



Shame as a moral mood in medicine

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Abstract

Background & Aims: The emotional underpinnings that facilitate and complicate the practice of ethical principles like respect warrant sustained interdisciplinary attention. In this article, I suggest that shame is a requisite component of the emotional repertoire than makes respect for persons possible.

Materials & Methods: I use person-centered interview data from a sample of 54 physicians (including 35 surgeons), 60% of whom are women, to examine the emergence and endurance of shame as a mood with moral significance. Drawing on anthropologist Throop's concept of a moral mood, I explore physicians' first-person narratives of the endurance of shame experiences.

Results: Narratives demonstrate that shame inheres in biomedical contexts that reinforce the physician's responsabilization and culpability for events beyond their control. As a persistent cognitive and affective state, mooded shame is a recursive and compulsory motive force for a physician's dynamic evolution as a moral actor.

Discussion: Variably distressing, looming and commonplace, mooded shame becomes an atmospheric and imaginative mode through which physicians contemplate their responsibilities and connections to patients. Sometimes in a hypercognized manner that conceals its emotional roots, physicians link the mood of shame to their incessant efforts to fulfill responsibilities to each unique patient.

Conclusion: I suggest that through reflection made possible within mooded shame, physicians develop a sense of being both accountable to and alongside patients, and I explore the ties between this position and philosophical concepts of respect.

KEYWORDS

affect, moral development, moral obligations, physicians, respect, shame, socialization

1 | INTRODUCTION

As an ethical principle, respect for persons is usually understood to center on autonomy: that individuals are treated as autonomous and entitled to information that supports self-governed decision-making. This definition frames biomedicine as a series of choices¹ and respect as an issue of "responsibility, power, and authorization."^{2(p. S164)} Yet

respect is a broader obligation than autonomy alone, and, as formulated by bioethicist Halpern, is inclusive of the "underlying conditions" and "emotional underpinnings" that shape decision-making.^{2(p. S164)} In this article, I focus on these underlying conditions and, as does philosopher Dillon, consider respect as an attitude and a form of regard: a set of feelings, perceptions, and judgements that together constitute "a mode of attention to and perception and acknowledgement of an object as

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having a certain importance, worth, authority, status, or power."³(p. 202) This article explores how patients, as people and as bodies, become objects of respect for physicians, "things that are worth looking at again, that merit our attention, that demand to be taken seriously."³(p. 203)

I suggest that shame is a requisite component of the emotional repertoire than makes respect for persons possible. I draw on interview data from physicians, primarily surgeons, to examine the phenomenology of physicians' shame in relation to specific clinical situations and over time. Physicians' emotional experiences are more than a matter of individual temperament. They are dynamically shaped and channelled through discourse, relational norms, technical modes of interacting and acting on the body, and other practices and structures.⁴ These multifactorial matrices that shape and reshape emotional possibilities within local biomedical contexts—what can be called affective arrangements⁵—are shot through with shame, with detrimental impact on biomedical actors.^{6,7} Yet I draw on anthropologist Throop's concept of a moral mood⁸ to provide a more ambiguous picture of shame's endurance and impact. As I will show, first-person experiences of shame as a persistent cognitive and affective state are commonplace and compulsory. Moreover, as a mood with moral significance, shame shapes the physician's dynamic evolution as a moral actor, particularly in relation to patients. I detail mooded shame as an atmospheric and intrinsic motivational force for a physician's moral striving, reinforcing and refining physicians' understandings of their connections,¹ culpabilities, and responsibilities in the clinical encounter.⁹

Like many feelings,¹⁰ shame is recognized less by its articulation than through its pattern of cognitive, behavioural, and affective accompaniments. Recognizable responses to shame may not be explicitly labelled as such by the experienter.¹¹ Stolorow¹² describes a family of emotions with shame at its core, including self-hatred, humiliation, mortification, self-consciousness, and others. Shame and guilt, often evoked simultaneously, may be difficult for the experienter to differentiate. Yet if in guilt an act or behaviour of the self is a focus of evaluation, shame is directed against the self.¹¹ In her influential psychoanalytic elaboration of shame, Lewis explains that one can lament in guilt that I have done a terrible thing and in shame that I am a terrible person. Shame positions the whole self as inadequate, unworthy, no good, wrong, diminished, and devalued.^{13–15} The intense hostility toward the whole self in shame "makes it difficult to find a solution short of a sweeping replacement of the self by another, better one."¹¹(p. 429–430)

Shame occurs in relation to the perception of an observing other.¹⁶ Lewis describes shame as "watching thoughts" in which one is consumed with thoughts about what the other is thinking about them, particularly as "a vicarious experience of the significant other's scorn."¹¹(p. 431) Shame is a feeling of presenting to others a self that is an "object of derision:" "unattractive and undesirable, diseased, decayed and injured."¹⁴(p. 211) This preoccupation with others' imagined

perceptions¹⁷ elicits wishes to hide, run away, fall through the floor, or disappear. In addition to a wish to escape the other's gaze,¹⁸ shame entails an acute awareness of the impossibility of invisibility. The devalued, worthless subject is left with "nowhere to be, and yet nowhere to hide or escape."¹⁵(p. 24) Through these processes, shame "separates, segregates, marginalizes and disengages"¹⁴(p. 211) Simultaneously, as a feeling tethering the self to others, shame is irreducibly relational.^{15,19}

Shame has been described as enlarging on itself, what Scheff²⁰ calls continuous loops of shame where one is ashamed of feeling ashamed and thus more ashamed. Mental health clinicians detail various forms of debilitating shame. Chronic shame,²¹ vulnerability to shame (i.e., dispositional shame, shame-proneness),²² and internalized shame comprise an enduring sense of the self as bad that may be reinforced in interaction and perpetuated internally.²³ Toxic shame²⁴ is a form of enduring shame that hampers the individuals' ability to feel anything else.

