

# The Art of Resolving Complex Health Care Disputes

BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS  
(Nancy N. Dubler & Carol B. Liebman). New York, NY: United Hospital  
Fund of New York,\* 2004. \$39.95 (paperback).

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## I. INTRODUCTION

When 82 year-old Edward Davidoff's<sup>1</sup> chronic, uncontrolled health problems were compounded by infections and respiratory problems after emergency bypass surgery, everybody caring for him recognized the futility of further treatment—that is, everybody except his wife. No one on the medical team had made the situation clear to her, yet they were frustrated by her determination to pursue every possible course of treatment to keep her husband alive; she, in turn, was frightened and angered by the apparent lack of response to her husband's condition. This scenario represents the quandary of how to find a middle ground between the emotional needs of loved ones and family members and the clinical realities that must be faced.

Traditionally, conventional tort litigation has been the most frequently accessed mode of “finding a middle ground” and settling health care disputes. However, the courts are merely a single source of dispute resolution. While conventional litigation is appropriate for some cases, the courts should not be considered as a universal dispute resolution method that is suitable for every claim. Mediation as an alternative to litigation offers several benefits, such as controlling frivolous lawsuits, alleviating high costs

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<sup>1</sup> In the description of this case, the name has been changed to protect the privacy of the patient, family, and health care provider.

associated with litigation, providing for confidential reflection and discussion and allowing for more flexible and creative outcomes.

In Mrs. Davidoff's case, mediation proved to be the optimal method for finding a middle ground between her emotional needs and the clinical realities that she had to face regarding her husband's condition. The primary nurse requested a bioethics consultation, which allowed for an open discussion of the issues and options. The consultation also enabled Mrs. Davidoff to decide that her husband would not want to continue invasive treatment, and it yielded a supportive care plan. Bioethics mediation was the key to defusing the conflict and resolving the seemingly incompatible needs of everyone involved.

## II. OVERVIEW OF *BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS*

The publication that is the subject of this review provides the necessary tools to resolve increasingly common medical care disputes. *Bioethics Mediation: A Guide to Shaping Shared Solutions* is based on more than ten years of hospital experience and offers not only theory, but also detailed guidelines and practice exercises for health care and related professionals. Drawing on real-world case studies and analyses, the book teaches skills for resolving conflicts in a way that respects the rights and interests of all involved parties. It explains 1) how bioethics mediation differs from both traditional mediation and traditional bioethics consultation, 2) how to apply mediation skills and techniques to health care disputes, and 3) how to implement a mediation program in a hospital or other health care setting.

The authors begin the book by answering a basic but important question: What is bioethics? It is, simply stated, an area of scholarship that has defined a set of ethical principles that support the therapeutic relationship between health care provider and patient. Under bioethics principles, the health care provider has certain obligations, including patient autonomy,<sup>2</sup> beneficence,<sup>3</sup> nonmaleficence,<sup>4</sup> and distributive justice.<sup>5</sup> However, bioethics is about more

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<sup>2</sup> The principle of patient autonomy involves supporting and facilitating the capable patient's guide to self-determination.

<sup>3</sup> Beneficence means promoting the patient's interests and well-being and protecting the patient from harm.

<sup>4</sup> Nonmaleficence is the preventative measure of avoiding doing harm to the patient.

<sup>5</sup> In this context, distributive justice means fairly allocating the benefits and burdens related to health care delivery.

than ethical obligations; it is about the patient, who is a unique individual, and whose medical condition affects a wide range of people, including family, friends, and health care providers.

As patient rights have come to the fore in recent years, bioethics disputes have become increasingly more common. Adding to the prominence of this issue is the recent shift in fee arrangements. In the past, fee-for-service medicine—and its incentives for overtreatment of patients—was prevalent. However, the growth of managed care has shifted fees to a capitated arrangement, which provides incentives for undertreatment.<sup>6</sup> This shift has fueled the recent tensions between all parties involved in the health care field. As tensions rise, so do disputes, and the need for new and innovative resolution tools becomes even greater. As *Bioethics Mediation* demonstrates, bioethics mediation has proven to be a valuable tool in resolving these increasingly common disputes.

