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Features

Surmounting Elusive Barriers: The Case for Bioethics Mediation

Edward J. Bergman

ABSTRACT

This article describes, analyzes, and advocates for management of clinical healthcare conflict by a process commonly referred to as *bioethics mediation*. Section I provides a brief introduction to classical mediation outside the realm of clinical healthcare. Section II highlights certain distinguishing characteristics of bioethics mediation. Section III chronicles the history of bioethics mediation and references a number of seminal writings on the subject. Finally, Section IV analyzes barriers that have, thus far, limited the widespread implementation of bioethics mediation.

I. MEDIATION

Mediation is a venerable dispute resolution process. In his authoritative work, *The Mediation Process: Practical Strategies for Resolving Conflict*, Moore notes that "mediation has a long and varied history in almost all cultures of the world."[1] Fundamentally, mediation is a form of assisted negotiation in which a neutral, the mediator, aids disputants in their creation of consensual resolutions to conflict. The integral relationship between mediation and negotiation requires that mediators possess a working knowledge of negotiation theory and practice, with a particular emphasis on integrative, principled, and interest-based negotiation, all of which emphasize the distinction between a party's positions and the party's underlying interests, as a source for the discovery of previously unrecognized common ground or compatibility.[2] The term *consensual* signifies a resolution that all parties can accept as preferable to alternative outcomes in the event consensus cannot be reached. A mediator does not impose an outcome on the parties, but functions as a facilitator and manager of the process. Thus, mediation can be characterized as the least authoritarian mode of dispute resolution, because its outcomes are not determined by third parties, as in arbitration or adjudication, but by the disputants themselves.[3]

There are differing, sometimes contentious, views of the extent to which mediators should perform evaluative as well as facilitative functions. There are also disparate viewpoints regarding a mediator's responsibility for the quality of a mediated outcome. Some argue that, as facilitators, mediators are accountable solely for the quality of the mediation process, including the assurance that each party has made its determinations freely and voluntarily, fully in-

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formed of all relevant information. Others contend that a mediator bears responsibility for the fairness of an outcome, and even for its impact on non-parties to the mediation, including society as a whole.[4] Neither of the above debates is susceptible of definitive resolution, and the continuing dialogue is undoubtedly a sign of the vibrancy of the mediation process.

A third point of contention within the mediation community involves the definition of *neutrality*, and the extent to which it is achievable. Classical mediation is premised on the perceived neutrality of the mediator as a cornerstone for the creation of trust that is prerequisite to an open exchange of information by the parties.[5] In addition, the promise of confidentiality serves as a catalyst for candor. The confidentiality of mediation communications is frequently protected by statute. Many states have adopted the Uniform Mediation Act, which privileges mediation communications, disallowing their use in subsequent court proceedings, with rare exceptions.[6] When a party is reluctant to share information with other parties to the mediation, she or he can confide in the mediator with the assurance that requested confidentiality will be honored, internal to the mediation process.

Mediation is generally viewed as an effective dispute resolution process that incorporates positive attributes of catharsis, party empowerment, potential for continuing relationships (or termination of relationships with a minimum of rancor), and a high likelihood of compliance, stemming from the parties' ownership of consensual outcomes. In the legal world, mediation has been embraced by proponents of efficiency and, simultaneously, by advocates for more humanistic dispute resolution processes.[7]

The mediation process, its stages and techniques, have been exhaustively described in books and articles that are required reading for the prospective bioethics mediator.[8] For purposes of this article, I will note simply that mediators are managers of a process which, utilizing both global sessions and caucuses with individual parties, assists disputants in defining the nature and scope of a conflict; identifying and prioritizing the underlying interests of each participant; understanding the extent to which those interests are identical, compatible, or conflicting; and seeking options for resolution that are optimally responsive to the interests identified.

Mediation is an informal dispute resolution process in which there is no audio record or written transcript of the proceedings. Significantly, there are no externally imposed limitations on the admissibility of statements or other evidence offered by the parties. While the mediator, as a manager, is responsible for the decorum he or she deems necessary to an effective process, constraints should be imposed cautiously to preserve cathartic potential through the expression of emotions that may be requisite to an effective process. Despite its consensual aspect, mediation should not be viewed or practiced as a process that encourages suppression of deeply held feelings.[9] The mediator should be a consummate listener and questioner who clarifies and summarizes the contributions of the parties, acknowledges those contributions, promotes mutual respect, elicits and provides creativity, educates the parties about the process, facilitates access to information that is relevant, and insures that individual decision making is the product of non-coerced, informed deliberation.

