share with patients and loved ones why they were turned down for an intervention and what was considered in the decision that was made—if patients and loved ones want to know. This may help them feel less abandoned, or not abandoned at all. If the decision makers considered going beyond the use of guidelines and/or the principle of utility, and/or considered other values in making the decision, learning this may enable patients and loved ones to better accept the decision that was made.

Another factor to be considered in allocation decisions is patients' pain. Their pain could be physical or emotional, visible or invisible, although, as these categories indicate, it may not be possible to use the extent of patients' pain to decide whose needs should be assigned priority. But the use of pain as a criterion may be optimal, because it is a negative aspect of illness with which we can all readily identify. By describing the use of such additional criteria to patients and loved ones, careproviders may be able to communicate that who those are mak-

ing allocation decisions are trying to do the best that they can.

To see if patients and loved ones want additional information, careproviders may take the initiative to ask whether they want to know the ethical grounds considered and why these decisions were made. Such initiatives and openness may help prevent patients and loved ones not feel abandoned. This introduces an idea that I will elaborate: that careproviders may present themselves as patients' allies by sitting side by side with them, and even indicate that they are helpless regarding decisions that have been made, as alien as that idea may be to patients, especially in a time of epidemic.

Responding to Anger

Even when patients and loved ones understand why patients will not receive treatment, they may still feel angry. I think of a doctor whose father recently died due to COVID-19. The father's careproviders denied him a medication that could have helped him and possibly could have saved his life. They didn't give it to him because it was in short supply at the time, and he was elderly. His daughter understood that this was plausible basis for this decision, but she remains no less deeply bitter today.

Since careproviders can know that patients and loved ones may respond with anger, they should be as prepared as they can be to respond to this in the best ways possible. There are many ways to reduce feelings of anger. Many are cognitive. One now used commonly that anyone can easily apply was taught by Elvin V. Semrad, a psychiatrist revered by colleagues and residents for, among other reasons, being exceptionally able to reach patients whom no else could reach. Patients who had been continuously psychotic would, for example, when speaking with him, suddenly become lucid, only to immediately become psychotic again once he left.¹⁴ He advised psychiatric residents when they felt angry to just push their right big toe down in their shoe and "keep quiet."¹⁵ I will refer to Semrad subsequently. His work supports a core intervention I will later suggest.

One approach careproviders sometimes use when patients and loved ones express anger is to try to "set boundaries." Careproviders may say, for example, "I will not accept you speaking to me in this way." I suggest that they instead seek to understand. Once they believe they do understand, they nonetheless should check

this out further: “Do I have this right?” they might ask themselves. They should then seek to support some basis for the expressed anger. There will always be some sound basis for it.

Careproviders may go further and indicate they believe they would feel the same way (if this is substantially true), even when anger may not be a rational response. Some careproviders report that when patients who seem emotionally walled-off suddenly feel understood, they spontaneously had tears. As Jonathan Haidt wrote, “Cultural psychologists tell us that the independent, thick-walled self is the norm in Europe and in North America, but not elsewhere.” We may be biologically more influenced by others than we think.¹⁶

Some patients may, on the other hand, seem to resent this kind of response. They may think careproviders who say this are expressing “crocodile tears.” Careproviders who want to avoid this risk may seek to lessen the possibility by saying something like, “I want to say how I think I would feel just like you do, but I feel scared that if I do, you might think that I see your pain as less than it is.” This could be seen as cliché, but still, it may be worth doing.

Patients and loved ones may, for example, be more affected by these statements later on. Later, they may note that their careprovider said these things and infer that, at that time, the careprovider really cared. Careproviders may even let themselves cry. This, too, may have pluses and minuses. Nadine Kaslow notes that when a careprovider cries, but not the patient, the careprovider can say something like, “I think I may be crying because . . .” or ask the patient, “What is your response to my shedding some tears?”¹⁷ This might evoke harmful anxiety, as the patient may be faced with whether or not to share a negative response.