### III. BIOETHICS MEDIATION VS. TRADITIONAL MEDIATION

The first portion of the book explains why mediation is a valuable tool for addressing the complex conflicts encountered in the medical context. The authors come to this conclusion by analyzing the experiences of an active bioethics consultation service in a large urban teaching hospital. Over ten years, the hospital used a combination of cases and scholarly discussions, and learned through both successes and failures. This portion provides essential background information for parties preparing to engage in bioethics mediation.

#### A. *The Case for Mediation*

Over the past several decades, mediators have been called upon to resolve disputes in several different areas, including employment cases, special education cases, family disputes, environmental disputes, consumer disputes, and labor-management disputes. Mediation has become appealing to parties because it helps them identify their goals and priorities and work toward a mutually acceptable solution. While a judge acquires information in order to determine what happened and who is to blame, a mediator gathers data to interpret what happened and accommodate the conflicting interests and needs of the parties.

Although mediation has proven to be a useful method of dispute resolution in several areas of the law, the question still remains: Is mediation

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<sup>6</sup> For example, in a capitated fee arrangement, the provider is reimbursed at a previously negotiated rate, regardless of the cost of treatment.

an appropriate mode of resolution of bioethics disputes? *Bioethics Mediation* answers this question affirmatively and posits that a mediator can have a crucial role in resolving bioethics disputes. That is, the mediator ensures that the options in a given case are based on respect for the parties involved, respect for the interests and rights of patients and their families, and regard for differences. To remove these elements from dispute resolution and simply allow the hospital to make all decisions would be a one-sided and authoritarian method of dispute resolution, which, of course, does not always lead to the ideal outcome.

### B. *Unique Qualities of Bioethics Mediation*

As the role of the bioethicist requires modification of some traditional mediation practices, bioethics mediation is unique in several ways. The authors outline several differences between traditional mediation and bioethics mediation. The following are the most notable differences:

- The bioethics mediator is generally employed by the hospital, whereas in most traditional mediation programs the mediator is a neutral party with no allegiance to either side. A bioethics mediator's status as a hospital employee ensures that he or she has the requisite substantive knowledge about the health care system. This knowledge often provides a crucial starting point for resolving conflicts.
- Deciding not to reach a resolution is not an option for bioethics mediators, whereas in most mediation contexts it is acceptable to fail to reach an agreement. Because the mediation revolves around the welfare of the patient, decisions *must* be made about whether to continue or end treatment.
- While confidentiality is the core principle of nonmedical mediation, confidentiality in bioethics mediation is limited to information not relevant to patient care. This is because good medical care requires that all providers share information about the patient's condition and care.
- The person with the greatest stake in the dispute, the patient, is often not at the mediation table. This differs from traditional mediation, where mediators often require that all stakeholders be present during the mediation or at least have an agent representing them. In bioethics mediation, a patient's medical condition often precludes him or her from participating. While the patient may have completed an advanced directive before he or she became incapacitated, few

patients do this. Therefore, it is quite common to draw out a patient's wishes through discussion with family members.

- In bioethics mediation, there may be a sequence of separate, prior meetings in addition to the group mediation. Contrast this with traditional mediation, where the norm is for the mediator and the parties to have limited contact before the formal mediation process commences. Bioethics mediators usually meet with members of the treatment team first to obtain relevant medical information, and may discuss with the treatment team how to present options to family members.
- The parties do not usually sign an agreement to mediate a bioethics dispute, as they often do in traditional settings. This difference can be attributed to three reasons: 1) most documents hospital patients are asked to sign are for the benefit of the institution, not the patient; 2) bioethics mediation is not truly confidential;<sup>7</sup> and 3) families who are under stress are likely to resist signing agreements.
- Bioethics mediators are often involved in following up on implementation of the agreement, whereas in traditional mediation the dispute escalates to court if one party fails to uphold his or her end of the agreement. In a hospital, unresolved conflicts are likely to return to the attention of the bioethics mediator.
- All participants in a bioethics mediation have a common interest in the well-being of the patient. There is no other mediation setting in which the parties always have a singular focus.
- While the stakes in traditional mediations vary, bioethics mediation consistently involves life and death issues. This means that parties bring extraordinarily strong emotions to the table, and handling this can often be more important than the facts of the case.