The foregoing, in its brevity, constitutes an overview of the classical mediation process to establish a context for those readers unfamiliar with mediation. Readers are urged to examine the sources cited in end notes one through nine for a fuller introduction to the process.

II. BIOETHICS MEDIATION

In 2004, Zaner wrote, "Every time I introduced myself, it seemed someone invariably thought that, since I was 'in ethics,' it was obvious that someone had been *un*ethical; otherwise, why else would someone like me be on the scene? And I, taken to be the local 'ethics cop,' there to catch' em out and put' em away! Curious, and not a little frustrating, how being seen as 'police'—even if merely from 'ethics'—puts such a damper on conversation".[10]

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Bioethics mediation encompasses the mediation of conflicts that arise in a clinical healthcare context between or among caregivers, patients, their surrogates, and families. The term *bioethics mediation* is not ordinarily applied to the mediation of healthcare policy issues, or to the mediation of disputes between patients and caregivers that have evolved into malpractice litigation, although these are important categories of healthcare mediation outside the scope of this article.[11] The expertise of classically trained bioethicists is frequently, and appropriately, sought in connection with health policy issues.

In some respects, the term *bioethics mediation* is misleading, as it obscures the fact that most clinical healthcare disputes, like those in other settings, emanate from more mundane sources than moral conflict. Communication, information, culture, and personality-based conflicts are more common than those that are typically characterized as ethical in nature.[12] Such conflicts can be addressed through the application of classical mediation techniques. Thus, a more accurate characterization of a clinical mediator's role might be "mediation of healthcare disputes in a clinical context," embracing the full spectrum of potential conflict.

On a further semantic note, the terms *bioethics* mediation/consultation and *clinical ethics* mediation/consultation are used synonymously. A more confusing semantic concern emanates from the terminologies referenced below, in which *mediation* is described as a "skill set" for, or approach to, "consultation," rather than as a separate and distinct modality. There is nothing inherently wrong with subsuming mediation within the broader category of bioethics consultation, other than the confusion it may engender.

The literature on bioethics mediation primarily addresses conflict that can be characterized as morally *aporetic*. *Moral aporia* indicates a state of perplexity, impasse, deadlock, or stalemate "from which there is seemingly no way out, thus forcing the conflicting parties involved to come to a mutual understanding of their ignorance and helplessness about how to proceed."[13] One party's perspective, informed by his or her own values, and driven by legitimate moral concerns, conflicts with another's principled judgment. For example, Daughter A may advocate for removal of her father's artificial life support, based on an assessment that the associated pain and perceived loss of dignity are not justified by a predictably brief prolongation of life with diminished quality. Daughter B may argue that their father is entitled to any intervention that will extend his life, and may also broaden the window of opportunity for a miraculous recovery. While these morally aporetic positions may be irreconcilable, a decision is required. It should be noted that, in bioethics mediation, it is also possible that one party may persuade another to reconsider, and ultimately revise his or her initially perceived moral calculus, breaking the "stalemate." Thus, resolution can occur via reconsideration of initially espoused principles, or by an acceptance of irreconcilability, along with the need to act, even in the absence of reconciliation.

Proponents of bioethics mediation argue that mediation provides a forum in which moral positions that emanate from disparate value systems can be articulated and challenged, leading to recognition of the legitimacy due each opposing position, and the realization that consensus on outcomes does not necessarily require consensus on principles. Indeed, Clouser and Gert conclude that "principlism" is of little utility in clinical ethics decision making, precisely because bioethics principles (beneficence, nonmalificence, autonomy, and social justice[14]), compete with one another for predominance in ethical conflicts.[15] It is inevitable that, in a morally aporetic situation, there can be no certainty that the correctness of any choice, by consensus or otherwise, enhances the possibility of consensus on outcomes.[16] Returning to the example of Daughters A and B, a decision to either terminate or prolong their father's life support cannot, when made, be assuredly correct or demonstrably superior to, the alternative. In consequence, the likelihood of reaching a consensus whereby, for example, the father's life support is continued for a period of time, after which, if there is no change in prognosis, it will be terminated, becomes more likely when the

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parties comprehend the uncertainty associated with either position and the legitimacy of both.

The teaching of ethics through moral dialogue, in which participants experience *catharsis*, defined as "cleansing" or "purification," has its roots in ancient Greek philosophy. In that moral dialogue, the teacher acts, not as the source of superior moral knowledge, but as a *pharmakon,* or medical remedy, through a process of cross-examination known as the *elenchus*. The *elenchus* tests individuals' purported knowledge and stated moral principles. The dialogue itself is the healer. The teacher is not.[17] While an analogy to the ethical education of physicians is not precise, parallels between the described role of a medical ethics professor and a bioethics mediator are striking.

