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A Commentary on Caplan and Bergman: Ethics Mediation — Questions for the Future

Robert Arnold, Mark Aulisio, Ann Begler, and Deborah Seltzer

Robert Arnold, PhD, is a Professor of Medicine in and Chief of the Section of Palliative Care and Medical Ethics; is Assistant Director of the Institute to Enhance Palliative Care; is Director of the Institute for Doctor-Patient Communication; and is Leo H. Criep Chair in Patient Care at the University of Pittsburgh, *rabob@pitt.edu.*
Mark Aulisio, PhD, is an Associate Professor of Bioethics in and is the Director of the Master's Program in Bioethics, Department of Bioethics, Case Western Reserve University; and is the Director of the Center for Biomedical Ethics at the MetroHealth Medical Center in Cleveland, Ohio.
Ann Begler, JD, is a Principal at the Begler Group, a Pittsburgh firm providing services in mediation, facilitation, and organizational development; is Co-Chair of the Pennsylvania Bar Association Alternative Dispute Resolution Committee; and is Chair of the Pennsylvania Joint State Government Advisory Committee appointed to study and make recommendation to the Pennsylvania Legislature regarding best practices in alternative dispute resolution.
Deborah Seltzer is the Director of the Research Development Center for Research on Health Care at the University of Pittsburgh and is the Associate Director of the Rand-University of Pittsburgh Health Institute.

Ethics consultation is now widely accepted in hospitals as a way to resolve ethical disputes between families, patients, and various healthcare providers. Exactly how consultation should be done, however, is not standardized. In 1998, the Society for Health and Human Values — Society for Bioethics Consultation Task Force on Standards for Ethics Consultation argued that ethics facilitation is the most appropriate approach for healthcare consultation.[1] Contrasting this model to an authoritarian model in which the consultant serves as a "moral expert" and makes a recommendation, and a pure facilitative model in which the consultant merely wants to forge consensus, the task force stated,

> We believe an ethics facilitation[2] approach is most appropriate for health care ethics consultation in contemporary society. . . . The ethics facilitation approach is informed by the context in which ethics consultation is done and involves two core features: identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus. . . .[3]
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> In contrast to an authoritarian approach, ethics facilitation emphasizes an inclusive consensus-building process. It respects the rights of individuals to live by their own moral values by not misplacing moral decision-making authority or acceding to the personal moral views of the consultant. In contrast to a pure facilitation approach, ethics facilitation recognizes that societal values, law, and institutional policy,

> often as discussed in the bioethics literature, have implications for a morally acceptable consensus. The ethics facilitation approach is fundamentally consistent with the rights of individuals to live by their own moral values and the fact of pluralism. It, therefore, responds to the need for ethics consultation as it emerges in our society.[4]

According to this view, the role of those performing ethics consultation is to help the parties articulate the contours of the conflict, clarify misunderstandings and questions, point out unrecognized implications of participants' views, recognize all parties' emotional and moral distress, and negotiate a compromise that satisfies all participants and is within societal and institutional standards.

Arthur Caplan and Edward Bergman come to a similar conclusion in their article, "Beyond Schiavo," although they use the term "mediation" rather than "facilitation."[5] First, they point out that "ethics" conflicts in the hospital do not typically consist of irresolvable conflicts of ethical principles, but instead are the result of misunderstandings, hurt feelings, and a disinclination to creatively discuss how everyone's values can be promoted. Second, they suggest that what helps the parties come to decisions that reflect their values is less a matter of sophisticated ethical analysis and more about bringing parties together, getting them to talk, and getting them to listen to each other in an attempt to find common ground. This is entirely consistent with our experience in which ethics consultations involve issues such as:

- A family who believes that their loved one cannot get better and is suffering and doctors who believe that the patient can get better.
- A patient who needs a high-risk, life-saving surgery, about which the surgeon is ambivalent. While the patient refuses the surgery, his competency is in question. An ethics consultation is requested when the surgeon and psychiatrist come to different decisions about the patient's capacity to consent to surgery. In investigating the situation, it becomes clear that, regardless of the patient's capacity, the patient's surrogate also does not want the surgery.
- A doctor who believes that further intensive care is "futile" and wants to stop treatment and thinks that the family does not "get it." In a meeting, the family agrees that the patient is likely to die, but wants to wait until his son comes home from the Army later in the week to forgo treatment (although they are willing to sign a do-not-resuscitate order for the patient, and to forgo resuscitation should the patient arrest).

