"Mediation in the Healthcare Context: Challenges and Responses"

By Sarah Stoller[*] (Jan. 1, 2008)

INTRODUCTION

Over the past few decades, as medicine has become more complex and the population has been gradually aging, disputes within the healthcare industry have increased at a staggering rate.[1] Questions may arise about whether a patient is competent to make a decision about his treatment plan; if he is not, physicians, nurses, and family members may disagree about the best course of action. Decisions range from choosing the appropriate level of pain medication to deciding whether a patient is a good candidate for surgery to determining when to "pull the plug" and stop treatment altogether. Since the controversial case of Karen Ann Quinlan in 1976, where the New Jersey Supreme Court announced that a young woman in a persistent vegetative state could be removed from a ventilator, thousands of such bioethical disputes[2] have entered the legal system. While the case law has helped clarify certain legal standards governing the decision-making process, complex issues continue to arise. Given the intensely personal – and often time-sensitive – nature of these disputes, courts have "almost begged" for an alternative decision-making process in end of life disputes.[3]

One alternative dispute resolution mechanism that has been used to resolve bioethical disputes in recent years is the process of mediation. As explored further below, mediation is a private, voluntary, largely confidential, informal process, where parties meet and discuss the dispute at hand. The

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[1] Marc R. Lebed & John J. McCauley, *Mediation Within The Health Care Industry: Hurdles And Opportunities*, 21 GA St. U.L. Rev. 911, 911 (2005).
[2] I will use the terms "bioethical disputes" and "healthcare disputes" interchangeably. In this paper, both refer to such decisions as terminating end of life care, which I will often use as a paradigmatic example of a dispute. Note that, as discussed below, many disputes will actually turn on miscommunications rather than conflicting bioethical principles.
[3] Diane E. Hoffman, *Mediating Life and Death Decisions*, 36 Ariz. L. Rev. 821, 821 (1994).

conversation is facilitated by a neutral third person who helps the parties come to a mutually acceptable resolution. The virtues of mediation have been recognized in various settings, but the place of mediation in healthcare disputes continues to arouse controversy. Some view it as a valuable tool in the handling of bioethical conflict, while others feel that despite its success in other areas, it has little to offer in the healthcare context.

This paper will argue that while healthcare conflicts do pose an especially challenging case for mediators, those challenges can be met. First, I will examine alternatives to mediation, discuss their shortcomings, and propose mediation as a process that might avoid those problems. Then, I will examine the criticisms leveled at mediation in the healthcare context. These criticisms generally fall under one of the following four categories: i) communication barriers, ii) inequalities and imbalances of power, iii) the problem of the zero-sum game, and iv) the inability to resolve moral dilemmas. I will respond to those criticisms by suggesting how mediation can adapt to the bioethical setting and work *with* those challenges and as an antidote to them, rather than being hindered by them. I conclude that mediation is not just a viable mechanism to resolve healthcare disputes, it is a desirable one. In many cases, what are seen as impediments to mediation in fact speak to its strengths.

DISPUTE RESOLUTION MECHANISMS: THE OPTIONS

Any debate over the strengths of mediation must consider alternative forms of dispute resolution. In addition to mediation, the healthcare industry and patients have used litigation, traditional ethics committee deliberation, and non-binding arbitration as methods to resolve conflict. While each has its strengths, each also suffers from some fundamental weaknesses.

Litigation, which is generally seen as a last resort in handling conflict, continues to be one of the most common means of resolving healthcare disputes.[4] The advantages of litigation include the presence of a neutral judge and the safeguards of due process, which may serve to protect the interests of the

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[4] Lebed & McCauley, *supra* note 1 at 911

weaker party.[5] However, the drawbacks of litigation are significant indeed. As in any legal battle, the costs to the parties in terms of time and money can be enormous. Litigation may be particularly problematic in the context of bioethical issues involving deeply personal, familial affairs. Litigation is a formal, adversarial process; it is to each party's benefit to attack the other's position. Such confrontation threatens to divide even deeper the rifts among family members that exist at the outset of the dispute. Furthermore, given the public nature of the litigation process, matters that the family may wish to keep private may become exposed to the public.[6] The public exposure may also invite unwelcome political involvement, threatening to interfere with the family's decision.[7] The case of Terri Schiavo provides a heartbreaking example of these risks. Finally, a case in litigation focuses solely on legal issues, when the root of the problem may have just as much to do with emotional issues that could not be resolved by a judge.