It is those conflicts of a morally aporetic nature that the critics of bioethics mediation target when they assert that mediation takes the ethics out of ethics consultation.[18] In effect, this criticism is premised on an assumption that there are morally "correct" solutions to aporetic conflicts, and that individuals with specialized training and credentials have access to superior moral judgment that enables them to divine the correct solution. The counter-argument can be stated as follows: "in non-ideal everyday situations it is very seldom possible to reach a moral solution that is undoubtedly right and that the real challenge consists rather in reaching an acceptable moral solution, i.e. a solution that all parties involved find they can live with. . . ."[19]

Just as the mediation of healthcare disputes in a clinical context is consistent with the concept of moral aporia, the use of mediation also flows from a contemporary view of the physician-patient relationship based on a negotiation model. Lazare and Dubertret both characterize the foundation of the physician-patient relationship as a negotiation,[20] while Groopman and Chen separately describe the clinical diagnostic interview in terms that incorporate negotiation skills such as rapport building, active listening, the use of open-ended questions, and acknowledgment of the patient.[21] If indeed the physician-patient relationship is a product of negotiation, and mediation is a form of assisted negotiation,[22] mediation appears a logical mechanism for the reclamation of a negotiated relationship gone awry.

Bioethics mediation is also wholly consistent with the contemporary view of medicine as practiced through a shared decision-making process and a collaborative physician-patient relationship. The parties are viewed as co-equal participants, each of whom contributes his or her particular competencies to the collaboration, and each of whom assumes responsibility for impasses that develop within the therapeutic relationship. The traditional paradigm of the "physician-as-expert," while maintaining relevance in the case of medical emergencies to which a physician must respond, and in cases when a patient actively seeks to delegate decision making to an expert,[23] has been supplanted by an approach in which self-determination trumps paternalism.

There are times, however, when individuals may need or prefer to rely on the opinion of others for decisions that are simply beyond their capacity to address.[24] With or without the existence of conflict between stakeholders, individuals are always free to elicit the views of others they respect. Such third parties may be bioethicists, but they may well be religious leaders, mental health professionals, medical professionals outside the immediate caregiver team, et cetera.

Referral of a dispute to mediation does not preclude the possibility that before or during mediation a party may consult with such individuals on her or his own, or upon a mediator's inquiry as to its possible utility. Such consultations can occur outside the immediate framework of the mediation, or a party may seek to incorporate third-party dialogue into the mediation process. One anecdotal, though not uncommon, example is the contribution of clergy when a party is manifestly unclear of the extent to which religious doctrine binds him or her to specific courses of action. Dialogue may reveal that perceived religious constraints can be relaxed in the context of crisis, altering the individual's view of his or her range of options.

It is within the mediator's purview to function as a resource for any information that may

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be of assistance to the parties in the process of informed decision making. What a mediator does not do, that a traditional bioethics consultant often does, is to personally assess and opine on the accuracy, weight, ultimate credibility, and relevancy of the disparate information to be considered by the stakeholders.

A skilled bioethics mediator will elicit and acknowledge the competencies of all parties, thereby promoting mutual respect, and will assist the parties in formulating a consensual resolution that reflects their respective competencies. If, for example, a physician believes that a specific physical therapy represents the way to a better, faster recovery, yet acknowledges that the recommended therapy will be more painful than the alternatives, a mediator may elicit the patient's own history of overcoming adversity for the opportunity to achieve future-oriented goals. The mediator may also inquire as to the basis for the physician's assessment, and the basis on which the treatment's efficacy is believed superior to less-painful alternatives. Confronted with that history, the patient may identify her or his own previous successes and use them to revisit her or his initial resistance to short-term discomfort. Conversely, the physician may reframe his or her recommendation as a cost-benefit analysis to be engaged in by the patient.

While the existing bioethics mediation literature does not explicitly acknowledge a familial relationship with narrative medical ethics, the values reflected in narrative ethics clearly resonate with many of the operative principles of bioethics mediation. Charon and Montebello, for example, have noted that

> on the juridical model morality is a matter of solitary judges applying codified rules derived from comprehensive theories as criteria for assessing wrongdoing and making rational choices. . . . The more one knows about the foundations of the theories . . . the greater one's claim to ethical expertise. In contrast, *the narrative approach . . . is collaborative in that it posits, not a solitary judge, but a community of inquirers who need to construct ways of living well together*. [Emphasis added.][25]

Thus mediation can, but need not be, conducted on a narrative model. Winslade and Monk posit just such a model in *Narrative Mediation: A New Approach to Conflict Resolution.*[26] A prospective dialogue between narrative ethicists and bioethics mediators might prove beneficial to both fields and to the individuals touched by each discipline.