Separately, scholars have highlighted the potential for shame to further social connection and purposeful action. Sartre discusses shame as a moral emotion by which I learn from the scorn of others that I have transgressed and the means for evaluating my own moral worthiness.²⁵ In making acutely uncomfortable a belief one has become a nonideal self, shame reinforces striving for a good self.²⁶ Shame may bolster a desire to act morally in complex circumstances²⁷ and could be harnessed to further desired social goals.^{28–30} Shame's power reflects the salience of hierarchy, competition, and social position in the constitution of one's sense of self-worth and moral rectitude.¹⁴

The shame that patients may feel within healthcare contexts has far-reaching consequences.^{6,31,32} However, in this article, I focus on the ways in which shame experienced by physicians can impact doctoring. Bioethicists acknowledge that physician affect—anxiety, worry, dread, and other feelings—can impact decision-making.^{33,34} For instance, if poor patient outcomes lead to physician regret, efforts to avoid regret may alter choices.³⁵ Schwarze et al.³⁶ demonstrate that surgeons' feelings may interfere with upholding patient autonomy, such as when a physician feels responsible for an unwanted outcome and is unwilling to give up on the patient's survival. In one study, surgeons told that a patient's complications resulted from surgeon error were significantly less likely to withdrawal support compared to surgeons told the complication was not due to error.³⁷

Responses to these scenarios exceed the individual physician's psychology. They reflect the sociotechnical structures, interpersonal dynamics, and discursive and material conditions that shape affective possibilities in context. These affective arrangements⁵ are often discussed as residues of the physicians' socialization during training.³⁸ Yet physicians' socialization, defined as "the way that people habituate particular means of normative evaluation, within a context that is simultaneously morally imbued and marked by asymmetric power,"³⁹(p. 122) is not limited to periods of training. In her ethnographic study of female surgeons, Cassell identifies surgeons' "paranoia," a perception that everyone is against them, which she links to the surgeon's inability to hide from judgement. As she says,

¹ I borrow Dolezal's (2017) use of the word "connections" to describe commonsense and varied forms of sociality, interpersonal interactions, and feelings of belonging or closeness.



"The surgeon's victory is *attributable*, both doctor and patient know who was responsible; it is also *visible*, it occurs before an audience."^{40(p. 239)} Shame is a common aspect of physician training⁴¹⁻⁴⁴ and may remain long thereafter a means of normalization, exclusion, and disciplining discourse and behaviour.¹⁵

These examples demonstrate that, in medicine, shame is constituted within a context of responsabilization. As a social theory, responsabilization describes the devolution of responsibility for cause and consequence to individuals who may have previously not conceived of themselves as accountable.^{45,46} Responsibilization also describes the circumstance of those who inhabit "structures of responsibility"⁴⁷ who internalize forms of governance of the self that facilitate accountability.⁴⁸ Physicians can be understood as unique subjects of responsabilization, experiencing singular accountability for the patient's life and wellbeing and operating in biomedical structures that assume and propagate responsibility for the patient. Simultaneously structural, intrapersonal, and interpersonal, responsibility is continually made and unmade within sociotechnical contexts⁴⁹ and routinely reinscribed via the "giving and monitoring of the accounts that we and others provide of ourselves, and of our actions."^{48(p. 1)} Shame becomes a disciplinary technique in medicine via responsabilization distributed across people and systems.

Moreover, physicians' shame occurs in contexts where the bounds of responsibility often cannot be cleanly demarcated. These contexts exacerbate what philosophers describe as the problem of moral luck,^{50,51} a circumstance in which moral blameworthiness can be assigned even in the absence of a negligent act.^{52,53} That is, a moral agent can be presumed to have culpability for an untoward event even though the event may not be her fault.^{54,55} As Story and Kenner explain, clinicians "seem to be morally assessable for things that are at least partially outside of their control"^{52(p. 1)} including expected risks and complications, chance events that unintentionally cause harm, and unexplainable outcomes. Though it may appear irrational to assign culpability for events due to chance, it is both defensible^{50,56} and observed in everyday contexts.⁵⁷ We routinely assign blame to the self and others in the absence of clear causal links.

Surgeon Gawande relates a dream that demonstrates interrelationships between responsabilization, moral luck, and shame. Gawande says he was "too guarded to cry" when he encountered his first patient deaths.^{58(p. 7)}

But I dreamt about them. I had recurring nightmares in which I'd find my patients' corpses in my house—in my own bed. "How did he get here?" I'd wonder in panic. I knew I would be in huge trouble, maybe criminal trouble, if I didn't get the body back to the hospital without getting caught. I'd try to lift it into the back of my car, but it would be too heavy. Or I'd get it in, only to find blood seeping out like black oil until it overflowed the trunk. Or I'd actually get the corpse to the hospital and onto a gurney, and I'd push it down hall after hall, trying and failing to find the room where the person used to be. "Hey!" someone would shout and start chasing me. I'd wake up next to my wife in the dark,

clammy and tachycardia. I felt that I'd killed these people. I'd failed.^{59(p. 7)}

Though Gawande labels this a dream of failure, it is more consistent with a scene of shame. The overwhelming mood of the dream is self-reproach. Gawande finds a corpse in his bed, and he would be denounced as a criminal if caught. He desperately struggles to evade exposure by restoring a prior proper state. But his panic accelerates as he finds he is inadequate to the task. He lacks physical strength. What he tries to conceal oozes out as a sticky mess. He cannot find the patient's room. Menacing others shout at him accusingly, close to exposing him.

Gawande did not commit the moral transgressions; he stumbled upon them. He "felt" that he'd killed these people, yet they are dead when he finds them and has no idea how that happened. He nonetheless assumes blame. He feels responsible to clean the mess up, and he makes passionate efforts to do so. Through a story of shame, Gawande's dream communicates an ethical expectation for the physician. Others' problems (especially patients') are yours to manage, and acts outside of your control (an unpredictable body) become your crucible. You may find restoring order impossible and yet compulsively required. Your capacities are likely to be inadequate, but this is no excuse to forego the challenge.