There is little with which to disagree in the article by Caplan and Bergman. They point out many of the advantages of mediation. They also raise some unresolved theoretical questions — such as what it means for the consultant to be neutral — that proponents of mediation need to flesh out. We hope to expand on their article in three ways. First, we want to point out that there are a number of models of mediation that consultants need to choose among. Second, we want to point out the educational implications of accepting the mediation model. Third, we call for more research on the relationship between mediation and consultation.

MODELS OF MEDIATION

The difference in how one looks at conflict influences the mediation framework that one adopts. In their analysis, Caplan and Bergman describe the conversation between parties in an ethics consultation as being about conflicting principles or values. Caplan and Bergman translate principles and values into an interest-based model of mediation. In this approach, described by Roger Fisher, William Ury, and Bruce Patton in their seminal work, *Getting to Yes: Negotiating Agreement Without Giving In,* one abandons the more traditional framework of positional bargaining and focuses, instead, on the identification of participants' mutually defined interests.[6]

Other models of mediation focus more on the relationship between conflicting parties. In the transformative model of mediation,[7] the assumption is that it is the absence of empowerment and recognition that prevents the parties from reaching a deeper understanding that is essential to resolving conflict. A primary

purpose of transformative mediation, therefore, is to change the relationship between disputants to a more beneficial and positive one. Another model of mediation, narrative mediation, assumes that underlying conflicts are misunderstandings caused when each person holds on to his or her story as the truth. Narrative mediation helps the participants let go of old, entrenched stories, and, through collaborative work, supports the disputants to form a new, mutually created story that becomes their story.[8]

Whether these relationship-focused views of mediation are ethically or empirically preferable to an interest-based model needs to be elucidated. However, these models of mediation are consistent with data on the importance of dealing with emotion both in making decisions and in healthcare communication. For example, neuro-cognitive data indicate that when people are emotional, the cognitive centers of the brain are less effective. Data suggests that emotion-handling and empathy are as important in predicting conflict, dissatisfaction, and even instigating lawsuits.[9] Recent work also emphasizes the importance of healthcare providers' emotions; reporting, for example, that doctors experience loss, sadness, and hopelessness as their patients become more ill; and that physicians who are close to their patients prognosticate less well than "neutral second opinions."[10]

Ethics consultants thus need to be as comfortable handling participants' emotional reactions as they are understanding and elucidating an individual's moral view. In addition, consultants, like relationship counselors, can help participants be more cognizant of and respond more empathically to other parties' emotional needs and concerns. In this way, consultants may not only solve the existing problem, they also help the other parties to learn to negotiate more successfully in the future.

TRAINING CONSULTANTS

The degree to which those who perform clinical ethics consultations have the skills to serve as mediators is unknown. We are worried, however, that most ethics committees underemphasize this aspect of their training. One expects that everyone doing ethics consultation has some familiarity with basic notions of autonomy, non-maleficence, beneficence, and justice. We wonder how many of those involved in ethics consultation have spent time reading a major work on mediation or conflict resolution. Do they know about the major types of mediation or how mediation is structured? This literature and the lessons it teaches are important for those performing ethics consultations.

Mediation, like ethical analysis, is a skill. Individuals engaged in consultation need to be observed and receive feedback on their ability to mediate conflicts as well as their knowledge and ability to manipulate ethical principles. Individuals engaged in ethics consultation can learn a great deal from how healthcare practitioners learn communication skills. In teaching physicians communication skills, we do not merely have students read books about how to communicate; instead, we have them practice communication with standardized patients, receive feedback on how they did, and then practice again. Those doing ethics consultation should, similarly, practice running meetings with standardized healthcare providers, patients, and families.