Another mechanism for bioethical dispute resolution is what I will call the "traditional" hospital ethics committee deliberation, which meets without the patient or family. As a summer intern in the ethics department of a hospital a few years ago, I participated in several of these meetings. The committee consisted mostly of physicians, as well as some nurses, board members, and social workers. Before the committee convened (generally at the request of a physician), the committee head would contact the treating team and the patient or the patient's family to gather information about the dispute. The committee would then meet to discuss the issue (in the meetings that I attended, the question generally centered on whether a patient was competent to make a healthcare decision). The most noticeable advantage was the speed with which the decision was made; the committee generally reached a resolution within an hour or two, mostly based on the treating doctor's assessment of the patient's competence. However, there were several problems with this approach. First of all, since the patient and family were not present, it is possible that some of their views were lost in the retelling of their story.

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[5] Hoffman, *supra* note 3 at 825.

[6] Joanna M. Canter, *Nonjudicial Alternatives for Resolving End-of-Life Decisions for Minors*, 43 Fam. Ct. Rev. 527, 527 (2005).

[7] Id.

Secondly, virtually all of the members were hospital staff and may have had similar biases; I noticed, for example, a common theme of fear of litigation if they stopped treatment, as well as a concern for allocation of resources. Compounding the problem, I often witnessed the same committee members (senior physicians or board members) dominating the conversation; there was no doubt that their voices were heard more than others. Moreover, as explained below, the source of a lot of bioethical conflict turns out to be miscommunication between physicians and patients or families; when that is the case, and the patients or families are not present during the resolution of the issue, the miscommunication might never be cleared up. Furthermore, I would imagine that the parties to the dispute resented their lack of participation in such a personal matter and having a judgment handed down. Finally, as in litigation, issues that are only tangentially related to the matter at hand but are important to the parties would be left off the table. [8]

A third option, ethics committee arbitration, involves both the ethics committee and the patients and families: each party (whether it be the patient, the family, the physician, or the nurse) presents its case to the ethics committee, which issues a non-binding recommendation (which is generally adopted).[9] The process is faster and cheaper than litigation, and involves greater patient participation than does the traditional ethics committee procedure. Like litigation, however, this method is still adversarial and confrontational. With each side pointing to the strengths of its own position and the weaknesses of the other, relationships could be severely damaged – both familial relationships and relationships between patients and their doctors. It is important to note that these disputes occur in the context of an ongoing course of treatment; frequently, the physician continues to treat the patient during the ethics consultation proceedings.[10] Therefore, it is essential that the trusting relationship between doctor and patient not be damaged during the process; in an adversarial arbitration, that trust may be eroded. Furthermore, in a confrontational setting, the parties might not feel comfortable airing some of the more personal matters

[8] This idea will be explored in greater detail later in the paper.
[9] Robert Gatter, *Unnecessary Adversaries At The End of Life: Mediating End-Of-Life Treatment Disputes To Prevent Erosion Of Physician-Patient Relationships*, 79 B.U.L. Rev. 1091, 1095 (1999).
[10] Id.

that are seemingly irrelevant but are actually critical to the issue at hand. Finally, there is again the risk that the arbitrating ethics committee, composed of hospital staff, may be biased in favor of the treatment team.