Dreams provide salient insights into mooded shame. For the surgeons I interviewed, mooded shame entails a blurring of the real and the imagined, and of what one knows and feels to be possible. In contrast to acute shame, mooded shame is an atmosphere⁸ that endures and inheres, shaping reflections about ethical dimensions of the self and others²⁵ and about past lapses, present dilemmas, and potential futures. As I elaborate below, shame as a moral mood calls to mind for physicians a specific kind of relationship with a patient: both an intimate connection and a paramount responsibility. This relational position, most fully experienced in fantasy, of being alongside and accountable to the patient, seems a vantage that allows for the possibility of respect. Through mooded shame, one regards the patient anew as meriting attention and demanding to be taken seriously.³

2 | METHODS

This phenomenological exploration of shame and its moral entailments is based on interview data collected from a cohort of physicians approached to explore depression and suicide among physicians.⁵⁹ Purposive snowball sampling was used to locate information-rich informants with a variety of perspectives⁶⁰ and to oversample for female surgeons in male-dominated specialties.⁵⁹ The sample included in these analyses comprises 54 physicians, 35 of whom are surgeons. Sixty percent of the physician informants (34 of 54) are women and 80% of the surgeon informants are women (28 of 35).

I conducted all interviews, one-third in person and two-thirds on the phone. I interviewed one-third of informants more than once. Interviews ranged from 45 to 180 minutes and were minimally structured. I asked all interviewees about a specific surgeon's suicide, psychological challenges of doctoring, mental health stigma, gendered aspects of work, untoward events, and other topics.



Interviews were audiorecorded and transcribed professionally or by the author. I selected thick disguises to hide informants' identities, balancing the need for accuracy with strategies for protecting privacy. Informants were offered the opportunity to edit, anonymize, and confirm the adequacy of privacy protection in data.

A grounded thematic approach was used to analyze data, with an initial phase of open coding that identified common topics (e.g., errors, shame, tenacity, gender, regret, etc.) that were synthesized and distinguished to identify and refine themes and subthemes. I used cross-case comparison, a search for falsifying cases, and triangulation of data to improve rigour.⁶¹ The UCLA Institutional Review Board approved the research protocol.

3 | RESULTS

3.1 | Fantasy and reality in shame

A psychoanalyst describes to me a surgeon's fantasy. When he's in the operating room, he imagines that someone has mounted a camera inside the surgical light over the table. The camera snaps photos every few seconds as he operates, taking high-zoom shots of his surgical field and each action. Every photo, the surgeon tells himself, must show technique of such high quality that it can be used in a surgical textbook. Moved by the mood of incessant pressure evoked, I associate to a fantasy told to me by a female surgeon. For decades into her career, every time she walks into the operating room, she thinks about a hypothetical surgeon down the street who has done the procedure more times than she has, and who really ought to be doing the procedure instead of her.

Alike in their potential to distress and spur vigilance in the surgeon, these two fantasies foreground the surgeon's potential to fall short without asserting any particular lack of competence. Both hinge on an ideal that remains just beyond attainment but also within reach. In this sense, each is fantastical while suggesting a perfectly possible circumstance. As the psychoanalyst summarizes my surgeon's fantasy: "if I were really a moral person, I would refer this patient to someone who's better than me." And, as one surgeon said to me when I shared the other fantasy, "well, that's true; they do put cameras in the lights!" Each fantasy gains poignancy according to its closeness to the real demands and possibilities of the surgeon's work.

Commonly, surgeons I interviewed describe real scenarios that become imbued with imaginative potency, including the means of assuming real-world power. For Jodi, perfect became "part of my theory during residency: nothing will go wrong. On my watch, nothing will go wrong. That was the key, my god, you were more responsible than God. God was allowed to make mistakes, but you weren't."² Perfect was a dream and a particular requirement of female surgical trainees of her generation. Where did you learn you

had to be perfect?, I ask: "I think the women in my residency told me that. I think that the women in my medical school told me that. 'You're going to have to be perfect because everyone is watching and ready to criticize any little mistake you make.'" Though acknowledging its sexism, Jodi is more proud than angry as she reflects on her unwillingness to abide failure, viewing her success in approximating perfection as a desirable trait. Would a patient want anything less?, she asks me. That Jodi recognizes her quest as fantastical does not strip it of its potency: "when I was an intern, I had this recurring nightmare that I was going to be arrested for impersonating a doctor," she tells me. "And I still have feelings like that occasionally. Perpetrating a fraud," she says casually. "I still have certain self-doubts," she says, indicating that her present experience remains in relation to the fantasy of being more perfect than God.

Such fantasies rely on and accentuate the presence of an audience of judging others. Patients both observe and participate: dependent and passive recipients of care who also tenaciously exert a demand for perfection. Marcia, a specialist surgeon a few years out of training, minces no words in calling bringing a patient into the operating room "torture," describing an intense awareness of responsibility. She recalls the first few cases as a new attending surgeon: "You never had this level of responsibility before. And even though you've been literally doing the same thing and the same acuity and maybe technically the same responsibility, in that your hands are doing the same thing, it's totally not the same thing." It is as if not only the surgeon but also the patient has been remade as a new presence once training ends. Her hands perform the same actions in a relational context reshaped *via* responsabilization. An immersion in catastrophic fantasies was a prominent, unavoidable aspect of her experience. She says, "the first few cases I did, afterwards, I literally would sit in the recovery room and just picture every bad thing that could happen and then start feeling like they were happening; you know, just a lot of stress I would say." More than that, her reflection concerns both the patient's body and the whole person: "that's not just being a doctor, but that's just being someone worried about someone who just had surgery." As I show in more detail below, Marcia feels responsible for the body and connected to the person.

