



Mediating Bioethical Disputes

Time to check the patient's pulse?

By Jerry P. Roscoe and Deirdre McCarthy Gallagher



The AMA estimates that the timing of 70 percent of deaths occurring in the acute unit of long-term-care facilities is a consequence of negotiation rather than natural causes.¹ However, direct patient involvement in the negotiation may be minimal if the patient is incapacitated. This raises the question: death negotiated by whom?

In fact, the negotiation often includes other stakeholders. There are family members and the medical team. There are also the courts, considered by many to be ill-suited to the task of directing end-of-life treatment decisions.² When negotiations among these stakeholders generate impasse, mediation is often considered.

The use of mediation in bioethical disputes has been encouraged. But the potential of mediation in this arena has yet to be realized, possibly due to an unlikely obstacle: the hospital ethics committee. Though the links between ethics committees and dispute resolution have been routinely endorsed, there are actually substantial and critical differences between the processes of ethics committee consultation and mediation.

Neutrality, participation and communication

The first difference is neutrality. The power of mediation rests on the neutrality and impartiality of the mediator who guides the process. In contrast, the power of the ethics committee rests on its ties to the institution, which serves as the primary source for committee mem-

bers. This institutional taint fuels the concern that ethics committees lack neutrality and are provider-focused.³

The second difference is participation. Mediation is, by definition, a participatory process. Parties, not the mediator, serve as the decision-makers in a mediation. Thus, party participation in the mediation is critical to crafting an agreement.

The ethics committee process may not be as participation-oriented. Due to their ready access to institutional resources, personnel and information, ethics committees may not need to consult patients or their representatives to render decisions about a course of treat-

ment.⁴ While an ethics committee may render a decision in a treatment dispute, the process to reach this decision can be exclusive.

may not consult the patient or his family. In reporting its decision, the committee generally targets the medical team and the hospital administration.⁶

Ethics committee adjudications, though involving patients, may even undermine communication. Some argue that the nature of the positional process exacerbates the conflict and further jeopardizes the trust relationship between the patient or his family and the physician.⁷

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Additionally, ethics committee efforts, presented as quasi-mediative⁸, can crowd out the use of mediation. The effect on the patient is considerable, for mediation is a mechanism which has the potential to keep the patient involved if

ment.⁴ While an ethics committee may render a decision in a treatment dispute, the process to reach this decision can be exclusive.

The third difference is communication. In mediation, communication is a procedural tool and, often, a substantive outcome. Procedurally, the mediator employs communication tools of reframing, reflecting and active listening to assist parties in achieving a mutually acceptable agreement. This process may encourage the substantive outcome of enhanced communication between parties.

Communication is not as instrumental to the ethics committee process. Often, physicians initiate the request for committee review of a case.⁵ In rendering its decision, the committee may or

the patient is competent. Disentangling the mediation model from the ethics committee efforts is the first step toward realizing this potential.

Power imbalances, patient autonomy

The application of mediation to bioethical disputes has generated substantial criticism and concerns. One overarching criticism of the mediation process is that it cannot account for the power disparity between the parties to a bioethical dispute.

Skeptics contend that any mediation outcomes would be tainted in favor of the well-educated and institutionally well-connected physician over the patient or patient's family.⁹ Competent mediators, however, are generally well-equipped to

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deliver a neutral process despite power imbalances.

Ultimately, through the mediation process, control over the conversation about a patient's treatment may shift from the hands of the physician to the hands of the mediator.¹⁰ Due to this shift in control, critics contend that physicians will be reluctant to participate in mediation.

This criticism overlooks the fact that in a mediation, the physician does not relinquish control over outcome. As a party to the process, the physician will help to craft any resolution that is reached. The mediator could employ techniques to assist the physician in understanding that the likely alternative to non-participation in a mediated process is litigation. Given these choices, the physician may be more inclined to engage in the mediation.

Another concern is that the mediation process cannot account for or manage the strong emotions accompanying end-of-life treatment decisions.¹¹ While conflicts over end-of-life treatment decisions are unique, the application of mediation to other high-emotion disputes can be informative. For instance, mediation has been successfully employed in divorce and custody disputes and victim offender dialogues.

