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Mediation and Moral *Aporia*

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As Art Caplan and Edward Bergman rightly point out, many clinical ethics conflicts involve genuine ethical ambivalence: there is more than one applicable moral principle, those relevant moral principles often conflict, and there is more than one ethically justified option as a legitimate outcome of the conflict.[1] Although some conflicts are really less about moral disagreement than miscommunication, many conflicts involve a clash between disparate moral considerations, values, or principles, and the morally correct decision or action in these situations is truly in dispute. The *Schiavo* case is a perfect example.

The philosophical term for this state of moral ambiguity is *aporia.* The term *aporia* comes from the Greek, meaning a "state of perplexity." In an *aporetic* situation, there will not be an immediate or automatic consensus among all of the parties involved about the morally appropriate course of action. In such cases, various stakeholders will appeal to the principles supporting their own preferred outcomes. The only way to avoid "winners" and "losers" in these conflicts is to employ a process that doesn't "take sides," but instead tries to navigate a solution that all parties can share. Bioethics mediation provides such a process.

Typically in these conflicts involving competing principles, the hospital's ethics consult service (ECS) will be called in, but the prospect for a shared agreement and a "win-win" resolution between the parties depends on the type of process utilized by that ECS. Many — if not most — consult services are verdict-based: they are working towards a concrete recommendation as the outcome of their deliberations and effort. In fact, the data from a national survey of ECSs report that 65 percent of ECSs always provide a recommendation, and a *single* best course of action is recommended 46 percent of the time.[2] The data don't speak to this question directly, but what is implied by these statistics is that the outcome of the consultation privileges one stakeholder — and the principles she or he prioritizes as most salient in the case — over another stakeholder and his or her preferred principles. Without a privileging of one set of values over another (and, correspondingly, siding with one set of stakeholders over another), it wouldn't make any sense for an ECS to provide a "recommendation," because there would be no conflict, no one advocating an alternative. "Recommendations" are only provided in a context in which choices among competing alternatives need to be made.

But models of ethics consultation that "take sides" in such aporetic disputes are of questionable moral legitimacy because all of the stakeholders are appealing to valid moral principles. If there are legitimate moral claims on both sides, then making a recommendation amounts to the judgment of some body of decision makers that has weighed the arguments and decided which are most compelling. But what gives us

confidence that this judgment is the ethically correct one? To be the arbiter between these competing principles, the ECS must have superior ethical knowledge and expertise to any of the actual stakeholders in the dispute. But what would lead us to believe that members of an ECS possesses such supreme moral expertise? It certainly isn't their training. The same national survey found, for example, that only one consultant in 20 had any formal ethics training and only 50 percent had any apprentice-based training.[3] In *aporetic* cases, it is unclear what level of training would be adequate to adjudicate between valid moral considerations, but these levels are surely insufficient. Once the moral expertise to make such choices is in question, there can be little basis for moral confidence about the verdicts or judgments made in those ethics consultations. The fact that nearly half of all ECSs *vote* at all and 20 percent of ECSs vote *half* of the time[4] exacerbates the concern about confidence in such decisions, because voting indicates the very uncertainty at issue: in these cases, an ECS may not have consensus among its own members (or else why would a vote be taken).

Mediation provides a better method of conflict resolution in these *aporetic* cases than verdict-based processes, because it works towards consensus about *outcome,* even where consensus about principles or values is not possible. Mediation facilitates the creation of a shared solution between parties without taking a stand on which moral principles or claims ought to trump the others in the disputed case. Because it is not verdict-based, it does not claim moral authority when there is none — its "ethical" reach does not exceed its grasp, as in so many traditional consults. And because it includes the voices of all of those affected by the outcome, it legitimizes the moral claims of all of the participants, thereby leveling the moral "playing field" in an arena with clear power and status differentials.

Bioethics mediation is often criticized for taking the "ethics" out of ethics consultation, raising the concern that a neutrally negotiated outcome represents a potential "anything goes," including an outcome that may be ethically suspect. But this criticism — at least in *aporetic* cases like *Schiavo* — is unwarranted: mediation actually provides a built-in ethical safeguard in the face of moral uncertainty, because it refuses to prioritize one set of values or principles over another in the absence of true moral knowledge and/or an authentic moral consensus about what the "right" answer actually is.

NOTES

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

2. E. Fox and D. Pearlman, "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics* 7, no. 2 (2007): 13.

3. Ibid.

4. Ibid.