Edward J. Bergman, "A Response to Dubler's Commentary on "Surmounting Elusive Barriers: The Case for Bioethics Mediation," *The Journal of Clinical Ethics* 24, no. 2 (Summer 2013): 144-7.

Commentary

A Response to Dubler's Commentary on "Surmounting Elusive Barriers: The Case for Bioethics Mediation"

Edward J. Bergman

ABSTRACT

Dubler's commentary[1] focuses on knowledge of clinical medicine and "institutional savvy" as pieces of the skill set required of bioethics mediators. Here, I describe why, as a practical matter, such requirements are unlikely to be achieved by a meaningful number of aspirants. Simultaneously, I examine the reasons why Dubler's criteria are inherently risk-laden and would be better addressed as a dialogue among experienced practitioners regarding the merits of alternative stylistic approaches, rather than as universal threshold criteria for the practice of bioethics mediation.

Nancy Dubler's commentary on my article, "Surmounting Elusive Barriers: The Case for Bioethics Mediation," in the spring 2013 issue of this journal, invites a response. While we are both zealous advocates for bioethics mediation, Dubler's piece summarizes important distinctions in our views of the future of its practice and the skills required of its practitioners.

Dubler places substantial emphasis on the mediator's working knowledge of clinical medicine and the mediator's possession of "institutional savvy."[2] There are five reasons for my skepticism regarding these baseline criteria.

First, economics militates against a likelihood that aspiring bioethics mediators will acquire the levels of training and expertise needed to fulfill Dubler's requirements as a precondition to practice. The scope of these wide-ranging competencies would require hospitals to compensate practitioners at a level commensurate with such erudition—an unlikely prospect.

Second, while the knowledge of clinical medicine prescribed by Dubler is available in the case of practicing clinicians, such individuals must still be persuaded to acquire substantial mediation training, not as a superficial gloss on their existing professional competencies, but in recognition of the demanding, independent discipline of mediation. The clinician may already be functioning as a clinical ethics con-

Edward J. Bergman, JD, is Founding Faculty and Principal Mediator, Penn Clinical Ethics Mediation Program, Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, and Affiliated Faculty, Department of Legal Studies and Business Ethics, Wharton School of Business, University of Pennsylvania, *ejb@gear3.net.*

sultant, employing a traditional, juridical approach. Dubler has previously lamented a woeful absence of mediation training in spite of the theoretical embrace of mediation reflected in the literature.[3] What Dubler apparently has not concluded is that clinical ethics consultants—entrenched in positions for which they have long been deemed qualified, and facing a threat to their very relevance—will not only decline such training but are likely to resist its legitimacy. Such resistance will bear little relationship to objective assessment of the virtues of clinical mediation. The majority of nonclinicians seeking to acquire knowledge of clinical medicine will primarily be relegated to the methodology described in the next paragraph.

Third, much of the medical knowledge for which Dubler advocates can be acquired by hospital mediators in the form of on-the-job training. A mediator focused on the management of conflict in a clinical context will be exposed to a vast array of clinical information. Mediators are notoriously quick studies, evidenced by their frequent capacity to manage dispute resolution across diverse subject matter areas. Mediators learn to acquire complex information necessary for the understanding of their tasks, a different order from the level of knowledge required of a practicing clinician.

Fourth, the institutional savvy mandated by Dubler can *only* be acquired by the mediator having been embedded in an institution and, consequently, cannot be posited as a precondition to the practice of bioethics mediation. Additionally, asymmetrical familiarity of the mediator with hospital staff risks displacement of a perception of mediator neutrality with a perception of bias, even cronyism.

Fifth, knowledge of clinical medicine and the acquisition of institutional savvy are themselves double-edged swords. Belief in one's substantive medical knowledge can create unintended bias stemming from intrinsically questionable expertise. Physicians, even specialists in a field, will frequently reach opposing conclusions on diagnoses, prognoses, and treatment choices. Prevailing medical uncertainty calls into question a mediator's substantive medical guidance. Some conversance with clinical medicine can facilitate a mediator's ability to formulate probative questions. This is precisely the kind of information that can be gained from extended exposure to the clinical environment. Such familiarity, as opposed to expertise, is unlikely to result in a perception that the mediator claims subject matter mastery that may be viewed as in competition with, or in support of, a disputant. While the knowledge that Dubler prescribes may prove helpful in particular cases, the medical activist portrayal of a bioethics mediator painted by Dubler in her "vignettes"[4] risks a redefinition of the mediator as a quasi-party to the conflict, rather than the manager of a process. While a mediator's role includes identification of information for the parties' consideration, the mediator as a primary source of subject matter expertise has, understandably, been viewed as a threat to her or his presumed neutrality.[5] It is difficult (although not impossible) to become the source of an option without being viewed as a proponent of that option. While the interventions that Dubler describes are admirable, these approaches are dependent upon mediator competencies that are only attainable in rare contexts.

Dubler's perspective on the foregoing issues is unique. Embedded in one medical institution—Montefiore Medical Center—for some 40 years, Dubler embodies an experience few, if any, have shared. Dubler's accomplishments constitute a legacy of immeasurable importance to the field of bioethics mediation. We would be wise, nonetheless, to consider that Dubler is likely *sui generis* and that, an attempt to "clone the leader,"[6] rather than to define viable pathways for the widespread adoption of bioethics mediation, will be fraught with peril. We should resist the temptation, and the naiveté, to believe we can train a cadre of institutional gurus, foolishly thought to possess the skill and wisdom accumulated by Dubler as the by-product of a life's commitment.