3.2 | "It's Vaguer Than That"

The audience for the physician's shame is an omnipresent watcher of every event. Bringing oneself under the gaze of this exacting observer is compulsory, Marcia says, "specifically for all of the sub-specialties that came through general surgery and [for] general surgery, that is how it is." Those who train you teach you to feel accountable for the entirety of the clinical field:

They tell you. You know, just because you're not the anesthesiologist, if the tube doesn't go in right, you know, your attending surgeon looks at you as the trainee and like, "Why did you let that happen? You should have been watching them. You should have," you know, "immediately stopped them if it looked like it wasn't going right, or you should have just done it yourself," even though,

²"For Sartre, the subject's deepest desire is to become like God: a being who exists in-and-for-itself, reconciling the split between subject and object. In shame, however, the subject experiences an "original fall," a "feeling of being finally what I am but elsewhere, over there for the Other."¹⁵(p. 26)



you know, obviously you're not trained to do everything. But, I think among general surgeons, there is a feeling that, you know, you should be able to do everything.

Another female orthopaedic surgeon describes similar lessons from an attending who stalked hospital halls after his duty hours ended, double-checking that everyone else's notes were complete. After seeing that every test had been ordered, he called down to the lab to confirm that every blood sample was in queue; and he confirmed lab results that others had already reported to him.

This training imparts a looming rebuke ("why did you let that happen?") that extends across space, time, and circumstance. Shame can be transformed here into a state of mind, perseverant and lacking an identifiable source. What is it you fear?, I ask Ruth, a urologist. Do you worry that you will do something wrong?, I ask. "No, it's vaguer than that," she responds. "I think there's a lot of just knowing that there are aspects of surgical care that we can't control. So, there is a sense of, 'am I good enough?' but it's also the sense of, 'I may be perfectly good enough and yet there are variables I can't control.'" Like Marcia, Ruth first noticed this experience "I would say pretty much the minute I became an attending." Like Marcia, she connects this experience to a surgeon's responsabilization. During training, "I remember a few times feeling great consternation when things didn't go well but almost all of the time, I felt that it was somebody else's responsibility, fundamentally." She also learned from examples of attendings who did not seem to feel this consternation, noticing what was said "in a disparaging way about some doctors who seem to not at all care," those doctors who "can stack a lot of wood and it doesn't matter to him." She explains the colloquialism: "stacking wood is like stacking up dead bodies." It's not a compliment, she clarifies. "It's black humor, it's the humor of the trenches and the war" where callousness serves as protection. Unlike those who stack wood, Ruth feels her patients' outcomes.

Ruth finds the emotions within the shame family partially appropriate to this experience. She tries not to take these experiences "personally," and I ask what she means by that: "I think I mean all the dimensions that that can conjure. I think it can mean empathy and it can mean sympathy and it can mean putting your own emotions into the picture. It can mean getting closer to your patient, it can mean blaming yourself, and it can be all of those. I don't mean to imply that it's instantly self-blame [that] is the first thing that come to mind, far from it." Ruth continues that "I think I experience it at different levels, some of which are positive. I really care about my patients a lot. I get a tremendous amount of satisfaction from the patient-doctor interactions." I suggest Ruth inhabits a mood of shame. Shame as moodedness occurs in front of a boundless and demanding observer, and it reminds the surgeon that the patient too is watching closely. But it simultaneously feels intimate, and it foregrounds the patient's vulnerability. Matthew, a senior male academic surgeon, similarly suggests that shame experiences intensify and distinguish the contours of the physician's relationship to a patient, telling me that during a procedure in which he began to panic that he was losing control as his patient exsanguinated, his attending "said to me, very calmly and coolly,

he says, 'Matt, just pack the wound and remember it's not your blood. Just stop the bleeding.'"

3.3 | From scenes of shame to mood

Shame as a mood may be more palpable in moments of reflection than during action. Ruth describes its ebb and flow, saying that "I probably feel it the most in terms of, I would say, sort of anxiety, so being up the night before surgery, worrying about it, and to some degree also, intraoperatively." Matthew tells trainees that certain emotional experiences are inherent to the work, that "it's the profession we chose, and this comes with it," likening the experience to a susurrant: "everybody's got these little whispers in their ears." Mark, an anesthesiologist, says of the surgeons he works with "got a result that she was less than happy with, she held herself responsible for that." Surgeons "talk about the loss of sleep at night because they're so worried about how something is going to settle in after surgery and how it's going to heal or how they're going to take care of this problem or this complication.... They take this stuff to heart."

Claire, a gynaecologic surgeon, responds to a question about the pressure of surgery by saying, "Well, listen, it happens. You make mistakes." An incident from "years and years ago" immediately jumps to mind. "I once left a clamp in somebody, we had to go back and get a clamp out, it was a total embarrassment, it was awful, you feel terrible." She continues: "it was a complex case and there were two surgeons, and it was the other guy's clamp that was left, not mine, but I was the last one in, I should have found it. He had left a clamp in the pelvis and I was working in another part of the abdomen ... but I still should have checked." First framed as a story of mistake, in fact Claire had not left a clamp in—another surgeon had—and in a part of the body she was not working in. She continues, reinforcing her culpability while repeating that she did not leave the clamp, but "I still should have checked." Again, "I was the last one in, it should have been my responsibility to check for what was left, just like we check for lap pads and other things. So anyway, it was my responsibility." The surgical team began to discuss who was to blame for the clamp. She wanted to hide but responded as she felt she must: "I was the last one there and I had to own up to it and deal with it." Avoiding blame was actually not an option: "What could I do; everybody knew."

Judy, an internist, answers a similar question about the stress of medicine by telling me, "I almost got thrown out of my residency program, I couldn't take the stress." In the next breath, she says, "I'm not bragging but I'm super-smart, and I'm an excellent internist, I really am," suggesting that her hurdles and skill intertwine. She describes a gaggle of doctors quizzing her after a difficult night:

Once when I was an intern... [on call on the night of] the first snowfall, there's a million heart attacks, so I was the intern in the [Cardiac Intensive Care Unit] and there were literally 8 MIs [myocardial infarctions], and in the morning, I was the intern and then it's a guest resident, and in the morning your other interns and



the resident, the attending comes. And I didn't even have time to make my little pocket notes of which MI and I couldn't keep one patient straight from the other and I just broke into tears, and I went home. "Which MI?," and "Who did I give what to?"