Bioethics mediation should be implemented in a manner that reflects the unique confluence of characteristics associated with conflict in a clinical healthcare setting. Those characteristics have been comprehensively delineated elsewhere.[27]

Here, we focus on four distinguishing characteristics of bioethics mediation.

1. *Power imbalances* between patient, family, surrogates, and caregivers are extremely common and frequently profound. Technical complexity, unfamiliar terminology, isolation, uncertainty, cultural differences, and, often, an extreme socio-economic gap lead to intimidation, anxiety, fear, suspicion, and confusion. While power imbalances are not unique to bioethics mediation, their prominence and magnitude place extraordinary demands on the mediator.

The creation of a previously non-existent forum for the management of clinical conflict that can be triggered by a patient or caregiver request may, itself, tend to ameliorate power imbalances. More significantly, the inclusive, respectful, and non-judgmental nature of the mediation process, along with its facilitation of information exchange and the clarification of otherwise opaque information, can bring lucidity to previously incomprehensible facts and opinions. The mediator's skill in eliciting and acknowledging the respective competencies of the parties can be a powerful tool for diminishing dramatic power imbalances.

2. *Neutrality*, in the context of bioethics mediation, has been an elusive concept. Initially, a question arises as to the impact on neutrality when the mediator is employed and/or paid by a hospital. While such conditions would be viewed as problematic in the traditional mediation of legal or business disputes, there are certainly exceptions outside the healthcare

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setting in which a mediator is provided or compensated by one of the parties. For example, the United States Postal Service operates and funds a mediation program using independent mediators trained by the service for the management of grievances filed by employees. The program, called REDRESS, has existed since 1994.[28]

Perhaps the biggest determinant of the perceived partiality of a mediator employed and/or paid by one disputing party is the ability of a mediator to credibly present him- or herself as impartial. If the non-payor party believes that the mediator's mandate is to facilitate consensual outcomes because such outcomes are inherently beneficial to the payor, regardless of the outcome in particular cases, the perception of neutrality may be sustainable. Thus, institutional policy in support of access to, and the fairness of, an effective conflict resolution process may be viewed as a credible initiative predicated on enlightened self-interest. The Bioethics Mediation Program at Montefiore Medical Center has operated on that premise since its inception.[29] Nonetheless, the issue of perceived neutrality will remain sensitive to the extent it cannot be guaranteed.

A more complex aspect of neutrality in bioethics mediation stems from the schism between those who believe that a bioethicist's expertise provides access to superior moral judgment and those who contend that training in the application of bioethical principles is tangential to decision making in morally aporetic situations. Superior access to ethically correct choices would render a bioethics mediator incapable of neutrality as to outcomes and limit the mediator to neutrality regarding the parties. This limited definition of neutrality will offend mediation purists as violative of the premise that advocacy for, or against, outcomes that parties reach consensually, is inherently partial. Outside the arena of clinical healthcare disputes, similar debate has arisen. Some commentators posit the view that mediators are charged with accountability to society for outcomes that are unconscionable or damaging to unrepresented parties, including future generations.[30] Opponents of that view counter that mediators have no standing nor accepted standards by which to judge the quality of outcomes voluntarily reached through consensus.[31] "It is, in its most benign form, an invitation to permit philosopher-kings to participate in the affairs of the citizenry."[32]

An equally skeptical critic opines, "clinical ethicists set up ethics consultation services in hospital wards, offering moral advice the way a consulting neurosurgeon might recommend a lumbar puncture or a dermatologist might suggest biopsy."[33]

3. A presumptive common concern for the patient's best interests distinguishes bioethics mediation from conflicts in which opposing parties have disparate and irreconcilable interests.[34] Unless the mediation dialogue reveals a party's self-interested agenda, for example, insistence on an outcome consistent with a caregiver's or a family member's religious beliefs, as distinct from those of the patient, or one that is motivated by personal financial gain, all parties share an objective—the best interests of the patient—and conflict inheres solely in how to achieve that objective. A skilled bioethics mediator will elicit the parties' recognition and acknowledgment of their common interest in the patient's welfare, which may itself reduce the level of conflict and render it more manageable.