Giving a Warning

When patients like the young man who knocked out a tooth and was not treated at the ER suddenly learn they will be turned down, it may be a sudden shock because they have received several pieces of bad news all at once. Careproviders may be able to reduce this shock by alerting patients in advance about the possibility that interventions may be denied.¹⁸ Careproviders may tell patients that there is a risk they may be turned down for limited resources when there is any possibility that may occur. For example, patients who have COVID-19 who

present at an ER may come to need a ventilator. Should they be warned there may not be enough ventilators when they first arrive? Or be warned when it appears they may need a ventilator? Or when they do need one, and there may not be one available? Giving patients this information early on respects them,¹⁹ as it may soften the blow of learning about it all at once. On the other hand, warning patients early on may evoke paralyzing fear and distrust.

Similar pros and cons can be applied widely. Ethics consultants may, for example, urge careproviders to provide an intervention for only a limited time, and then, later on, to continue the intervention if it is warranted. In these instances, careproviders can tell patients and loved ones in advance that this may be a time-limited intervention. Careproviders may go even beyond this and share with patients the criteria that will be used to make allocation decisions, if patients want to know the criteria, when there is time. This offers the careproviders, patients, and loved ones the possibly of recrafting the decision-making process. Working together in this way represents the kind of alliances that may seem paradoxical and even alien, that I urge careproviders to consider.

Both the pros and the cons here are substantial, and there is likely more than one ethically reasonable view regarding whether or not to warn patients in these circumstances. Would most patients want such advance warning? This answer might differ based on the patients themselves. Some may, for example, be able to use the emotional defense of denial very successfully.²⁰ That is, they may be able to pretty much ignore the risk that they may later need a ventilator and not have access to it. But other patients may lack this capacity. In response to such a warning, they may anticipate the worst-case scenario and obsess about it. Their quality of life may be negatively affected because their obsessions may interrupt everything for them. They might be better off not knowing.

Careproviders face uncertainty, as they cannot know how patients will respond. Careproviders have several options. They may decide not warn. Alternatively, they may ask patients and loved ones whether denial has worked for them in the past. Based on this answer, patients and careproviders may decide together when, if ever, careproviders should warn.

There is a more paternalistic option: careproviders may advise patients to not imagine

worst-case scenarios. Careproviders may go even further and refuse to discuss worst-case scenarios, and explain that doing so would be too likely to do harm. This could be softened by an offer to refer patients and loved ones to another careprovider who might be willing to discuss a warning with them.

Patients might feel ruffled by this last approach, and careproviders would have another, final alternative. They may tell patients and loved ones why they do not want to discuss this, but let them make a decision about it. Practically, this may not be possible, because even raising the question may alert the patients and loved ones to the possibility that they may later need a ventilator but one may not be available. This is like the dilemma careproviders face when loved ones request, before a diagnosis is made, that careproviders not tell patients if they have a fatal illness. If careproviders ask patients about who should receive diagnostic findings, it may lead patients to conclude that it is possible they have a fatal illness.

Implications in Non-Crisis Situations

While it is important that careproviders anticipate patients' needs during a crisis, as the dentists did in the cases in the article by Ritwik, Patterson, and Alfonzo-Echeverri, in some ways it may be much more important to do so when a crisis isn't ongoing, due to the much greater numbers of patients that may be involved. An example I will use to illustrate this is children who need dental care. Even under "normal" conditions, some children who have more severe special needs may have difficulty accessing the exceptional care that they need.

I think here of children with severe autism and similar conditions that may result in their screaming in terror when they come to a dental office if they have previously received treatment in a dental chair.²¹ I recall, for example, unforgettably, a mother who told me of her experience seeking the dental care she needed for her child. She needed to find a dentist who would be willing to sedate her son before treatment so that he could sit in a dental chair and get the care he needed. She finally did. Such parents and children need optimal care that is not always easy to access.²²

Nursing schools, medical schools, and other institutions that train careproviders are now teaching students how to better provide exceptional care. Students learn, for example, the mnemonic

IHELLP to easily remember core areas in which patients are likely to need their help, namely their "external" needs to better access medical care: income, housing, education, legal status, literacy, and personal safety. "Income" includes patients' housing, electric, heating, and telephone bills. "Legal" includes immigration status.²³ Students learn how best to ask questions; when asking patients about income, for instance, they might say, "Do you have difficulty making ends meet at the end of the month?"²⁴

Careproviders who are at the "front-lines" may be best suited to ask patients such questions. They might need readier access to others who can implement the remedies that they, through these frontline inquiries, have unearthed. The dentists Ritwik, Patterson, and Alfonzo-Echeverri model how to do this. They anticipated patients' needs that only others could provide and referred patients who needed this special care to them.