Setting the bar for the training of bioethics mediators at ambiguous and/or unrealistic levels presages two likely outcomes. Aspiring mediators may enter the practice with substantial breadth of knowledge that is skin deep and difficult to apply. Alternatively, prospective bio-

ethics mediators will be deterred by a perception that its range of mandatory competencies is practically unattainable.

Perhaps the foregoing dilemma is soluble, in part, by drawing a distinction between preconditions to the practice of bioethics mediation and aspirational considerations for the experienced practitioner. Such a distinction would help clarify, and render attainable, baseline requirements, leaving open to debate a multiplicity of tactical and stylistic approaches to the craft. After all, debate over distinct mediation styles has always been lively outside the realm of clinical healthcare conflict.[7] One might also question the advisability of a doctrinaire approach to a process that encompasses elements of artistry, emanating from unique personal attributes of its practitioners.

On a specific point, Dubler's dismissiveness of the concept of moral *aporia*, as referenced in my article,[8] was a surprise. Dubler's suggestion that "arcane" and "unfamiliar" words intrinsically confound elusive concepts[9] is an unusual assertion in the framework of scholarly discourse, where discovery of useful analogies or nuanced language to describe complex phenomena is highly valued. Dubler may mistakenly believe that I am advocating the use of arcane phrases in the *practice* of bioethics mediation. I learned about moral *aporia* simultaneously, but independently, from the work of Fiester[10] and Solbaak.[11] I have found that term of art a powerful tool for understanding and teaching the virtues of bioethics mediation—a process suited to conflict management in situations that involve competing, yet legitimate, moral claims.

Paradoxically, Dubler authored a commentary to Fiester's earlier article in this journal, "Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting."[12] In that commentary, Dubler quotes Fiester: " 'The term *aporia* comes from the Greek meaning "a state of perplexity." In a clinical ethics case it is a helpful term to use to describe ethical ambiguity in a case in which there is a sharp clash between disparate moral considerations, values, or principles, or significant disagreement about which moral consideration ought to trump the others in the case.' "[13]

Dubler goes on to state, in support of mediation as the antithesis of ill-conceived adjudication between legitimate moral claims: "Fiester says it eloquently: 'Mediation as a process honors the validity of both sides in a dispute . . . because it takes no stand on which moral principles or claims ought to trump in a disputed case. It does not claim moral authority when there is none to be had.'"[14] Far from asserting its inutility, Dubler lauded the relevance of moral *aporia* to clinical ethics cases, much in the way I applied the concept. While, as Dubler notes, bioethics mediation is not limited to aporetic conflict,[15] the significance of such disputes in a healthcare setting is a signature component of clinical ethics conflict.

CONCLUSION

While I agree with Dubler that the literature referenced herein is part of "a vital current conversation,"[16] I am conflicted about my own contribution to a dialogue that may be interpreted by naysayers to bioethics mediation as more divisive than is actually the case. I would be saddened if that perception provided solace to those who oppose widespread adoption of a mediation model for the management of clinical conflict.

Advocates of bioethics mediation should move forward, in concert, agreeing to disagree, without compromising our capacity to nurture a clinical dispute resolution model that reflects the inclusive, collaborative, patient-centered healthcare enterprise of the 21st century.

NOTES

1. N.N. Dubler, "Commentary on Bergman: 'Yes . . . But," *The Journal of Clinical Ethics* 24, no. 1 (Spring 2013): 25-31, commentary on E.J. Bergman, "Surmounting Elusive Barriers: The Case for Bioethics Mediation," *The Journal of Clinical Ethics* 24, no. 1 (Spring 2013): 11-24.

2. Dubler, see note 1 above, p. 26.

3 N.N. Dubler and C.B. Liebman, *Bioethics Mediation,* 2d ed. (Nashville, Tenn: Vanderbilt University Press, 2011), xiii.

4. Dubler, see note 1 above, pp. 27-30.

5. C. W. Moore, *The Mediation Process: Practi-*

cal Strategy for Resolving Conflict, 3d ed. (San Francisco, Calif.: Jossey-Bass, 2003), 288.

6. W. Allen and M. Brickman, *Sleeper* (Beverly Hills, Calif.: United Artists, 1973).

7. Bergman, see note 1 above, pp. 11-2.

8. Ibid., 13-4.

9. Dubler, see note 1 above, p. 26.

10. A. Fiester, "Mediation and Moral Aporia," *The Journal of Clinical Ethics* 18, no. 4 (Winter 2007): 355-6.

11. J. Solbaak, "Therapeutic Doubt and Moral Dialogue," *Journal of Medicine and Philosophy* 29, no. 1 (2004): 97; J. Solbaak, "Catharsis and Moral Theory I: A Platonic Account," M*edicine, Health Care and Philosophy* 9 (2006): 63.

12. N.N. Dubler, "Commentary on Fiester's 'Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting,'" *The Journal of Clinical Ethics* 22, no. 4 (Winter 2011): 373-9, commentary on Fiester, see note 10 above.

13. Dubler, see note 12 above, p. 373.

14. Ibid., 379.

15. Dubler, see note 1 above, p. 26.

16. Ibid., 25.