You hadn't slept, I suggest. "Hadn't slept at all and there were so many acutely ill patients and then they put you on the spot, like 'How old was this one? What was his—well, his CPK [lab abnormality in MI],' 'Well, what did his EKG look like? Was he wheezing?'" Judy broke down. "I just burst into tears." As we do from shame, she hid: "I walked out for two, three days."

Both Judy and Claire tell these stories not to share what happened but to explain what happened *next*, for neither disappeared. Judy returned to work and was sent to see a psychologist, which she portrayed as slightly silly; then she met with the chief resident who reassured her she had not needed to flee: "that would put hair on your chest," he told her, framing her morning as a masculine rite of passage. Judy saw through him, too. She became an *excellent internist* herself by transcending the comical circumstance: "I was like, just what I really need is hair on my chest." Judy laughs at her tormentors, while Claire laughs with them. The forgotten clamp became an affectionate inside joke and a shared commitment. "Now we laugh," she says, "about the fact that we count instruments because I left the clamp." The practice of counting instruments before and after a procedure emerged around the same time but, of course, had nothing to do with Claire. "I was embarrassed but people understood. They understand how it happens. What they said behind my back, I don't know, but somehow they still come as patients. They still send their relatives." These narratives highlight shame's fundamental ambivalence¹⁵ as a mechanism of social diminishment and a means of finding solidarity and mastery.

3.4 | Living with mooded shame

Shame as a mood is temporally recursive and atmospheric, a dynamic background that accompanies the responsabilization of the physician's tasks. Its affective contours are not always clear. It may be alternately distressing, a minor annoyance, or a strong empathic pull. Julie, a general surgeon, says, "I know I relive my bad outcomes over and over again." Physician Peter says, "I think we always consider that when we have a bad outcome...we always are a little hard on ourselves and wonder whether we may have somehow caused a bad outcome." Matthew emphasizes accommodation, saying "I think that through our training and socialization we've become somewhat inured to some of these sort of ups and downs of the practice." A plastic surgeon, Jeff, describes an unbidden hyperattention to lapses, saying, "I've done almost 2000 cases now and the vast majority of them, the things are good. Things turn out well, but those are not the ones that are in my mind. They're the ones, I don't know, they just kind of gloss over..... the ones that are in my mind are the ones that things just can get a little bit better. And those are the ones that are in my mind."

Like Ruth, neurosurgeon Nikki uses the language of 'taking less personally' and not 'internalizing' practice problems. She finds the feeling unbounded and challenging to describe:

more kind of the issues like if I had operated sooner, or we had gotten that treatment earlier, you know, those kind of things, the "what ifs." Whenever you're dealing with a patient [who has died] you always wonder, well, what if? What if I got this patient on this treatment and if things would have been different. The answer may have been no, but you had more the doubt and the "what ifs"....[was there] more I could have done.

The mood of shame contains the accompaniments of acute shame—the panic of inadequacy, the burning fear of the others' awareness of one's unworthiness, the inability to escape scrutiny. Mooded shame feels unavoidable and uncontrollable, repetitive and relentless in fantasies that do not answer to the facts on the ground. Nikki's habitual concern about "what ifs" analyzes probabilities and bargains with chance: "luckily, knock on wood, I never had any surgical kind of malpractice issues or anything like that."

I ask Adrienne, an upbeat, accomplished surgeon, whether she'd had an experience of feeling culpable for a patient's bad outcome. "Oh, I feel that all the time." Adrienne describes a shift from a discrete, distressing feeling to a pervading experience that includes a demand for self-improvement. When she was more junior, "I guess I always felt a little more, if there was an error or something like that, a little more like on the defensive." As a senior surgeon, "You've seen lots of errors over the years, things that could happen, and things that are just unpreventable when they happen." Though these events "depress me less now than they used to," she strives for tolerance, not resolution: "I mean, oh, you live with it. I think every physician lives with it." In fact, she intentionally holds focus on it: "Someone dies, you say, 'Hmm, maybe I should have done that, or oh, I didn't realize that was what was going on,' and you learn from it, and you move on. You have to learn, otherwise you would be a basket case." She tolerates: "I feel bad all the time. But, you know, I don't beat myself up about it, but I'm saying, 'I see it,' and I think you have to see it, because then you don't learn. I mean, if you think, 'oh, they would have died anyway,' maybe that's true, but what about the next case? So, that's what you have to, kind of, look at it [*sic*]."

As a moral mood, shame is imbricated with the means of betterment of the self. Adrienne intentionally embraces shame as a reflective mode that spurs improvement. She does so for "the next case:" not for solipsistic ends⁶² but to serve others better. Adrienne's improvised version of reflexive and responsive ethics^{63,64} remakes shame-like feelings into her own philosophy of practice. Similarly, in telling the story of the forgotten clamp, Claire resists my effort to emotionalize the experience. She prefers a philosophical interpretation:

[It's such pressure.] [*matter of fact*] It's mistakes. It happens. [Every day, in a way, you have to start at



square one and prove...] [Claire breaks in] You can't be perfect. There are going to be times when you have to make the best decision you can at the time and go with it and it's not right. There's times, and even when you think you're doing it right, it doesn't work.

Claire's mission statement ("you have to make the best decision you can") conceals its origin in shame, portraying medicine as a series of choices.¹ In its articulation, she seems determined to puncture the fantasy of perfection with tough-minded realism.

At its extreme, remaking shame into a set of moral imperatives obscures its emotional content. Another female surgeon describes a habit of detaching from emotion, again to foreground decision-making. Physicians may not share what they feel "because that's what we're taught. It's like you're there for other people and you can't really...you have to make decisions literally for them and then sometimes you have to live with the decision you make for them, and you learn to separate that." The feelings, posed as oppositional to proper action, are set aside to orient to responsibility: "patients live with my decision, but I also have to live knowing that maybe I did not make the right choice sometimes." Just as Adrienne orients to the "next case," this surgeon feels distress when "my selection was not the right selection.... But you like to separate that because you see one patient, another patient, another patient, another patient...then even though you made these decisions...you still separate them." Shame "always implies self-questioning,"^{63(p. 895)} and in this hyper-cognized form, shame as a moral mood distresses because it *confuses*: an intellectualized ethical demand on the self, a concept of service to others in need, and yet less recognizable as a distressing emotion.