CAREPROVIDERS

When careproviders must make allocation decisions, they may experience extreme stress, as Ritwik, Patterson, and Alfonzo-Echeverri note. For example, doctors in Italy have been reported as "weeping in the hospital hallways" in response to the choices they have had to make.²⁵ As an example of the anguishing decisions they may have to make, they might have to withdraw a ventilator from patients who might or even would survive if they could stay on a ventilator. This might need to be done to save greater numbers of patients. Doing this requires careproviders to break their implicit promise to patients, and is not, obviously, at all why most if not all entered medicine.²⁶ A switch from a patient-centered ethic to a public health ethic that favors the interests of many is stressful.

An approach commonly used to reduce such stress is to wholly separate careproviders' roles of treating and triaging patients. There may be an additional process that careproviders may use to help them further. This is to acknowledge the differences among careproviders in the degree to which they take patients' suffering home with them, and adopt the role that they will play during a crisis accordingly. I have discussed how patients may differ in the extent to which they can effectively use denial. Likewise, careproviders may differ in the extent to which they can

leave what they feel for patients at work, so that it does not impair them at home, or, as is said, to “compartmentalize.”

There may be subtle but still implicit pressure on careproviders to appear as if they are sufficiently resilient when they see patients, despite their different degrees of suffering. It may be that this pressure and culture should be changed, to the extent that differing degrees of suffering do exist. Careproviders could be encouraged to explore where they are along this continuum, and could then seek or be assigned to treating or triage duties based on where on the spectrum they are.²⁷

Granted, it could be possible for careproviders who could be excused on this ground from treating or triage duties, if they abhor one or the other, to game this system.²⁸ They could claim that they have a vulnerability to one kind of stress when they don't. Still, to any degree that this approach could reduce careproviders' stress when they see patients, in either of these contexts, it is most likely to be beneficial to patients and careproviders. Any decrease in tension that careproviders feel may decrease patients' stress as well. As Semrad said, “People affect each other.”²⁹

The goal is to benefit careproviders, patients, and loved ones by creating a professional medical culture in which careproviders can most fully acknowledge themselves as they are. This is the same plan of openness that I will suggest careproviders adopt when they engage with patients who have been turned down for an intervention.

HELPING PATIENTS AND LOVED ONES FEEL LESS ABANDONED

I have outlined steps that careproviders can take to help patients and loved ones feel less abandoned when they are turned down for treatment, if that is at all possible: thinking through in advance the best rationales for the allocation of resources and then sharing them with patients and loved ones, if they want to know about it. Patients, loved ones, and careproviders may decide on any additional steps careproviders might want to take to help patients and loved ones get what they want. This might include, for example, going with patients or loved ones to appeal a decision to someone who has the authority to make a different decision, when there is still time. And careproviders could choose to

support, rather than confront, patients and loved ones should they “retaliate” with anger.

Beyond these interventions, the most important intervention that careproviders should consider is to offer to share with patients and loved ones their feelings about why the decision was made to turn down treatment for the patient. In these situations, careproviders may also feel helpless. The choice made may be the opposite of the one that they wanted made. They can acknowledge that their feeling of pain is but a small fraction of the pain they imagine patients and loved ones feel. They can explicitly state this.