Finally, there is the process of mediation. In a typical bioethics mediation, the parties will include the patient (if he is competent), the patient's family members, several members of the treatment team, and the mediator. The mediator is generally employed by the hospital, but may be from outside the institution.[11] The mediator is there as a neutral third party to facilitate the conversation, draw out the issue, and help the parties fashion their own remedy to the problem. The process of mediation may combine the strengths and avoid the weaknesses of litigation, traditional ethics committee deliberation, and arbitration. Some of these advantages are explored in more depth below, but briefly, they are as follows: i) the patient and/or her family participate in the process and craft their own resolutions, and thus feel like they have more control over the process, ii) the process is non-confrontational and therefore promises to better preserve relationships and trust among parties[12], iii) during the conversation, issues may come out that are crucial to the dispute that would likely not be addressed by the other dispute resolution mechanisms, iv) it may cure misunderstandings from miscommunication, and v) while not as speedy as traditional ethics committee deliberation, it is still faster and cheaper than litigation.

Despite these advantages, the healthcare industry still primarily resolves its disputes either in arbitration or in court, rather than following the national trend of adopting mediation as a significant tool of conflict resolution.[13] Indeed, the idea of mediation in the healthcare context has been met with great resistance and challenges. These challenges are explored below.

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[11] Nancy N. Dubler & Carol B. Liebman, Bioethics Mediation: A Guide to Shaping Shared Solutions 40 (United Hospital Fund of New York 2004) (2004).

[12] Studies have shown that mediation better preserves relationships between disputants than does adversarial processes. Gatter, *supra* note 9 at 1111-1112.

[13] Lebed & McCauley, *supra* note 1 at 911.

THE SUITABILITY OF MEDIATION IN THE HEALTHCARE CONTEXT: CHALLENGES AND RESPONSES

Scholars have attributed the healthcare industry's opposition to mediation to a multitude of factors.[14] As mentioned above, these factors generally fall into one of four categories: i) communication barriers, ii) inequalities and imbalances of power, iii) the problem of the zero-sum game, and iv) the inability to resolve moral dilemmas. While I agree that healthcare disputes present an especially challenging task for mediation, I will argue that these challenges can be met. In fact, what sometimes seems a barrier to mediation may actually point to its strengths.

1. Communication Barriers

One reason for the healthcare industry's resistance to mediation that scholars have identified is the existence of communication problems between physicians and their patients and patients' families.[15] Indeed, it has been argued that the disconnect in communication styles between physicians and patients is so great that they do not even "speak[] the same language,"[16] as they do in, for example, business to business disputes. Studies have shown that:

> Poor communication plagues physician-patient communication. Studies reveal that physicians generally do not communicate well with patients. During clinical encounters, physicians often interrupt patients with questions and ignore patients' comments. Similarly, physicians tend to use medical jargon when explaining medical conditions and treatments to patients. As a result, patients often lack or misunderstand crucial information about their medical conditions and treatment options.[17]

Accordingly, the healthcare industry may view mediation between physicians and patients as akin to cross-cultural mediation – a daunting task that it does not feel it is equipped to handle.[18]

What this analysis may be missing is the fact that miscommunication does not necessarily pose a *further* challenge to the resolution of a dispute – it may be the source of the dispute itself. For example, it

[14] See, e.g., Lebed & McCauley, *supra* note 1, Hoffman, *supra* note 3.

[15] Lebed & McCauley, *supra* note 1 at 913-14.
[16] Id.
[17] Gatter, *supra* note 9 at 1114-1115.
[18] Lebed & McCauley, *supra* note 1 at 913-14.

may be the case that a dispute over whether to honor a patient's Do Not Resuscitate (DNR) order, with the treatment team wishing to honor it and the family members wishing to disregard it, may stem from the language the physician used to identify the patient's prognosis were he to be resuscitated. The doctor may say that the resuscitation will "revive" the patient, meaning only that the patient will continue to live, while the family may interpret that to mean that the patient will be restored to a previous level of health. Interestingly, the literature sometimes suggests that disputes stemming from miscommunication are somehow less "real" than other disputes and therefore less deserving of mediation. In one article, for example, the author discusses the impediments to mediation in the healthcare context. She notes at the outset of her discussion, however, that what are labeled as disputes are actually often merely miscommunications and therefore "false disputes", as compared to "real disputes" that center on such things as conflicting ethical or religious principles. She then goes on to address mediating only the "real disputes."[19] The implication seems to be that such "false disputes" could be resolved by methods other than mediation – perhaps by providing better communication training to doctors, for example. Certainly, conflicts stemming from miscommunications may not be as profound as religious conflicts, but they are no less important to the decision-making process. Perhaps additional communications training to physicians *is* needed – but as long as there continue to be misunderstandings that form the basis of disputes, mediation has much to offer.