3.5 | "That Heightened State"

Ethical principles and priorities may serve, but they do not resolve feelings. Describing the death of a patient after complications, this surgeon continues, "when I think back, I felt sad, but two minutes later, I move onto the next patient, move onto the next case, I move on," to a new task. She may find "a medical part that's going to be... can be separated" to mull as a lesson, but "maybe after a while you kind of accumulate that and it starts reflecting and all the things, like, 'are you a good physician?, are you good enough?, maybe you're not,' all these things and then you start interpreting maybe other things, additional things in a different light." As Guenther says, "The trouble with shame is that, when it really takes hold of me, I cannot even stand myself."^{17(p. 24)}

This "next case" orientation is not an impersonal one; just the opposite. Like the camera in the light recording for posterity, every instance demands renewed attention and exertion. Marcia elaborates on the next case orientation:

It's like every interaction that you have with patients or whatever makes you, I guess, feel your responsibility to them....And then, you know, after every case,

you always think about it and then you think about the things that you would have done better or whatever. You know, a lot of times you think, "Oh, I wish I had done that. I wish I had done that." I don't know. It's like you think about it and you just feel like, "Ah." I don't know how to describe it because it's still sort of weird to me, but you just always wish you could have done it better.

Unable to name the "weird" feeling, she nonetheless vibrates with the demand: "it's so much of being a surgeon because you can't go back and fix things....Everything is so irreversible. You only had one chance." Ruth, too, can feel lost in mooded shame. I ask what she thinks in the midst of the stress. "Have I earned this?" or "do I know enough?" I offer. She replies, "I think I would probably say small components of all of those, but I don't feel that there's an overwhelming refrain, I think it's just when you have a moment or an interaction that's very stressful, surgical or not, if you need to immediately look to yourself for how you let that happen or how the circumstances made that happen to you."

Jennifer, a gynaecologic surgeon, also struggles to describe this experience, finally summarizing that, "You don't wanna miss something. Something could be bleeding or something. You could put a hole in [sic]. A cancer... 'did I miss this?'" She continues that, "in surgery you're always saying 'should I have done it this way?, did I do this?, did I cause this person to bleed?'" Jennifer says, "Those things"—the contemplation of the work—"put you in that heightened state." Jennifer, Ruth, and Marcia inhabit this heightened state not because they have made a mistake but because they might have, could still, and cannot. As if uncomplicated, Julie says the surgeon's task is "just making sure you understand what you can and cannot do, making sure you do the best you can, making sure that you prepare and have it the best you can be." Recall that Nikki also knocks on wood.

Mooded shame feels compulsory because these surgeons find no sustainable state of being free of connections to others. Indeed, Marcia says she "can't imagine that the torture is ever going to completely go away," precisely because there is nothing impersonal or routinized about it. "I mean, every single patient is so different and sometimes terrible things happen no matter what, and you see that happening to the most experienced surgeons also. You see them feel tortured, you know. And that's just, I think, part of the job and why it's meaningful." In her ethnographic study of moral luck, Kuan says the act of taking responsibility "will be an involuntary rather than voluntary matter" where people have "friends, family, lovers, and projects they care deeply about."^{65(p. 171)} More specifically, Kuan posits a form of momentary merging with the one in need, just as Matthew needed to be reminded the blood in the abdomen was not his own. Where one is tasked with managing the other's catastrophe, "the interest of the other is already an interest of her own."^{65(p. 171)} As Marcia says, if there were no discomfort involved, "well, then you wouldn't be doing something that had so much impact potentially."

4 | DISCUSSION

This phenomenological exploration of mooded shame demonstrates the persistence among these physicians of a cognitive and affective state that shares features of shame, but as a moral mood, becomes an atmospheric, shifting, and looming force that shapes reflections about connections and responsibilities to patients. Real and imagined affective experiences endure in the moral mood of shame, constituting a background that animates improvement. A connection to the patient precedes and is transformed in the mood of shame. Sometimes in a hypercognized manner that conceals its emotional roots, physicians link the mood of shame to their incessant efforts to fulfill responsibilities to each unique patient. The dynamics of these states are not similar to self-enlarging loops of shame, internalized and recurrent shame, or temperamental perfectionism. States of mooded shame allow the self to reflect about and prepare to meet moral commitments to others to create a hoped-for future. If acute shame leads the self to imagine itself inadequate, shame as a moral mood allows the self to be made good.

These data come from a small sample of primarily female surgeons, and they may not describe the shame experiences of all physicians. Moreover, gender may impact experiences of shame and others' reactions to shameful experiences;¹⁷ these data do not address this. Nonetheless, these data indicate the salience of a growing body of scholarship that attends to the impact of emotion on biomedical practice. Such scholarship contends with what Paddington calls the emotional sanitization of medicine,⁶⁶ biomedical actors' tendency to discourage or short-circuit emotional expression. These data demonstrate that biomedical discourse can obscure feeling states and that some physicians retain a sense that emotions are antithetical to proper practice. Some interviewees seem less comfortable focusing on feelings than on what Kuan calls "the hyperhermeneutic search for the causes, reasons, or intentions that have given rise to an unfortunate event."^{3(p. 37)}