As noted above, when careproviders share their own feelings, it may break down the emotional isolation that patients and loved ones may experience at being turned down for a treatment. This occurs even with suicidal patients, and if careproviders can help suicidal patients by sharing their feelings, this might be possible in other contexts. Psychiatrists who have written about Semrad note, it may be that the heightened emotional investment required to develop a connection “can be lifesaving.”³⁰ There is perhaps no better example of this than one which involves Semrad:

[A] chronically self-lacerating, suicidal patient suffering from a schizo-affective disorder reduced her first-year resident psychotherapist to a state of helpless self-doubt and anxiety by escalating her behavior in the face of his somewhat detached, rather impersonal interpretive approach. He consulted Elvin Semrad. During their discussion he burst into tears, so great was his distress at his patient's plight. Semrad said, ‘I think if you will show your patient what you have just shown me, she will stop cutting herself.’ The resident confessed his distress and helplessness to his patient, and told her he desperately wanted to help her, but did not know how. She stopped cutting herself.³¹

Careproviders cannot be sure that patients and loved ones will respond positively when they share their feelings. As the psychiatrists who wrote about Semrad noted, “Some patients benefit from being able to experience feelings with a caring, empathic therapist, and some apparently never do. Perhaps ‘as long as it takes’ can be ‘never.’ Yet we may not be able to know how long, if at all, ahead of time.”³²

Such sharing may include crying, even though many careproviders may see this as un-

professional. In one study, three-fourths of therapists said they had cried during a treatment session.³³ Patients and loved ones may not respond positively; they may think, for example, “But this is not about you, this is about my feeling pain,” whether or not they say it. Worse, they may infer from careproviders’ saying they know how patients and loved ones feel indicates that the careproviders can’t fathom the extent of the pain that they feel.

Careproviders who anticipate such a possible response may seek to reduce this risk by first noting that they know what they feel is only a tiny fraction of what they imagine patients and loved ones are going through.

Careproviders’ personal disclosure may have a strong effect. Diana Cejas, a pediatric neurologist, shares with patients who have a disability that she has a disability that is otherwise invisible. She writes:

Their stories are all different. There was the boy with cerebral palsy who just wanted to play little league. The teenage girl who’d had a stroke who wondered if she’d ever get used to her new crooked smile. . . . Most of them with conditions they were born with, encoded in their DNA. . . . At some point during our first or fifteenth appointment, I turned to them and told them a secret: their doctor had a disability just like they did.³⁴

She believes that when careproviders share their own vulnerabilities, it can make a profound difference in patients’ lives. She says, “how rare it was to see a doctor openly speaking about their disabilities. . . . We know that when doctors and patients share common experiences, their partnership can be strengthened.” There is “some controversy,” she explains, “about whether physicians should disclose their disabilities to patients. . . . This kind of thinking separates physicians from patients entirely, dismissing the fact that some of us are both physician and patient.” This separation, she suggests, may be a gap that careproviders can and should seek to overcome. This involves the hope that careproviders might pursue, even in this context, a common ground they share with patients and loved ones, even though their roles and power differ.

Patients and loved ones may find meaning when careproviders offer to share their feelings. As Semrad noted, the “one thing . . . any of us need is to be connected with someone.”³⁵ Further, he said, “If patients have one relationship

in which they feel comfortable, they don’t go crazy.” He said to such patients, “The one thing I can promise you is I will hear you, I will actually with a heart and a half, look to sit with you and really try and have an opportunity to walk with you through this time. . . .”³⁶ This connectedness echoes what Cejas has experienced and urges.

The last link in this chain may be that patients and their loved ones will never again feel bonded with their careproviders after they have been turned down for a needed intervention. Whether or not an allocation decision makes sense, patients’ and loved ones’ emotional responses may be simply too reactive and predominant for such severing not to occur. Yet, there may be another seemingly paradoxical emotional response that is possible. Patients and loved ones may still be able to bond with careproviders, even when they have just been turned down to serve another a medical good. They may, notwithstanding their feelings of pain, be able to transcend this emotion if they can find meaning that is sufficient to overcome it.