Ethics consultants must also think about educating other healthcare providers about the assumptions underlying their work. If the healthcare team does not understand that a consultant's role is to serve as a neutral mediator who helps all parties come to consensus, then the team may expect the consultant to convince a family to take the actions the healthcare team wants. Then, if this doesn't occur, the healthcare team may perceive the consultant as "being unhelpful" and request consults less often.

RESEARCH AT THE MEDIATION/CONSULTATION INTERFACE

Finally, more scholarly work is needed in the field. First, with rare exceptions, there is little scholarly work at the interface of ethics consultation and mediation.[11] We need to reach out and work much more closely with our colleagues in business and the law. We need to understand more about the psychology of conflict and its resolution, about different models of mediation and their strengths and weaknesses, and the

growing literature on ethical issues faced by mediators. (There is also, of course, the theoretical matter of defining what counts as a "good" outcome for clinical ethics consultation.)

Conversely, mediators may learn more about their field from working with those involved in ethics consultation on healthcare. Caplan and Bergman point out how healthcare mediation is like negotiation in a diplomatic crisis. If mediators spend more time practicing in healthcare, it may lead to advances in both the science and the art of mediation.

There also is a tremendous need for empirical work. Other than one recent article, we know of no studies of what those who do "bioethics mediation" actually do.[12] Of particular importance here would be knowledge of how bioethics mediators take into account key contextual features such as societal values that give rise to the rights of individuals, institutional mission and policy, and other key normative issues such as conceptual clarification of the notions like "surrogate" or "best interest" and the like.[13] We need to both better describe the different ways mediation is done and to start to analyze how various methods of mediation may influence the outcomes of patients, family members, and healthcare providers.

We appreciate that Caplan and Bergman point out the importance of "mediation" for ethics consultation. We think there is a growing consensus on this. What needs to be done now is to better characterize what mediation means for ethics consultation. This includes how those involved in ethics consultation might draw on mediation models and techniques and how such models and techniques might be taught to those who are engaged in ethics consultation in clinical settings. We look forward to better understanding and operationalizing the role of mediation in ethics consultation.

NOTES

1. Society for Health and Human Values — Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation, *Core Competencies for Health Care Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998), 6. Robert M. Arnold, MD and Stuart J. Youngner, MD served as co-directors of the Task Force; Mark P. Aulisio, PhD served as executive director.

2. While the conflict resolution literature may treat the terms differently, for the purpose of the present commentary, *ethics facilitation* and *ethics mediation* are synonymous.

3. *Core Competencies,* see note 1 above, p. 7.

4. Ibid.

5. A. Caplan and E. Bergman, "Beyond *Schiavo,*" in this issue of *JCE.*

6. R. Fisher, W. Ury, and B. Patton, *Getting to Yes: Negotiating Agreement Without Giving In,* 2nd ed. (New York: Houghton Mifflin, 1991).

7. B. Bush and J.P. Folger, *The Promise of Mediation: Responding to Conflict Through Empowerment and Recognition* (San Francisco, Calif.: Jossey-Bass, 1994).

8. J. Winslade and G. Monk, *Narrative Mediation: A New Approach to Conflict Resolution* (San Francisco, Calif.: Jossey-Bass, 2000).

9. W.G. Anderson et al., "What Concerns Me: Expressions of Emotion by Advanced Oncology Patients During Outpatient Visits," *European Journal of Cancer Supplements* (in press).

10. W. Evans et al., "Communication at Times of Transitions: How to Help Patients Cope with Loss and Re-Define Hope," *Cancer Journal* 12, no. 5 (2006): 417-24.

11. N.N. Dubler, *Bioethics Mediations: A Guide to Shaping Shared Solutions* (New York: United Hospital Fund, 2004).

12. L.T. Watkins, G. Sacajiu, and A. Karasz, "The role of the bioethicist in family meetings about end of life care," *Social Science & Medicine* (11 September 2007): (epub ahead of print).

13. *Core Competencies,* see note 1 above, pp. 6-8.