Indeed, rather than viewing communication problems as a barrier to mediation, the better perspective is that those challenges create an even greater need for mediation. After all, miscommunications are even less likely to be cleared up in traditional ethics committee deliberation or arbitration, where the members of the committee are mostly practicing physicians who may be less attuned to patterns of poor communication that are causing the disputes (not to mention the fact that in traditional deliberation, the patient is not even present – surely reducing the chance of clearing up the miscommunication). And in both the arbitration and litigation context, the parties might just talk over one another; a decision might be made without the underlying miscommunication being identified or

[19] Hoffman, *supra* note 3 at 828-29.

cleared up. Indeed, mediation seems like the ideal vehicle in which to address miscommunications. Firstly, the presence of a third party who is not a physician (and therefore removed from medical jargon) may help in the identification of the communication problem. Furthermore, since mediation resolves disputes through mutual agreement, is to the advantage of each party to persuade the other of the correctness of his position, which can only be done if he makes an effort to explain it clearly.

If mediation may be the best way to resolve miscommunications in theory, in practice, there are several steps a mediator can take to best achieve that outcome. To begin with, while it is beneficial for a mediator to have substantive familiarity with the subject matter in whatever field in which he is mediating, that is particularly true in the medical context; if the mediator does not understand a patient's prognosis or doctor's treatment plan, it will be difficult, if not impossible, for him to identify the miscommunication. Furthermore, the mediator should undertake more extensive fact-finding before the session than he might if he were mediating a different issue, where an initial bare bones understanding of the conflict might suffice. Given the complexity of medical matters, the mediation would likely go more smoothly if the mediator understood the patient's condition and the issues associated with it before the session begins; then, in the beginning of the session, when the parties present their views on the situation, the mediator can more easily identify the gap between the understanding of the patient or family and the understanding of the physician.

Perhaps most importantly, during the session, the mediator can take steps to minimize the risk of miscommunication. The mediator should slow down the discussion of the medical facts, asking the treatment team to explain its terminology.[20] When summarizing what the parties have said, the mediator should avoid euphemisms about a patient's prognosis, particularly in end of life situations. Studies have shown that while physician/patient communication is poor in general, it is even worse at the end of life than in other contexts. As one scholar has noted,

> Physicians commonly perceive a patient's dying as a professional failure; thus talking to a patient or patient's family about the imminence of death is, to many physicians, conceding such failure.

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[20] Dubler & Liebman, *supra* note 11 at 26.

> As a result, physicians may be more likely to avoid or inadequately address [end of life treatment] decisions than any other kind of treatment decision. [21]

Furthermore, members of the treatment team may provide mixed messages about the patient's prognosis, each assuming that another care provider will take responsibility for providing the painful news.[22] A mediator who can speak in direct terms about the patient's condition may be able to clear up the miscommunication and help resolve the dispute.

2. Inequalities and Imbalances of Power

Another identified barrier to mediation is "widespread inequalities and imbalances of power" between the physician and the patient or family.[23] Critics argue that mediation cannot cure the power imbalance and that the resulting settlement will be "tainted by the inequality inherent in the physician-patient relationship."[24] First of all, it is important to note that inequalities exist in various fields that currently employ mediation as a problem-solving tool, such as in the employment context. Nevertheless, it may be true that the power differential is greater in healthcare disputes. The power imbalance in healthcare conflicts stems from various sources: the different level of knowledge and expertise between the physician and patient, the "highly technical and unfamiliar physical setting" of the hospital, and the physical or emotional stress of the patient or her family during what is undoubtedly an enormously trying time.[25]