Here, I rely on the work of Victor E. Frankl, who lost loved ones in a concentration camp during World War II. He survived his own imprisonment and believed that if we can find meaning in our lives, we may be able to transcend its worst horrors. He related the words of a Polish prisoner: “ ‘if the SS leads you to a gas chamber or to a mass grave to execute you on the spot, and you can’t do anything about it—except for going your way with dignity—you see, this is what I call heroism.’ ”³⁷ The prisoner identified that he still had agency: he could walk forward in his own way. This is ‘attitudinal heroism,’ so to speak,” Frankl added.

Similar positions are put forth elsewhere. Members of the military who are captured know that all may break due to torture and stress, and they may find meaning in being able to survive it. This is illustrated, with apologies for its grotesqueness, in the following, harrowing example. A father detained by a Guatemalan military group was given a choice: he could rape his teenage daughter or watch a guard rape her. He chose the latter. After this he was forced to rape her himself. Steven M. Southwick and Dennis S. Charney, who report this in their book, *Resilience: The Science of Mastering Life’s Greatest Challenges*, state that finding meaning for some people after such an unbearable event is just to retain “a modicum of sanity.”³⁸ As these authors

imply, there may be some meaning even in this, but, we might ask, what if the father had refused and chosen death over harm to his daughter? Both may have survived, but at what cost?

These last two examples are horrific. My only reason to include them, with apologies, is that they suggest why patients and loved ones may, if they are able find meaning in their careproviders' offer to share what they feel, be able to continue to be able to bond with their careproviders, and find benefit in those relationships, although some "choices" such as the ones posed here are brutal and murder the soul.

CONCLUSION

In this article I have pursued a resolution that may be impossible: for patients and loved ones to feel bonded with their careproviders, and not abandoned when they are turned down for a medically warranted intervention that they need or want. Logically, the allocation decision may seem justifiable, but it still may be a decision that they emotionally can't accept. Perhaps they never will. Still, if careproviders share the feelings of helplessness that they too may feel, bonding may be possible.

I have discussed whether careproviders should warn patients that a treatment may be denied; that careproviders could work to improve patients' access to treatments in "normal" times; and whether careproviders might be able to acknowledge their lack of capacity to "take home" patients' suffering. In regard to the last topic, I suggested that careproviders may be able to relieve their stress by changing whether they treat or triage patients, and that doing this may benefit patients as well as themselves.

My core point, though, has been that careproviders may try, when they feel they must turn patients down, to take additional measures, in the hope that it may help patients and loved ones to continue to bond with them, to go through the steps together, side by side. The chief intervention I suggested is to offer to share their own feelings with patients and loved ones. Patients, loved ones, and careproviders may all feel helpless, although in wholly discrepant degrees. Merely making the offer to share their feelings may plausibly connote that they still care.

The attitudinal framework, to quote Frankl, that underlies this intervention is, in some ways, radically different from the one many careproviders may subscribe to now. This new frame-

work is that careproviders can be allies of patients and loved ones in facing obstacles that none of them can overcome, rather than for careproviders to keep their distance, since they are better off.³⁹ As Semrad put it, "We're just big messes trying to help bigger messes, and the only reason we can do it is that we've been through it before and have survived."⁴⁰

NOTES

I thank Norman Quist for numerous insights he gave me on this article.

1. P. Ritwik, K.K. Patterson, and E. Alfonzo-Echeverri, "What Is Best for the Child? Pediatric Dental Care during COVID-19," in this issue of *The Journal of Clinical Ethics* 32, no. 3 (Fall 2021).

2. E.M. Magnan et al., "When Physicians Say No: Predictors of Request Denial and Subsequent Patient Satisfaction," *Journal of the American Board of Family Medicine* 33, no. 1 (January 2020): 51-8; D.A. Paterniti et al., "Getting to 'No': Strategies Primary Care Physicians Use to Deny Patient Requests," *Archives of Internal Medicine* 170 (2010): 381-8.

3. D.T. Ozar, "Learning about Professional Ethics from Inter-Professional Dialogue," in this issue of *The Journal of Clinical Ethics* 32, no. 3 (Fall 2021).

4. D.T. Ozar, "Is It Ever Ethical for an Organization to Pressure Professionals to Violate Their Professions' Ethical Minimums?" *International Journal of Ethical Leadership* 7, no. 6 (2020): 80-8, 81.