#### **IV. APPLYING MEDIATION SKILLS AND TECHNIQUES TO HEALTH CARE DISPUTES**

The second part of the book serves as a practical guide to preparing for and conducting a bioethics mediation program. The methods presented in this section combine lessons learned from real-life bioethics consultations with

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<sup>7</sup> In traditional mediation settings, the mediator usually asks the parties to sign an agreement to mediate in order to provide for confidentiality of mediation communications.

mediation literature. The result of this clever combination is a flexible framework that the mediator can customize to fit his or her particular case.

### *A. Helpful Considerations Before Beginning a Bioethics Mediation Program*

First, the authors outline the basic knowledge that every bioethics mediator should have. This includes knowledge of ethical and legal principles, a general understanding of medicine and the medical environment, and an awareness of the culture at a particular institution. Regarding ethics, a bioethics mediator should be familiar with the four central ethical principles on which bioethics rests: patient autonomy, beneficence, nonmaleficence, and distributive justice. In addition to these ethical principles, the mediator should have an understanding of the principles of negotiation and conflict management. Furthermore, it is helpful if the mediator is familiar with the culture of the particular health care setting. This is most efficiently achieved by teaching the process of mediation to professionals who are already knowledgeable about the intricacies of bioethics.

### *B. Stages of Bioethics Mediation*

Next, the book contains an outline of the stages of a typical bioethics mediation. The outline is designed to describe the mediation process and show how it works. While the seven stages are described in a set order, they need not be taken as sequential. That is, most mediations will not flow through the stages in perfect chronological order. As such, the stages are meant to be used as guideposts and not as a rigid structure that must be adhered to.

The first stage is "Assessment and Preparation" in which—not surprisingly—the mediator assesses the situation and prepares for the mediation. Assessment involves receiving the consultation request, evaluating the nature of the dispute, gathering information about the medical facts, establishing the decision history of the case, meeting with the care team, meeting the patient and family, assessing the time constraints, and identifying areas of uncertainty. Once these initial stages have been completed, the mediator must prepare for the mediation. Preparation involves identifying the decisionmakers and determining whether the patient is capable of making decisions, determining who should be at the table, determining what additional supports are necessary, discussing the decisionmaking process with the patient if he or she is capable of making

decisions, identifying family members and friends who may seek to participate in decisions, and arranging a location for the mediation.

Once the mediator has completed the preliminary steps of assessment and preparation, he or she moves on to stage two, "Beginning the Mediation." The mediation convenes by the mediator introducing him or herself and inviting the parties to do the same. Next, the mediator gives an opening statement that should cover topics such as the mediator's role, the process of mediation, goals, ground rules, and confidentiality.

In stage three, "Eliciting the Medical Facts," the mediator begins the discussion by asking one of the doctors to describe the case and the patient's history. If the medical facts are in dispute, the mediator must focus on interpreting the facts as proposed by the parties. It is also important for the mediator to bridge communication gaps during this phase. It is often the case that patients and family members will not understand the technical language used by doctors and nurses. The mediator must be sensitive to this, as well as to cultural and ethnic differences, and work to help the patient and family members understand the medical facts.

After eliciting the medical facts, the mediator enters the fourth stage, "Gathering Information," and invites each party to speak. This means allowing each participant to make a statement without interruption. After everyone speaks, the mediator should identify the issues, interests and feelings that came out through each person's statement. The mediator should then frame the issues and interests and set an agenda for discussion. Next, the mediator should educate the staff, patient and family members about the relevant ethical and legal principles. After the issues have been framed and the parties have been educated, the mediator should develop a working hypothesis, being careful not to let the hypothesis drive the parties to a premature solution.