As was the case with miscommunications, however, the power imbalance inherent in doctor/patient relationships only speaks to the need for mediation. One of mediation's greatest strengths is its ability to neutralize imbalances of power; this is no less so in the context of healthcare disputes. In any mediation, a mediator can do several things to help level the playing field. First of all, he can lay down and enforce ground rules establishing, for example, that all parties must be allowed to speak

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[21] Gatter, *supra* note 9 at 1115.
[22] Dubler & Liebman, *supra* note 11 at 50.
[23] Lebed & McCauley, *supra* note 1 at 915.
[24] Gatter, *supra* note 9 at 1120.
[25] Dubler & Liebman, *supra* note 11 at 11.

without interruption. Second of all, he can initiate caucuses. Caucusing privately with the patient or family would allow them to express feelings that they might not feel comfortable sharing directly with the physician. Furthermore, caucusing with the physician alone would allow the mediator to challenge the physician in ways that the weaker parties might not have felt comfortable doing – by, for example, laying out the BATNA in the form of a lawsuit. [26]

Other aspects that are unique to healthcare disputes suggest further steps a mediator might take to neutralize the power advantage. First of all, the mediator should be mindful of the number of parties involved. More so than in other contexts, there might be a great imbalance in terms of the numbers of people on each side of the dispute; given the increasing specialization of medicine, a treatment team might consist of a dozen members, all advising the patient or family, which could be overwhelming. While the views of everyone on the treatment team should be represented at the mediation, they do not – and should not – all be physically present (even if it would be possible to coordinate everyone's schedules). Rather, the mediator should seek to include those with the greatest involvement in the case, as well as those with whom the patient or family feels most comfortable; frequently, the patient and family are most comfortable with the nurses, who spend the most time with them.[27] The mediator should also arrange the seating such that patient or family is seated near the members of the treatment team with whom they feel most comfortable, so as to provide them with a sense of support. Finally, the mediator can help level the playing field in the language that he uses to frame the issues and the way in which he focuses the conversation. If the physician is using highly technical or impersonal terms, the mediator can steer the focus back to the patient. For example, the physician may speak about the acceptability of administering morphine (which numbs pain, but also speeds the process of death) to dying patients. The mediator might shift the conversation away from general views on morphine administration to the actual patient at hand – the desirability of providing *Mary* with morphine, for example. This tactic may accomplish two things. Firstly, emphasizing that the hardships being discussed refer to an actual person,

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[26] Gatter, *supra* note 9 at 1121.
[27] Hoffman, *supra* note 3 at 833.

and a family member at that, might serve to validate the family's emotional stress (as well as to remind the physician of that hardship). Secondly, by shifting the focus back to the patient, the mediator highlights the *family*'s expertise, as compared to the physicians. In a healthcare dispute, the one area where the family has the informational advantage is its knowledge of the patient and what she would want were she competent. Throughout the discussion, the mediator should encourage the family to talk about the patient as a person. Emphasizing the family's informational advantage in this area could empower them in the discussion.

Based on the above analysis, it is clear how mediation can alleviate the power imbalance better than could a traditional ethics committee deliberation (where the weaker parties are not even present) or arbitration (where there is less room for informal shifting of power). Still, however, some argue that mediation cannot correct the imbalance to the extent that litigation, with its associated due process protections, could do.[28] Some argue that the mediator, who is generally a hospital staff person, may not be truly neutral, as a judge in a court of law is (or at least, would not *appear* to be neutral to the patient or family). I think that this is a fair concern, and I would recommend that hospitals employ independent mediators. For now, however, hospitals generally prefer to use a staff member, explaining that insiders understand the inner workings of the hospital, are more comfortable with the setting, are more knowledgeable about the power and political camps, etc.[29] If the hospital cannot be convinced that neutrality (or the appearance of neutrality) offsets these benefits, then, at the least, the mediator should acknowledge at the beginning of the session his relationship with the hospital, and assure the patient or family that he will truly act impartially. Furthermore, in terms of the option of litigation, it may be the case that if the patient or family does indeed feel threatened by the imbalance of power, they might be too intimidated to take the matter to court; mediation might seem like a less confrontational and more acceptable option. And with the mediator there, caucusing and checking in with the parties, there is not a

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[28] Hoffman, *supra* note 3 at 825.
[29] Dubler & Liebman, *supra* note 11 at 40.

great risk of the patient or family getting trampled on and not feeling like they would be able to litigate if they so chose.