5. R.M. Veatch, "The Sources of Professional Ethics: Why Professions Fail," *Lancet* 373, no. 9668 (21 March 2007): 1000-1, 1001; R.S. Crawshaw, B.A. Foster, M. Iles-Shih, and M.J. Stull, "The Uses of Medical Oaths in the Twenty-First Century," *Pharos Alpha Omega Alpha Honor Medical Society* 79, no. 2 (Spring 2016): 20-5, 24.

6. Ozar, "Is It Ever Ethical," see note 4 above.

7. "Kimberlé Crenshaw on Intersectionality, More than Two Decades Later," *Columbia Law School Stories and News*, 8 June 2017; *The Intersectional Approach: Transforming the Academy through Race, Class, and Gender*, ed. M.T. Berger and K. Guidroz (Chapel Hill, N.C.: University of North Carolina Press, 2009); A. Carastathis, "The Concept of Intersectionality in Feminist Theory," *Philosophy Compass* 9, no. 5 (May 2014): 304-14.

8. U.C. McMyler and S. Prymachuk, "Do 'No-Suicide' Contracts Work?" *Journal of Psychiatric Mental Health Nurse* 15, no. 6 (August 2008): 512-22; V. Saigle and E. Racine, "Ethical Challenges Faced by Healthcare Professionals Who Care for Suicidal Patients: A Scoping Review," *Monash Bioethics Review* 35, no. 1-4 (July 2018): 50-79.

9. J.M. Glasgow, K. Vaughn-Sarrazin, and P.J. Kaboli, "Leaving Against Medical Advice (AMA): Risk of 30-Day Mortality and Hospital Readmission," *Journal of General Internal Medicine* 25, no. 9 (Septem-

ber 2010): 926-9.

10. R.A. Borracci, G. Ciambone, and J.M.A. Gallesio, "Correlation Between Moral Courage Score and Social Desirability Score of the Medical Residents and Fellows in Argentina," *Journal of Educational Evaluation for Health Professions* 17 (January 2020): 6.

11. H. Schmidt, "Vaccine Rationing and the Urgency of Social Justice in the Covid-19 Response," *Hastings Center Report* 50, no. 3 (May 2020): 46-9.

12. S. Fink, *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital* (New York: Crown, 2013).

13. *Ibid.*

14. M.I. Good, "Elvin V. Semrad (1909-1976): Experiencing the Heart and Core of Psychotherapy Training," *American Journal of Psychotherapy* 63, no. 2, (2009): 183-205, 199.

15. *Ibid.*, 199.

16. J. Haidt, "Comment," in S. Wolf, *Meaning in Life and Why it Matters* (Princeton, N.J.: Princeton University Press, 2010), 92-101, 98, citing H.R. Markus and S. Kitayama, "Culture and the Self: Implications for Cognition, Emotion, and Motivation," *Psychological Review* 98 (1998): 224-53.

17. L. Collier, "Is It OK to Cry? Patients aren't the only ones to tear up during therapy—sometimes therapists do, too," *APA.org*, January 2016. I wish to thank Norman Quist for pointing out to me many times how interventions that are well-meant may be misconstrued or even be delivered perfunctorily as clichés.

18. D.B. White and B. Lo, "A Framework for Rationing Ventilators and Critical Care Beds during the COVID-19 Pandemic," *Journal of the American Medical Association* 383, no. 18 (12 May 2020): 1773-4; A.B. Cooper et al., "Scarcity: The Context of Rationing in an Ontario ICU," *Critical Care Medicine* 41, no. 6 (June 2013): 1476-82.

19. L.J. Fallowfield, V.A. Jenkins, and H.A. Beveridge, "Truth May Hurt but Deceit Hurts More: Communication in Palliative Care," *Palliative Medicine* 16, no. 4 (July 2002): 297-303.