Simultaneously, recent attention to emotion in medicine sometimes seems to reinforce emotional sanitization, such as by framing negative experiences like shame, depression, anger, or emotional exhaustion as hazardous conditions to be avoided. Taking seriously the data above, it is hard to imagine medicine without shame. Looking after others depends on a capacity to feel and respond in ways that do not distill to choices, and the body surprises, resists, and dies in ways that cannot be forgotten.^{1,57} Moreover, emotional experiences have dynamism and temporality unique to the individual. For Throop, moral moods represent residues of emotional experiences, fusing the self with its social and material world in dynamic ways that allow emotive reflections to take form. Throop specifies that moral moods often contain an element of return: a view toward the past, including moral failings, allowing re-examination of present problems in ways that shape a vision of "what the future should ideally entail."^{10(p. 66)} As Claire and Judy contemplate old scenes of shame, they reinhabit the past while engaging with present worries, and they spur themselves to vigilance for the next case.⁶⁷

Shame is a piece of the affective arrangements that make respect for persons possible. I suggest a reflective vantage where one feels accountable to and alongside the patient creates the possibility of respect; Ruth proposes stacking wood as the anti-ideal. As Dillon says, "to ignore, disregard, or be oblivious to something, [or] to dismiss lightly or carelessly...is to not respect it."^{5(p. 203)} Physicians come to see patients as objects that demand to be taken seriously and thus treated meticulously. These surgeons tell me the countless ways the patient constrains their attitudes and actions, and they acknowledge that every single "next case" must be accorded her due.³ Cutting in error, missing something important, and choosing incorrectly must forever be avoided. Doing one's best, including by preparing and focusing for each scenario, is also required. Philosopher Darwall theorizes that respect for persons means the patient has the authority to make a demand, and the "authority to demand implies, not just a reason for the addressee to comply, but also his being accountable for doing so."^{68(p. 45)}

But these data also demonstrate that through mooded shame physicians come to feel strongly connected to patients. "Taking this stuff to heart," as Mark frames it, seems an additional component of respect for persons. Darwall says that conferring respect requires granting the other the "standing of an equal," for only where the physician assumes the possibility of reciprocity would the patient have the authority to make demands.^{68(p. 43)} Above I reference Kuan's formulation of a temporary merging with the one in need, which she further elaborates as an intimate attunement to another who is not entirely other.⁵⁷ Dolezal theorizes shame as "intimately connected with bodily vulnerability" such as the physical dependence on others we all experience developmentally.^{27(p. 435)} In Marcia's experience of mooded shame, I hear a recognition of shared vulnerability to death and disease. She worries about how a wound will heal because she was trained to do so, and she worries about a person who just had surgery because she is also a person. Shame demonstrates that others matter to us,²⁵ and its endurance grants physicians a mode of closeness with patients because we acknowledge that the clinic is the place we all go. Thus, it is not only being accountable to but also alongside—alike and feeling with—the patient that allows respect for persons. In this sense, shame as a moral mood marks the shared predicaments of patient and physician: living within a body, needing others, and trying to live a good life despite the corpses we find in our houses.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

**DATA AVAILABILITY STATEMENT**

Research data are not shared.