3. The Problem of the Zero-Sum Game

Perhaps the biggest perceived obstacle to healthcare mediation is the notion that the object of bioethical disputes is indivisible. In "zero-sum" situations, one party wins and the other loses; there is no room for compromise. In disputes outside of the healthcare context, such as a conflict in the workplace, there may be a variety of possible outcomes – an employee could be fired, retained, transferred, put on probation, etc. In bioethics disputes, by contrast, it may seem that the conflict is not amenable to compromise: either the patient will be resuscitated, or he won't. Either the physician will withdraw life support, or she won't. Where there is one indivisible issue on the table, the suitability of mediation (generally touted for its ability to "expand the pie") is questionable.[30]

There are multiple flaws in this analysis. To begin with, medical decisions are not always so black and white. For example, there may be a disagreement about how much morphine is desirable or acceptable for a dying patient. Or there could be a decision to allow the treatment team to resuscitate a patient in the event of a cardiac arrest but to agree that the parties would reconvene in a week to assess the patient's condition and reconsider the DNR option.

In other situations, the range of decisions may not be apparent from the start, because the relevant interests of the parties may not have been identified; it is in these cases where mediation can be of most use. Mediation, unlike any other dispute resolution mechanism, is tailored to drawing out the story and identifies the parties' underlying concerns. It does this by allowing the parties to share what they are feeling, even if those feelings do not seem directly related to the narrow issue at hand, and by having the mediator follow up with probing questions. In their book Bioethics Mediation, Nancy Dubler and Carol Liebman provide a good example of underlying interests coming out during the course of a mediation. In "Jennifer's Case," Jennifer, an 18-year-old patient who suffered from Von Recklinghausen's ("Elephant

[30] Hoffman, *supra* note 3 at 867.

Man") disease, had been hospitalized many times. The condition was disfiguring and life-threatening, and her latest admission to the hospital had been prompted by the growth of a tumor on her neck that closed her trachea and prevented her from breathing without a ventilator. Tests determined that it would be possible for Jennifer to undergo surgery to remove enough of the tumor to enable her to breathe on her own. However, Jennifer communicated by pad and pencil that she did not want the surgery because she had suffered enough. She understood that she would die as a result. Her attending physician wrote the following note in her chart: "Patient is an adult and is capable of choosing the kind of care she wants. She should be removed from the intensive care unit and placed in a private room to die. Morphine should be provided when needed." A bioethics mediation was called. During the session, Jennifer's nurses appeared uncomfortable with the doctor's order. At first, they stated that their ethic of care required that they not contribute to a patient's death. Further discussion, however, revealed that the nurses felt their real obligation was to show respect and provide comfort to Jennifer, and not to let her die alone; the stark directive to place Jennifer "in a room to die" had disconcerted them. In the end, although the nurses still wanted to try to persuade Jennifer one last time to opt for surgery, they accepted her decision. The care plan was changed, however, to allow Jennifer to remain in the intensive care unit with the nurses, and the nurses would ensure that she would receive enough morphine to relieve her discomfort as she passed away. The nurses were satisfied with the result.[31]

While underlying issues may lurk beneath the dispute in a variety of contexts, they might be particularly prevalent in end of life decisions; given how emotional the situation is, it may be difficult for the parties to sort out their feelings. Having to respond to probing questions (for example, in Jennifer's Case, the mediator might have asked the nurses if there was anything the team could do to make Jennifer's death more acceptable) may be the only way to pinpoint the problem. Drawing out underlying issues might also be particularly useful in the healthcare context, where parties – be they family members or members of the treatment team – will continue to interact with each other in the future. In Jennifer's Case, the discussion might result in a systematic change, such as the doctor writing more respectful notes

[31] Dubler & Liebman, *supra* note 11 at 47-49.

in the chart. Again, the nurses might not have realized that the stark instruction had been responsible for their discontent – and if even if they had, they might not have felt comfortable outside a mediation context to complain to the physician about such a seemingly trivial matter.