After the mediator has framed the issues and interests, he or she moves into stage five, "Problem Solving." This is where the mediator helps the patient and family understand the medical facts, assimilate the possible consequences, measure the range of outcomes against shared values, and evaluate and choose options in response to medical questions. It is during this stage that the mediator should be most concerned with managing the discussion, as parties may begin to experience conflict when solutions are proposed. The mediator should develop and explore options and remind participants of the range of possible solutions. After identifying and discussing all possible outcomes, the mediator can begin shaping solutions and helping the parties to make choices.

Stage six is entitled "Resolution," despite the fact that the parties may not have reached an agreement yet. If the parties have reached an agreement, the mediator should test the agreement to ensure that the terms are realistic. If

the parties have not reached an agreement, the mediator should make sure each participant knows what will happen next in order to resolve the dispute and who will be making the decisions. At this point the mediator should thank the participants and acknowledge the difficulty of the situation. If another mediation session is needed, either because of time constraints or because the parties need more time to think or get more information, the mediator should end the current session by summarizing the discussion. The mediator should also state any provisional agreements and tasks to be completed before the next session. At the end of the mediation session, the mediator should review the decision reached and document it in the patient's chart.

The final stage, "Follow-up," is where the mediator works with the parties after an agreement is reached to help with implementation. The mediator has several responsibilities in this stage, including ensuring that the agreed-upon resolution is implemented, following up with family and staff to see whether support is needed, and debriefing medical staff on medical, ethical, and policy issues. Also, if the case has been affected negatively by a hospital policy or procedure, the mediator should identify the policy so that it may be evaluated.

### *C. Techniques for Mediating Bioethics Disputes*

The final portion of the book's practical guide highlights mediation techniques that are especially relevant to bioethics mediation. The techniques are broken down into three very broad categories, including summarizing, questioning, and generating movement. Each technique will be discussed in turn.

The authors characterize summarizing as one of the most critical mediator skills. An effective mediator should constantly summarize what is being said, throughout the mediation session. While summarizing is an effective tool that ensures all participants have heard what is said, it can also be used to focus on particular issues or to move the discussion forward. For example, a mediator can use a summary to point out something the parties have in common, or to acknowledge feelings the participants have expressed.

Questioning is another simple yet very effective technique. Mediators can ask questions for a variety of reasons, such as to obtain a broad overview or further information, to clarify abstract ideas, to introduce a hypothetical idea or generate new options, or to encourage participation in the discussion. The manner in which the mediator asks questions is also very important, and he or she should choose carefully when to ask open-ended, narrow, or closed questions.

Another important technique is generating movement, which is used to overcome an impasse and to keep the discussion moving. The authors suggest several specific techniques for generating movement and moving the parties toward a resolution, including:

- **Asking Problem-Solving Questions:** These are questions that ask the parties to focus on their interests and possible solutions.
- **Reframing:** The mediator can reframe what the participants have said by dropping sharp words and looking beyond statements of position to recognize interests.
- **Raising Issues:** Asking questions about issues the parties have not addressed can allow a mediator to hint at underlying issues and test whether they can safely be discussed.
- **Hearing Proposals:** The mediator should listen for proposals that are made in the midst of heated statements, and inquire about them at the appropriate time.
- **Stroking:** This involves acknowledging feelings and recognizing the work of the participants in the mediation.
- **Allowing Silence:** Sitting quietly and waiting for a response gives people time to think before speaking, and can be a subtle tool for eliciting information.
- **Holding Caucuses:** These private meetings between the mediator and one of the parties may be necessary to help the parties articulate their questions, explore the interests underlying their positions, and order their values and preferences.
- **Reality Testing:** This technique encourages parties to abandon extreme positions and think more realistically about possible solutions.
- **Reversing Roles:** The mediator can encourage insight into possible solutions by inviting a party to consider how the other party experienced the situation.
- **Developing Options:** Taking time to develop a range of options often leads to richer solutions.
- **Normalizing:** This is simply letting people know that others have found themselves in similar situations and have found that solutions can be very helpful.

- Packaging Proposals: A proposal is more likely to be accepted if it is packaged as a gain rather than as a loss.
- Focusing on the Future: It is the mediator's job to redirect the parties' concern about blame and focus on what needs to happen now.