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REFERENCES

- Mol A. *The logic of care: health and the problem of patient choice*. Routledge; 2008.
- Halpern J. Creating the safety and respect necessary for "shared" decision-making. *Pediatrics*. 2018;142(Suppl_3):S163-S169.
- Dillon RS. Respect: a philosophical perspective. *Gruppe Interaktion Organisation Zeitschrift für Angewandte Organisationspsychologie (GIO)*. 2007;38(2):201-212.
- Arnold-Forster A. 'A small cemetery': death and dying in the contemporary British operating theatre. *Med Humanit*. 2020;46(3):278-287.
- Slaby J, Muhlhoff R, Wushner P. Affective arrangements. *Emotion Rev*. 2019;11(1):3-12.
- Lyons B, Dolezal L. Shame, stigma and medicine. *Med Humanit*. 2017;43(4):208-210.
- Bowman D. Vulnerability, survival and shame in Nina Raine's Tiger Country. *Med Humanit*. 2017;43(4):264-268.
- Throop CJ. Moral moods. *Ethos*. 2014;42(1):65-83.
- Parish SM. Between persons: How concepts of the person make moral experience possible. *Ethos*. 2014;42(1):31-50.
- Yarns BC, Bromley E. Communicating about feelings: examples from depression care. *Improving Communication in Mental Health Settings*. Routledge; 2021:140-157.
- Lewis HB. Shame and guilt in neurosis. *Psychoanal Rev*. 1971;58(3):419-438.
- Stolorow RD. The shame family: an outline of the phenomenology of patterns of emotional experience that have shame at their core. *Int J Psychoanal Self Psychol*. 2010;5(3):367-368.
- Lester D. The role of shame in suicide. *Suicide Life-Threat Behav*. 1997;27(4):352-361.
- Gilbert P. Shame and the vulnerable self in medical contexts: the compassionate solution. *Med Humanit*. 2017;43(4):211-217.
- Guenther L. Shame and the temporality of social life. *Cont Philos Rev*. 2011;44(1):23-39.
- Bero S. The audience in shame. *Philos Stud*. 2020;177(5):1283-1302.
- Johnson EL, Moran P. *The female face of shame*. Indiana University Press; 2013.
- Kilborne B. Fields of shame: anthropologists abroad. *Ethos*. 1992;20(2):230-253.
- Zahavi D. Shame and the exposed self. In: Webber J, ed. *Reading Sartre: On Phenomenology and Existentialism*. Routledge; 2011:211-226.
- Scheff TJ. *Introduction: Shame and related emotions: An overview*. Vol 38. Sage Publications; 1995:1053-1059.
- DeYoung PA. *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*. Routledge; 2015.
- Leeming D, Boyle M. Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychol Psychother: Theory, Res Pract*. 2004;77(3):375-396.
- Kaufman G. *The psychology of shame. Theory and Treatment of Shame-Based Syndromes*. Springer; 1989.
- Zupancic MK, Kreidler MC. Shame and the fear of feeling. *Perspect Psychiatr Care*. 1999;35(2):29-34.
- Dolezal L. Shame, vulnerability and belonging: reconsidering Sartre's account of shame. *Hum Stud*. 2017;40(3):421-438.
- Lindsay-Hartz J, De Rivera J, Mascolo MF. Differentiating guilt and shame and their effects on motivation. 1995.
- Morgan M. *On Shame (thinking in action)*. Routledge; 2011.
- Jacquet J. *Is Shame Necessary?: New Uses for an Old Tool*. Vintage; 2016.
- Brown-Johnson, CG, Prochaska, JJ. *Shame-Based Appeals in a Tobacco Control Public Health Campaign: Potential Harms and Benefits*. Vol 24. BMJ Publishing Group Ltd; 2015:419-420.
- Bayer R. Stigma and the ethics of public health: not can we but should we. *Soc Sci Med*. 2008;67(3):463-472.
- Dolezal L, Lyons B. Health-related shame: an affective determinant of health? *Med Humanit*. 2017;43(4):257-263.
- Dickerson SS, Gruenewald TL, Kemeny ME. When the Social Self Is Threatened: Shame, Physiology, and Health. *J Pers*. 2004;72(6):1191-1216.
- Kontos N, Freudenreich O, Querques J. Beyond capacity: identifying ethical dilemmas underlying capacity evaluation requests. *Psychosomatics*. 2013;54(2):103-110.
- Hardy C. *A Phenomenological Approach to Clinical Empathy: Rethinking Empathy within its Intersubjective and Affective Contexts*. Dissertation. University of South Florida; 2017.
- Hemmerich JA, Elstein AS, Schwarze ML, Moliski EG, Dale W. Risk as feelings in the effect of patient outcomes on physicians' future treatment decisions: a randomized trial and manipulation validation. *Soc Sci Med*. 2012;75(2):367-376.
- Schwarze ML, Redmann AJ, Brasel KJ, Alexander GC. The role of surgeon error in withdrawal of postoperative life support. *Ann Surg*. 2012;256(1):10-15.
- Pecanac KE, Kehler JM, Brasel KJ, et al. It's big surgery: preoperative expressions of risk, responsibility, and commitment to treatment after high-risk operations. *Ann Surg*. 2014;259(3):458-463.
- Bandini J, Mitchell C, Epstein-Peterson ZD, et al. Student and faculty reflections of the hidden curriculum. *Am J Hosp Palliat Care*. 2017;34(1):57-63.
- Guhin J, Calarco JM, Miller-Idriss C. Whatever happened to socialization? *Annu Rev Sociol*. 2021;47:109-129.
- Cassell J. On control, certitude, and the "paranoia" of surgeons. *Cult, Med, Psychiatry*. 1987;11(2):229-249.
- Rose A. Shame-to-cynicism conversion in The Citadel and The House of God. *Med Humanit*. 2021;47(2):219-227.
- Bynum WE, Goodie JL. Shame, guilt, and the medical learner: ignored connections and why we should care. *Med Educ*. 2014;48(11):1045-1054.
- Brooks JV, Bosk CL. Bullying is a systems problem. *Soc Sci Med*. 2013;77(C):11-12.
- Hautz WE, Schröder T, Dannenberg KA, et al. Shame in medical education: a randomized study of the acquisition of intimate examination skills and its effect on subsequent performance. *Teach Learn Med*. 2017;29(2):196-206.
- Trnka S, Trundle C. Competing responsibilities: moving beyond neoliberal responsabilisation. *Anthropol Forum*. 2014;24(2):136-153.
- Barnes B. *Understanding Agency: Social Theory and Responsible Action*. Sage Publications; 2000.
- Ferguson J. Structures of responsibility. *Ethnography*. 2012;13(4):558-562.
- Power M. *The Audit Society: Rituals of Verification*. OUP; 1997.
- Taylor-Alexander S. Unmaking responsibility: patient death and face transplantation. *Curr Anthropol*. 2016;57(4):511-516.
- Chinnery A. On moral luck and nonideal moral education. *Educ Theory*. 2015;65(2):169-181.
- Pritchard D. Moral and epistemic luck. *Metaphilosophy*. 2006;37(1):1-25.
- Story D, Kenner C. Moral luck in team-based health care. *Nursing Philosophy*. 2021;22(1):e12328.
- Domsy D. Tossing the rotten thing out: eliminating bad reasons not to solve the problem of moral luck. *Philosophy*. 2005;80(4):531-541.

54. Williams B. *Moral Luck: Philosophical*. Cambridge University Press; 1981:1973-1980.
55. Nagel T. Moral luck. *Mortal Questions*. 1979. Cambridge University Press; 1979:31-32.
56. Peels R. A modal solution to the problem of moral luck. *Am Philos Q*. 2015;73-87.
57. Kuan T. The problem of moral luck, anthropologically speaking. *Anthropological Theory*. 2017;17(1):30-59.
58. Gawande A. *Being Mortal: Medicine and What Matters in the End*. Picador; 2014.
59. Bromley E. Uncertainty, bewilderment aversion, and the problem of physician suicide. *Curr Anthropol*. In press.
60. Creswell JW. *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. Sage Publications; 2013.
61. Ryan GW, Bernard HR. Techniques to identify themes. *Field Methods*. 2003;15(1):85-109.
62. Just D. From guilt to shame: Albert Camus and literature's ethical response to politics. *MLN*. 2010;125(4):895-912.
63. Uebel M. Dirty rotten shame? The value and ethical functions of shame. *J Human Psychol*. 2019;59(2):232-251.
64. Waldenfels B. Responsive ethics. In: Zahavi D *The Oxford Handbook of Contemporary Phenomenology*. Oxford Handbook Online; 2013.
65. Kuan T. Vicarious responsibility and the problem of 'too much': moral luck from the perspective of ordinary ethics. *Monist*. 2021;104(2):168-181.
66. Paddison CA. Moral distress amongst physician trainees: reflections on the emotional sanitization of medicine. *J Gen Intern Med*. 2016;31(5):462.
67. Throop CJ. Being otherwise. *Moral engines: exploring the ethical drives in human life*. Vol 5. Berghahn Books; 2017:61-82.
68. Darwall S. Respect and the second-person standpoint. *Proc Address Am Philos Assoc*. 2004;78(2):43-59.

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