Finally, in addition to identifying underlying substantive interests, mediation also recognizes what may be equally important: procedural interests, such as having one's voice heard or feeling like one is part of the decision-making process. In the hospital where I worked, I recall an ethics committee meeting designed to decide who the appropriate decision-maker was in a particular case concerning an incompetent patient. It was determined that the patient's son had the authority to make the decision – not his estranged sister, who had flown in from out of town. The decision was handed down and the case was closed. The mediation simulation we did in class about two brothers dividing their father's estate reminded me of that situation. During the mediation, it came out that Ted, who had been living in California for years, was more concerned about learning about his father's demise and how the money had been spent than in actually obtaining the money; he felt out of the loop and wanted to be brought into the process. It also came out that his brother, Bill, who had taken care of their father for the past decade, felt somewhat resentful that Ted had disappeared for so long, only to come back demanding money. It strikes me that a situation like this might come up in the context of an end of life care dispute. If the son and sister in the case mentioned above had been brought together to discuss the situation, they each might have appreciated a chance to hear their voices heard – even if, in the event of a disagreement, it was determined that the son had the power to make the decision. Mediation might have allowed both parties to better cope with their loved one's death by exploring the son's resentment of his aunt's abandonment or her resentment of being kept out of the loop during her brother's final days.[32] In all of these ways, what might seem like a zero-sum situation immune to the benefits of mediation could actually be greatly enhanced by the process.

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[32] Some will argue that such a time-consuming process is not appropriate for a hospital to engage in; the son and sister, after all, are not the hospital's patients. This objection will be addressed below.

4. The Inability to Resolve Moral Dilemmas

Another argument against mediating healthcare conflicts is that mediation is not well suited to address ethical disputes. Although the majority of "bioethical disputes" often turn on matters such as what treatment plan will prove most promising for the patient, or what the patient would have wanted were he competent, occasionally, there is a "true" moral dilemma. Parties may disagree, for example, on the ethical permissibility of administering morphine – which, as mentioned, alleviates pain, but also speeds the process of death – to a dying patient. Or, a family may wish to keep a relative on life support even when there is no chance of recovery; a physician might argue that it is morally wrong to waste those resources, given the number of patients in need. Some have argued that "if any party views the dispute as one in which there is a definite right or wrong answer and about which they have a highly moral or fundamentalist view, mediation might not be effective. Such individuals may view compromise as an admission of 'normative weakness.'"[33] If compromise is not available, the argument goes, mediation can be of no use. In a way, this critique is a sub-argument of the zero-sum game line of reasoning.

Like the zero-sum game argument, however, the analysis is somewhat flawed. A mediator trained in bioethics may help the parties to understand the validity of each others' moral viewpoints.[34] For example, if a family member is opposed to administering morphine to a dying relative, comparing it to assisted suicide, the mediator might begin by relaying some of the institutional responses to the acceptability of morphine provision. She would point out that the Supreme Court, the American Medical Association, and the bioethics literature have all stated that the secondary effect of hastening death should not prevent a health care provider from using medication to alleviate pain.[35] Understanding that the legal

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[33] Hoffman, *supra* note 3 at 863.

[34] Note, however, that the mediator should not try to convince one party of the correctness of the other's moral belief; the following discussion explains only how he might help the parties *understand* each others' convictions. As in other mediation contexts, the mediator should not impose his own norms. The only exception would be when there is a proposal on the table that is *clearly* unethical, such as the possibility of terminating life support when there is a good chance of recovery and when the patient himself has requested that all efforts be taken to keep him alive. Based on my personal experience and on the bioethics literature, this kind of dispute hardly, if ever, arises.