4. *Mediation in the absence of the patient* is extremely common in the clinical healthcare setting, as conflict often arises when a patient lacks competency or consciousness.[35] While mediation outside the clinical context is sometimes conducted through agents, those agents can ordinarily confer with their principals, seek ratification from their principals, or be contemporaneously authorized to act on behalf of their principals. In bioethics mediation, the patient is frequently inaccessible for consultation or ratification, and authorization is achieved by an advance directive—a living will or medical power of attorney—or by a statute designating a succession of family members to serve as a surrogate for the patient. Some statutes also provide criteria for the surrogate's exercise of power: frequently, what the patient would have done as determined by prior statements or by

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other evidence.[36] If the legal representative or surrogate does not possess unconditional decision-making power, a bioethics mediator can ensure that the mediation dialogue illuminates legal standards to be employed by the surrogate in the event no consensual resolution is reached.

III. HISTORY OF BIOETHICS MEDIATION

Bioethics mediation has been extensively advocated for as a preferred mechanism for the management of clinical healthcare disputes and as a primary vehicle for the practice of clinical ethics. In part, this support can be attributed to a dismal assessment of the performance of hospital ethics committees (HECs), documented in the well-known report, "Ethics Consultations in U.S. Hospitals: A National Survey," authored by Fox, Myers, and Pearlman.[37]

While HECs were initially developed by Roman Catholic hospitals, primarily in the 1960s and 1970s,[38] they became progressively more common in the wake of *In re Quinlan,* in which the New Jersey Supreme Court opined that medical institutions should develop forums to resolve conflict in end-of-life situations that demand professional, subject-specific knowledge and experience.[39] The development of HECs was facilitated by rapid advances in medical technology related to end-of-life care, and by a new cadre of professionally trained bioethicists.[40]

Unfortunately, HECs, as they ultimately were developed, possess no uniform standards for (1) the training and qualifications of members, (2) processes and decision-making rules, and (3) involvement of patients and families in the dispute resolution process. HECs are also notable for their widespread use of authoritarian, top-down decision making in consultation. This decision-making style embodies the questionable premise that ethical "expertise," coupled with titles and degrees, can provide access to superior moral judgment. This judgement is often rendered in the form of definitive "recommendations," rather than as a range of options, each of which may be ethically defensible. Some HECs vote on their recommendations by majority, raising paradoxical concerns about the ethical status of the minority view.[41] Despite the ubiquity of HECs, Fox and colleagues report that few receive substantial numbers of requests for consultation. This appears anomalous, given the widespread perception that clinical healthcare conflicts abound.[42]

While HECs were proliferating in the absence of consensual approaches to the management of clinical healthcare conflict, Nancy Dubler and her colleagues at Montefiore Medical Center in New York, whose active bioethics consulting service dates to 1978, began to explore the application of alternative dispute resolution approaches to conflicts among patients, families, and caregivers. A mediation program was developed and an internal evaluation concluded that classical mediation approaches had been successful, but that, in some instances, a model specific to the hospital setting was needed. A report entitled *Mediating Bioethical Disputes* was published in 1994, describing the initiatives of, and principles embraced by, the Montefiore Bioethics Mediation Project.[43]

In 1992 an article, "Introducing Mediation to Hospital Ethics," by R.J. Wagener appeared, describing the formation of a center in California specializing in bioethics mediation.[44]

In 1994, articles entitled "Mediating Life and Death Decisions" by D.E. Hoffman[45] and "Mediation for Ethics Committees: A Promising Process" by J.M. Gibson[46] were published. Since 1994, bioethics mediation has been widely discussed. "Patient decision-making: medical ethics and mediation," an article by Y.J. Craig, appeared in the *Journal of Medical Ethics* in 1996.[47]

In 1998, the American Society for Bioethics and the Humanities published the first edition of its *Core Competencies for Health Care Ethics Consultation,* in which two of the three skills required for ethics consultation were designated as "process skills" and "interpersonal skills.[48] " Process skills" are described as inclusive of the following:

- create an atmosphere of trust that respects privacy and confidentiality and that allows parties to feel free to express

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their concerns (e.g., . . . skill in addressing intimidation and disruption due to power and/or role differentials). . . .
- help individuals critically analyze the values underlying their assumptions, their decision, and the possible consequences of that decision
- negotiate between competing moral views
- engage in creative problem solving.[49]

Interpersonal skills are described as inclusive of the ability to:
- listen well and to communicate interest, respect, support, and empathy to involved parties[ ]
- elicit the moral views of involved parties
- represent the views of involved parties to others
- enable involved parties to communicate effectively and be heard by other parties
- recognize and attend to various relational barriers to communication.[50] [End note reference number removed.]