Admittedly, mediation may be ineffective in situations where the emotional stalemate is motivated by conflicting moral beliefs about life and death.¹² If a physician believes that treatment should be terminated and a family believes that life should be preserved regardless of the quality, then mediation may not resolve the dispute. However, the process of mediation may still be useful in containing conflict escalation and narrowing the issues in dispute.

Another concern is that the interests of the incapacitated patient will not be protected in a mediation process.¹³ One argument is that mediators may not be qualified to identify and enforce the legal rights and duties of patients in end-of-life treatment disputes. Procedurally, this can be addressed in two ways.

First, if the mediator does understand the legal constraints, then she can employ the tool of reality-testing to communicate these constraints in a non-

biased way. Second, if the mediator feels that this approach compromises her neutrality, or that she does not understand the relevant law, then the mediator could provide an expert to educate the parties about the legal constraints in the end-of-life arena.

The counter argument to the charge that mediation will not protect the incapacitated patient is also legally supported. In involving the family in decision-making, the mediation process follows the lead of states, hospitals and courts in relying on those who are perceived as most capable of making decisions for incapacitated patients.¹⁴

Though logical, this simplistic argument sidesteps the challenge of whether mediation, unlike other mechanisms, could protect and preserve patient autonomy in the area of consent. Settling

parties to the mediation¹⁷ or as experts on medical and ethical issues.¹⁸ Incorporation of any of these models risks institutionalizing the role of the ethics committee in the mediation model and displacing the patient in decisions about his treatment.

The proposal for a new, patient-oriented mediation model is informed by established principles of mediation, and the lessons learned through the ethics committee experience. Mediator neutrality provides the foundation of this model. While the ethics committee has been suggested as a natural home for a mediation program, the history, experiences, and perceptions of the committee could inevitably taint the validity of the process. To ensure the unchallenged neutrality of process, the new mediation model must be independent

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on a mediation process that negates the role of the incapacitated patient will not answer this challenge. The mediation model must be reexamined and reformulated to meet the unique challenge posed by bioethical disputes.

Shifting the focus

The mediation models that have been proposed to address conflicts of consent are overwhelmingly located within the institutional context. Mary Best West and Joan McIver Gibson's 1992 proposal recommended training ethics committee members to act as shuttle facilitators or small-and-large-group mediators for ethical disputes.¹⁵ Another proposal involved the identification of an ethics committee member to educate parties about the relevant ethical considerations and direct a mediation outcome consistent with relevant ethical principles.¹⁶

Even those proposals that recommend neutrals as mediators involve ethics committee members, either as interested

from the institution, the medical team and the family.¹⁹

Many will likely challenge the effectiveness of so-called independents as mediators. Will an outside mediator, unfamiliar with the hospital context and, perhaps, the ethical disputes at issue, be effective? Making available a roster of health-care mediators, rather than general mediators, could dispel some of these concerns. Making available a roster of internal and external experts might also address this issue.

But the role of the mediator provides the most powerful rationale. The mediator is a process guide, not an expert decision-maker or dispenser of medical opinions. The mediator's role is to provide parties — the true experts — the space to communicate their concerns and work together to reach a mutually agreeable resolution to their dispute.

Another important characteristic of this model is inclusion. To provide an effective alternative to patients, families,

physicians and hospitals in conflict over treatment decisions, the new mediation model must be inclusive.

Interestingly, this proposed model, rather than stripping physicians of a role in the process, provides a more substantive role for physicians than the typical ethics committee consult. For the inclusive mediation process will provide the space for doctors to express their responses to and concerns about family and patient treatment decisions.²⁰

One benefit of providing this opportunity is that "health care providers may not feel compelled to practice 'defensive medicine,' which tends to bypass the interests of patients and family members in order to reduce the possibility of liability exposure for health care providers."²¹

The proposed model also creates a seat at the table for patients' families, both as representatives of the patient and as entities affected by the life-and-death treatment decision for a loved one. Though the family values that affect the decision on treatment may be intertwined with the patient's values, the family is contending with different issues than the patient. Thus, just as physicians should have the opportunity to voice their thoughts and concerns, families, too, should have the opportunity to articulate their interests and concerns.