[35] Dubler & Liebman, *supra* note 11 at 49.

and ethical community have accepted the permissibility of morphine provision might soften a party's strong stance against it. While the same information presumably could have been provided by the attending physician, it would likely seem more credible coming from a neutral third party.

Of course, a party who views the administration of morphine as assisted suicide might not take the Supreme Court's word that it is permissible. The mediator should therefore not only be up to date on bioethical literature, but should also be familiar with bioethical principles and methods of reasoning herself. For example, the mediator should be prepared to answer the question of *why* hastening death by using morphine is different from, say, the tactics used by Dr. Kevorkian. The mediator should be able to point to what bioethicists call the "morally relevant differences" between the two situations. For example, she might point out the fact that the patient at hand, unlike Kevorkian's patients, would die anyway of the underlying disease, even without the morphine. Or she might note the moral significance between an act whose primary purpose is death (in Kevorkian's case) and an act where death is only the secondary effect (as in morphine provision, where the primary goal is the alleviation of pain). The mediator might also find it useful to frame the dispute in terms of bioethical principles: a consequentialist approach would underscore the fact that that the overall consequences are better with morphine than without because the patient will experience a faster and less painful death, while a deontological approach, which demands respect for others, would also laud a mechanism meant to alleviate discomfort and honor a person's dignity by hastening a more comfortable death.

Critics might respond that such arguments will not persuade a person with a deeply held moral belief to change her mind, and there may be a great deal of truth in that. Even if that is the case, however, the process of mediation can de-escalate hostility and allow parties to communicate respectfully with one another.[36] A striking example of this is the Common Ground Project, where mediators facilitated discussions between pro-choice and pro-life advocates about the moral dimensions of abortion. At the end of the session, while the participants had not changed their views on the permissibility of abortion,

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[36] Gatter, *supra* note 9 at 1129.

they "found some areas of agreement…. [and] reported having less stereotypical perceptions about those with whom they disagreed and feeling less prone toward using extreme tactical measures in the ongoing abortion debate."[37] In the context of personal healthcare disputes, this de-escalation of hostility is particularly important, given the familial relationships at stake. Moreover, even if the parties continue to disagree and decide to litigate the issue in court, the reduction in hostility might make the litigation process go more smoothly and be less emotionally trying.

CONCLUSION

Given the analysis above, it seems that mediation is not only workable as a dispute resolution mechanism in the healthcare context, but may actually be particularly well-suited for the job. It can clear up miscommunications that form the basis of disputes, help equalize imbalances of power, identify points of compromise or additional interests in what seems to be a single, indivisible issue, and help the parties understand each others' ethical viewpoints. As compared to the alternative forms of dispute resolution, mediation may be the best route.

A final challenge to mediation, however, presents a more practical problem. Doctors and other members of the treatment team may assert that there is simply not enough time in their schedules to accommodate mediation as presented above; their main concern, they might argue, is the health of the patient, not the emotional concerns of the patient's relatives. Several responses might be offered to this contention. First of all, the time spent in mediation will likely be partially offset by the gains of avoiding litigation, assuming some of the disputes would go to court in the absence of mediation. Furthermore, dealing with some of the more "emotional" issues among family members may not have to include the presence of the treatment team. A final, perhaps more controversial suggestion, is to adopt a broader sense of what the healthcare industry is supposed to accomplish. While a hospital's primary purpose should be the health of its patients, a more family-centered approach to healthcare – as is adopted in some other cultures – would elevate the coping of a family with the death of a relative to a higher priority than it is now given. Dealing with the process of the death of a loved one is one of the most painful

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[37] Gatter, *supra* note 9 at 1129-30.

experiences a person can endure. Hospitals may be able to better incorporate that concern into their care of a patient, and use mediation as a vehicle for doing so.