All of the aforementioned skills are generally recognized elements of a mediator's craft.

Core Competencies goes on to conclude, "the development of these skills is tied to hands-on experience. *Formal training in specific techniques such as mediation, conflict resolution, or facilitation is one way to obtain advanced interpersonal and process skills.*"[51] (Emphasis added.) *Bioethics: An Introduction to the History, Methods, and Practice* appeared in 1999, and contained an article by West and Gibson, "Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques."[52]

Subsequently, in 2004, Dubler and Liebman published *Bioethics Mediation: A Guide to Shaping Shared Solutions*,[53] written with the hindsight of 10 years of additional experience at Montefiore. That seminal work, now succeeded by a second edition, articulates the case for mediation of conflict in clinical settings, and examines the unique characteristics of clinical healthcare mediation. *Negotiating Health Care: Resolving Conflict to Build Collaboration*, by Marcus, Dorn, and McNulty, appeared in 1995.[54] While Marcus and colleagues do not focus on the mediation of healthcare disputes in a clinical setting, they extol the virtues of mediation across healthcare concerns, inclusive of health policy and management. The winter 2007 issue of *The Journal of Clinical Ethics* featured an article entitled "Beyond *Schiavo*," by Caplan and Bergman,[55] with commentaries by Dubler;[56] by Arnold, Aulisio, Begler, and Seltzer;[57] and related articles by Quist[58] and Fiester ("Mediation and Moral *Aporia*.")[59]

In 2009, Dubler, Webber, Swiderski, and the faculty and the National Working Group for the Clinical Ethics Credentialing Project (of which this author was a member), published "Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation," in the *Hastings Center Report*.[60] The "definition of clinical ethics consultation" adopted in that article includes "negotiating decision making in complex medical situations and, *whenever appropriate, mediating conflicts between staff members or among staff patient and family*."[61] (Emphasis added.) The section entitled "Measures for Credentialing CE [clinical ethics] Consultants," reads: "Interpersonal Skills: Consultants should have *training and proficiency in the techniques of facilitation, negotiation or mediation*, in order to gather and communicate information, address issues of uncertainty and help resolve disagreements."[62] (Emphasis added.) In 2009, the Center for Bioethics of the University of Pennsylvania published *The Penn Center Guide to Bioethics,* which includes a chapter devoted to "Mediation and Health Care" by this author and Autumn Fiester.[63] Dubler and Liebman's second edition of *Bioethics Mediation* was published in June 2011, reflecting disappointment by the authors concerning the lack of commitment to bioethics mediation training evidenced since publication of their first edition.[64]

This section is, in no sense, a critical or complete history of the literature. Its limited objective is to create awareness that bioethics mediation has been embraced by a wide spectrum

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of credible commentators across the healthcare and bioethics communities.

IV. BARRIERS TO WIDESPREAD IMPLEMENTATION OF BIOETHICS MEDIATION

The criticism that clinical ethics mediation is devoid of a moral compass should be subject to evaluation in light of the following concerns.

In an era during which patient autonomy has become an overriding principle,[65] we do not ordinarily subject patient/surrogate medical decisions to ethical scrutiny unless issues of competency arise. Most healthcare decisions are made by individuals—patients or surrogates—in the absence of objection by other legitimate stakeholders. Such decisions are not outsourced for the imprimatur of "experts."

Some healthcare decisions are made by individuals who are legally empowered to make them, although they are informally challenged by other stakeholders who yield to the decision maker's power without formal protest. Here too, there is no guarantee that a decision maker's access to moral authority is superior to that of a challenger's basis for disagreement.

The lack of certainty referenced in the preceding two paragraphs is manifest because there is no universal clinical ethics canon and, perforce, no uniform system of decision making with appropriate safeguards. Resort, in traditional ethics consultations, to "authority," in the form of opinion voiced in the bioethics literature, and claims that said literature constitutes a consensus, are subject to widely differing interpretation and selectivity of sources.

By contrast, the adjudicatory process at the core of our legal system is premised upon the social contract requisite to a society operating under the rule of law.[66] Fairness inheres in the objective application of external norms embodied in statutes, published case precedents, and constitutional guarantees. Such norms are presumed to be just, since they are the product of democratic processes. They are legislated by duly elected representatives or articulated by judges appointed by elected executives, or themselves elected. Rights of appeal and, ultimately, the right to elect successor executives, judges, or legislators support the promise of fairness.