## V. IMPLEMENTING A MEDIATION PROGRAM IN A HEALTH CARE SETTING

The final three sections of the book provide useful materials for implementing a mediation program in a health care setting. In Part Three, the authors present analyses of three different cases encountered by bioethics consultants. Part Four provides role plays that health care professionals can use to develop and practice their skills in bioethics mediation. Part Five offers annotated transcripts of actual role playing sessions that utilized the scripts from Part Four. Each section provides useful material for anyone wishing to put into practice a mediation program in a health care setting.

### A. Case Analyses

The case descriptions and analyses demonstrate the wide range of issues that a bioethics mediator must tackle. While all three case studies are captivating, Mrs. Leonari's<sup>8</sup> case is the most noteworthy because of its complexity. Mrs. Leonari was the matriarch of a large and close-knit Sicilian American family. She had five children, several grandchildren, and a devoted husband. When she suddenly fell seriously ill, it hit her family like a tornado and the best way they knew how to support her was to have someone from the family at her bedside at all times. While the hospital rules allowed for twenty-four-hour visitation in the intensive care unit, the literal meaning of this regulation had not been tested—up until now. All members of the Leonari family are devout Roman Catholics and they sincerely believed that their mother's condition would improve if they engaged in continuous prayer at her bedside.

The conflict in this case arose when the medical staff attending to Mrs. Leonari began to complain that the family was becoming burdensome. They were not following the rules (such as the prohibition against cellular phone use in the hospital room) and were interfering with care. As such, the attending physician crafted new, restricted visitation hours for the family. Upon learning of the new regulation, the Leonaris became outraged and

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<sup>8</sup> The names have been changed and the medical history altered to protect the privacy of the patient, her family, and her care providers.

maintained that their mother's condition would worsen if they were not constantly by her side. Two bioethics mediators were called upon to address the dispute between the family and the medical staff. Their actions demonstrate that the process of mediation and its various steps became key components of the outcome.

The mediators began by letting the staff express their feelings. In an initial meeting with medical staff only, they came together and expressed their anger and frustration at the behavior of the family. Next, the mediators attempted to help the family understand the situation. They tempered their comments about the staff as a united front by repeating the praise the staff had given the family for their devotion to their mother. The mediators then identified the existence of the conflict, which in this case was not about the care Mrs. Leonari was receiving. Rather, it was about the family intimidating the staff and interfering with the best care for their mother. The mediators then began to develop options for resolving the conflict and presented them to both the staff and the family members. They then acted as an advocate for the forged solution, the core of which was the idea that the family abide by the rules and the staff expand the usual visiting hours. The mediators were eventually forced to recognize an impasse when it was clear that the family was uncooperative. In the end, the patient's husband Mr. Leonari accepted the mediated solution and the responsibility of imposing it on his devoted yet stubborn family members.

### *B. Role Plays*

The role plays and accompanying annotations serve as valuable materials for health care professionals to develop and practice their skills in bioethics mediation. Through role playing, professionals can practice the principles suggested in this book and learn how to address real-life conflicts and move toward solutions. There are four role plays that are created from both experience and imagination, including 1) discharge planning for a dying patient, 2) an at-risk pregnancy, 3) HIV and post-surgical complications in the ICU, and 4) treating a dying adolescent. By acting out these scenarios, the "players" are exposed to the distinctive challenges and configurations of bioethics mediation. The role plays can serve as an excellent pedagogical tool for mediators working with bioethics student and professionals. It can also be a valuable resource for mediation workshops and classes.

## VI. CONCLUSION

*Bioethics Mediation* provides an introduction to mediation for bioethics committees, consultants, and other health care professionals. It also provides

mediators with an introduction to the types of conflicts prevalent in contemporary health care. The authors recognize that as the American health care system becomes increasingly more complex, there is an even greater need for innovative strategies for addressing the conflicts that arise among health care professionals, patients and their families and insurance companies. This book is designed to address those needs, and it has the potential for transforming how conflicts are handled and resolved in health care settings across the country.