Finally, the proposed model creates a symbolic seat at the table for the patient whose treatment decision lingers in the gray area of consent. Mediation may provide a process to consider the interests and concerns of the medical team, the family and, most importantly, the patient.

Limitations

Undeniably, this proposed mediation model will not provide a panacea for end-of-life treatment disputes. Mediation is simply not appropriate for every dispute. For example, mediation cannot provide a forum to resolve a scientific question about whether the treatment requested or offered is medically feasible.

Similarly, if legal or moral considerations demand that a decision be imposed on one or all of the parties, then the mediation model's interest-based approach

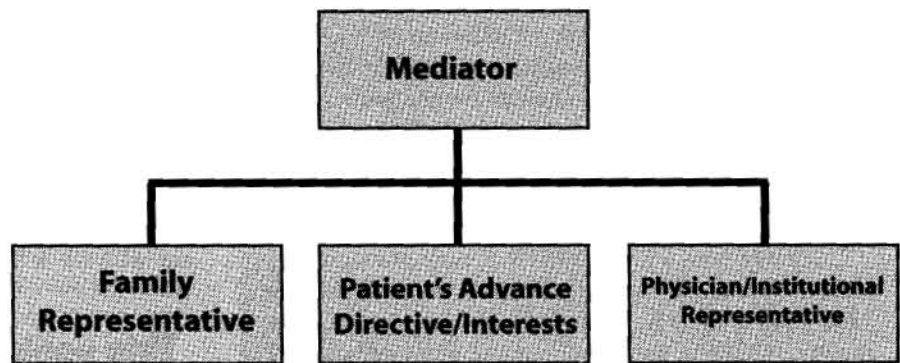
may be irrelevant. While the process could assist parties in understanding the rationale for proceeding in a certain way, the limits of the process must be acknowledged and disclosed.

The mediation model proposed above is simple. It requires an independent, neutral mediator. It requires participation from the physician, the family and, most importantly, symbolic participation by the patient.

Some may dismiss the model as cumbersome or inoperative. Yet, "when

it comes to the all-important human dimension of medical care, there is only one informed consent that counts:" the patient's.²²

The mechanisms currently in place do not always uphold patient autonomy. The proposed model may provide another option, another opportunity to ensure that patient autonomy is preserved and protected through a decision-making process directed by those most affected by treatment decisions — the patients.



Endnotes

¹ Nancy Neveloff Dubler & Leonard J. Marcus, *Mediating Bioethical Disputes: A Practical Guide 2*, UNITED HOSPITAL FUND OF NEW YORK, PRACTICAL GUIDE SERIES (1994).

² See Thomas Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329, 343 (1999).

³ Diane E. Hoffman, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 847 (1994).

⁴ Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End of Life Treatment Disputes to Prevent Erosion of Patient-Physician Relationship*, 79 B.U. L. REV. 1091, 1117-18 (1999) (examining the arguments raised by Law Professor Diane E. Hoffman.)

⁵ See Hoffman, *supra* note 3, at 843.

⁶ *Id.*

⁷ See Gatter, *supra* note 4, at 1095.

⁸ *Id.* at 1117-18.

⁹ *Id.* at 1099.

¹⁰ *Id.* at 1122.

¹¹ See generally Kimberlee K. Kovach, *Neonatology Life and Death Decisions: Can Mediation Help?*, 28 CAP. U. L. REV. 251, 286 (2000).

¹² See Gatter, *supra* note 4, at 1129.

¹³ *Id.* at 1127.

¹⁴ *Id.*

¹⁵ Mary Beth West & Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE 293, 294-95 (Nancy S. Jecker, et. al, ed., 1997).

¹⁶ See Hoffman, *supra* note 3, at 876.

¹⁷ *Id.*

¹⁸ *Id.* at 875.

¹⁹ See Kovach, *supra* note 11, at 284.

²⁰ See Judith Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1270-71, n.129 (1993).

²¹ Hafemeister, *supra* note 2, at 361.

²² Dubler, *supra* note 1, at 98.