When clinical conflict occurs, legitimate stakeholders can, and sometimes do, seek access to the courts for resolution. But courts are not in the business of deciding ethical questions, other than those embodied in legal doctrine. In consequence, courts frequently, as in the famous *Terri Schiavo* case,[67] decide the identity of the appropriate decision maker and/or whether that decision maker has properly applied criteria set forth in statutes or case law. These determinations do not speak to the moral quality of the decision, but to its implementation in accordance with legal criteria.

Parenthetically, traditional ethics consultation, on a juridical model, sometimes occurs in decision making by vote,[68] rendering the moral status of the minority view unclear in the absence of a duly constituted reviewing authority. Nonetheless, the majority recommendation may have cataclysmic consequences for stakeholders who are in disagreement with the majority.

The biomedical principles of beneficence, nonmalificence, patient autonomy, and social justice can be confused with an ethical canon. It has been noted by Clouser and Gert that such principles merely function as useful chapter headings for ethical discussion, but do not designate outcomes in specific cases. The principles do not provide a methodology by which their often competing concerns can be balanced to arrive at a decision.[69]

The premise that a clinical ethics mediator should be, first and foremost, a professionally trained bioethicist is dubious, in that the primary skills demanded are in the realms of empathy, communication, insight, creativity, trustworthiness, and process management. This is not to suggest that basic knowledge of bioethics principles should be omitted as a component of clinical ethics mediation training, but that the dominant skill set lies elsewhere. Indeed, bioethics principles may be useful to the practitioner in the creation of chart notes expressed, for the benefit of peers, in a common language.[70]

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Clinical ethics mediation is non-coercive in that no stakeholder can be compelled to participate in a consensus. Absent consensus, stakeholders retain all of the rights and options they possessed prior to mediation, although they may, as a result of an attempt at mediation, know significantly more about why consensus was unattainable. In the event mediation is unsuccessful, the conflict will be subject to resolution by a legally empowered decision maker, or by application to the court, for a determination of the appropriate decision maker.

A special attribute of bioethics mediation is the value placed on open dialogue among stakeholders, even when the identity of the decision maker is known. Validation of the moral legitimacy of a position that the holder is not endowed with power to enforce can serve to acknowledge that individual—her or his hopes, fears, beliefs, and good faith—irrespective of power. In some cases, validation may create the possibility of modifying the empowered party's perspective. Many conflict situations can be mitigated or even resolved by the mere fact of such recognition.[71] Meaningful inclusion in a process that affords a voice and encourages the expression of feelings and ideas, cuts against the marginalization of all but the empowered party.

The suggestion that an unacceptable moral relativism is inherent in clinical ethics mediation is, in the author's view, a gross mischaracterization. We have examined the reasons why clinical conflict resolution via the application of purportedly settled doctrine is not viable. Yet recognition of the inevitability of value pluralism among stakeholders is not synonymous with an acceptance of moral relativism. It is, instead, a recognition that my moral calculus may differ from yours and, while both of us may hope for reconciliation via persuasion or epiphany, in the absence of that epiphany, we are compelled to make real world decisions without the benefit of a mutually agreed upon source of moral authority. Philosophers undoubtedly believe in the moral precepts they advocate, their sources, and the arguments that support them, but they also know that their contributions are placed within a world of ideas in which no single idea is likely to gain universal traction. This does not, and ought not, diminish the ardor of their advocacy nor compel their conversion to indifference. After all, we inhabit a world in which individuals routinely part company on sensitive matters that are deemed to be ethical in nature. The pro-life/pro-choice issue is but one instance in which deep differences are likely to persist indefinitely, while society functions, absent anarchy, in a state of moral perplexity.

Lassman notes, "Rawls argues there is a deep division between the dominant tradition that holds there is one true conception of the good and an alternative tradition that recognizes the existence of a plurality of reasonable but opposing doctrines of the good."[72] A somewhat less abstract variant of the foregoing proposition can be seen in Larmore's formulation:

> Pluralism is often associated with an appreciation of the possible conflicts among our values and with the recognition that not all good things can exist together in life and society. . . . Sometimes we can find a solution to such conflicts, not by appealing to a common denominator of value, but rather by the exercise of judgment. For just this reason, however, the pluralist will recognize that discerning the correct solution (where one can indeed be found!) can be inherently difficult and open to controversy.[73]

The consensus aspect of clinical ethics mediation is consistent with the concept of medicine as an enterprise for "healing," with an emphasis on empathy, shared decision making, communication, and patient-centered care.[74] The resolution of clinical conflict by institutional fiat does nothing to enhance the likelihood that the whole patient and his or her constellation of concerns has been treated, leaving the patient, careproviders, and family members in a position to move forward in the absence of recrimination. Just as classical mediation has been appreciated on a humanistic level for its embodiment of a "harmony model" of dispute resolution, antithetical to the alienation engendered by processes focused on winners and los-

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ers, or right and wrong,[75] clinical ethics mediation offers the potential for healing in the context of managing clinical conflict.