20. T. Patnaik, "Defense Mechanisms," <https://www.psychologistworld.com>.

21. D.H. Como, L.D. Stein, J.C. Polido, and S.A. Cermak, "Oral Health and Autism Spectrum Disorders: A Unique Collaboration between Dentistry and Occupational Therapy," *International Journal of Environmental Research in Public Health* 18, no. 1 (December 2020): 135; see also J.L. Elmore, A.M. Bruhn, and J.L. Bobzien, "Interventions for the Reduction of Dental Anxiety and Corresponding Behavioral Deficits in Children with Autism Spectrum Disorder," *Journal of Dental Hygiene* 90, no. 2 (April 2016): 111-20.

22. AMA Education Consortium, *Health Systems Science*, ed. S.E. Skochelak and R.E. Hawkins (Philadelphia, Penn.: Elsevier, 2017).

23. *Ibid.*, 143; D.B. White and B. Lo, "Mitigating Inequities and Saving Lives with ICU Triage during the COVID-19 Pandemic," *American Journal of Res-*

piratory Critical Care Medicine 203, no. 3 (1 February 2021): 287-95.

24. AMA Education Consortium, *Health Systems Science*, see note 22 above, p. 142.

25. R.D. Truog, C. Mitchell, and G.Q. Daley, "The Toughest Triage—Allocating Ventilators in a Pandemic," *New England Journal of Medicine* 382, no. 21 (21 May 2020): 1973-5, 1974; D. Sperling, "Ethical Dilemmas, Perceived Risk, and Motivation among Nurses during the COVID-19 Pandemic," *Nursing Ethics* 28, no. 1 (February 2021): 9-22.

26. K.J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53, no. 5 (1963): 941-73, 949.

27. S. Camporesi and M. Mori, "Ethicists, Doctors and Triage Decisions: Who Should Decide? And On What Basis?" *Journal of Medical Ethics* (10 July 2020).

28. V.P. Khazanie and M.H. Drazner, "The Blurred Line between Gaming and Patient Advocacy: Heart Transplant Listing Decisions in the Modern Era," *Circulation* 140, no. 25 (17 December 2019): 2048-50

29. Good, "Elvin V. Semrad," see note 14 above, p. 188.

30. *Ibid.*, 814.

31. J.T. Maltzberger, "Treating the Suicidal Patient: Basic Principles," *Annals of the New York Academy of Science* 932, no. 1 (April 2001): 158-65, 160-1.

32. Good, "Elvin V. Semrad," see note 14 above, p. 192.

33. A.C. Blume-Marcovici, R.A. Stolberg, and M. Khademi, "Do Therapists Cry in Therapy? The Role of Experience and Other Factors in Therapists' Tears," *Psychotherapy* 50, no. 2 (June 2013): 224-34.

34. D. Cejas, "I Have a Disability Too, I Told My Patient," *Medpage Today*, 30 June 2021.

35. Good, "Elvin V. Semrad," see note 14 above, p. 810.

36. L. Havens and N. Ghaemi, "Existential Despair and Bipolar Disorder: The Therapeutic Alliance as a Mood Stabilizer," *American Journal of Psychotherapy* 59, no. 2 (2005): 137-47, 140; Good, "Elvin V. Semrad," see note 14 above, p. 814.

37. V.E. Frankl, *Man's Search for Meaning* (Boston, Mass.: Beacon Press, 2006), 48.

38. S.M. Southwick and D.S. Charney, *Resilience: The Science of Mastering Life's Greatest Challenges* (New York: Cambridge University Press, 2012), 77.

39. R.L. Street, Jr., H. Gordon, and P. Haidt, "Physicians' Communication and Perceptions of Patients: Is It How They Look, How They Talk, or Is It Just the Doctor?" *Social Science & Medicine* 65, no. 3 (August 2007): 586-98; M. Weaver, "The Double Helix: Applying an Ethic of Care to the Duty to Warn Genetic Relatives of Genetic Information," *Bioethics* 39, no. 3 (March 2016): 181-7.

40. Good, "Elvin V. Semrad," see note 14 above, p. 191; F. Wright, "Personal Reflections on Hugh Mullan: Existential Group Therapy," *International Journal of Group Therapy* 62, no. 1 (2012): 23-52, 32.