In the second edition of *Bioethics Mediation*, Dubler and Liebman bemoan that "the landscape has changed and mediation is an accepted part of Clinical Ethics Consultations. Our concern, however, is that this acceptance of . . . mediation has arrived without a robust and powerful commitment to the skills that the discipline demands."[76] The skill sets and knowledge bases of mediation and bioethics that are awkwardly conjoined in the ASBH *Core Competencies* and *Charting the Future* may be causally linked to the paucity of commitment to mediation skills observed by Dubler and Liebman. The rigor necessary for acquisition of effective mediation skills is unlikely to be achieved while those skills are explicitly or implicitly painted as supplemental rather than as primary. While professional bioethicists can certainly become skilled mediators, substantial commitment and training are required. Maintenance of the *status quo* is served by continuing to countenance the primary role of clinical ethicists as providers of traditional bioethics consultation, which may be useful at the margins of clinical conflict, but will not serve the pressing needs of hospitals that have been long underserved by HECs and by clinical ethicists. As the authors of *Malignant: Medical Ethicists Confront Cancer,* opine, "Critics argue that the increased presence of medical ethicists in . . . hospitals hasn't done much to improve how patients are treated. According to the critics, the field has not done enough to promote a more patient-centered approach to medical care."[77]

CONCLUSION

Adoption of bioethics mediation as a primary clinical dispute resolution process, available at the request of patients' families, surrogates, and caregivers, would dramatically enhance the manner in which hospitals address conflict. Reliance on *bioethics consultation* by those who are expert in bioethics principles, for imposition of juridically based decisions on individuals in crisis, premised on questionably superior access to moral judgments, has been nothing short of "scandalous" and an embarrassment to the healthcare system.[78] Patients and their families, in particular, are entitled to a nonthreatening, inclusive forum in which they can be heard and respected for their relevant competencies.

Healthcare professionals from across the United States who participate in the intensive mediation courses offered by the Penn Clinical Ethics Mediation Program report increasing utilization of mediation-based skills and techniques at their institutions. As such, their ethics consultations, while not purely mediative, have moved away from an authoritarian model, while adopting greater emphasis on input from the patient/family side of disputes with caregivers. Their approaches frequently acknowledge the consultant's inability to access definitively correct moral decisions.

A strong argument can be made for mediation training that is directed at a wide range of healthcare professionals who regularly encounter conflict in a clinical setting. While many recipients of such training may never attain the skill level of committed professional mediators, familiarity with mediation theories and techniques, particularly when accompanied by participation in simulated clinical role plays,[79] can provide useful tools for the informal management of clinical conflict which, in some circumstances, may circumvent the need for a more formal mediation process. This distinction was recognized by Marcus as early as 1994 in the Montefiore report, *Mediating Bioethical Disputes*.[80]

The frequency of clinical healthcare conflicts that are not typically characterized as ethical[81] and the marginal relevance of bioethics principles to the management of morally aporetic conflicts, evidence the need for skilled mediators with a complimentary understanding of bioethics principles, or other value-sensitive constructs, for addressing pluralism in the realm of ethical conflict. While discussion of bioethics principles and prior case histories may serve as catalysts for the development of moral dialogue, so may other aspects of humanistic inquiry—psychology, philosophy, sociology,

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drama—that implicate and challenge fundamental values forged in the cauldron of life experience.

Resistance to change, the protection of turf, and the vestiges of archaic, authoritarian institutional structures, create substantial (yet surmountable) barriers to the adoption of a clinical dispute resolution model that reflects the egalitarian, collaborative healthcare enterprise of the twenty-first century. The civil rights, consumers' rights, and patients' rights movements, coupled with the democratizing effects of an explosion in information technology, have forever altered the landscape of society and healthcare. The broad spectrum of informed support for bioethics mediation and its synchrony with contemporary values bode well for its future at the foreground of clinical ethics.

NOTES

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5. See note 1 above, p. 53.

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12. See, e.g., *Core Competencies for Health Care Ethics Consultation,* 1st ed. (Glenview, Ill.: American Society for Bioethics and the Humanities, 1998).

13. J. Solbakk, "Catharsis and Moral Theory I: A Platonic Account," *Medicine, Health Care and Philosophy* 9 (2006): 63.

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18. See note 16 above, p. 356.

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