

Articles

MEDIATING LIFE AND DEATH DECISIONS

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I. INTRODUCTION

Assume for just a moment that you are lying in a nursing home bed. You have advanced Alzheimer's disease, that is, you cannot walk, you cannot bathe, dress, or feed yourself, or carry out your most private of functions. You no longer recognize your family or your caretakers. You are not in pain but your cognitive awareness is significantly limited. Your disease has reached a point where you can no longer take in sufficient amounts of nutrition by mouth to sustain yourself. Your doctor wants to insert a feeding tube. Your spouse refuses to consent to the insertion. The doctor thinks the feeding tube is medically warranted because you are not terminally ill or in pain. You could in fact live more than a year with a feeding tube in place. There are two ways this "dispute" can be resolved within the nursing home. The dispute can be taken to the ethics committee — a multidisciplinary committee composed of two physicians, two nurses, a social worker, a minister, a bioethicist and a local school teacher — who will provide your spouse and physician with a recommendation based on prevailing ethical and societal norms. Alternatively, the dispute can be mediated, i.e., a third party can assist your physician and spouse try to reach an agreement on their own. If neither of these options is attractive, the case could be decided by a judge in court. Which method would you choose?

Beginning with the case of Karen Ann Quinlan in 1976, patients, their family members and health care providers have come to the courts on several thousand occasions seeking guidance and resolution of disputes involving termination of life support.¹ In the early years, these cases appeared to be a

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1. As of September, 1994, approximately 200 such cases had been documented. Choice in Dying, Right to Die Case & Statutory Citations, September, 1994. Yet most of the cases are undocumented and unpublished. A study by the National Center for State Courts determined that from the "issuance of the Quinlan opinion in 1976 by the Supreme Court of New Jersey, until May of 1992, 114 published final judicial ... opinions were issued" involving termination of life support. The cases included 82 appellate court opinions and 32 trial court opinions. COORDINATING COUNCIL ON LIFE-SUSTAINING MEDICAL TREATMENT DECISIONMAKING. GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE SUSTAINING MEDICAL TREATMENT CASES 6 (West, Rev. 2d ed. 1993) [hereinafter GUIDELINES]. Based on a 1989 survey of 905 state trial court judges, Hafemeister estimated that 2,357 state trial court judges

response to the seemingly unquestioning application of life saving technologies by physicians to patients who were terminally ill or permanently comatose and who could no longer interact meaningfully with others. In these suits parties sought clarification of who had the right to make decisions about the continuation or termination of life support for both competent and incompetent patients and what guidelines should inform these decisions. Although in many jurisdictions the case law has helped to clarify the decision-making process, these disputes continue to occur.² In addition to disputes between health care providers and their patients or their surrogates, where the physician wants to continue treatment, cases have involved disagreements between family members³ and disputes where the health care provider wishes to terminate treatment and the patient's family members desire that everything be done for the patient.⁴ In a number of these cases, the courts have almost begged for an alternative decision-making process, not wishing to "play God" or otherwise feeling that the adversary process is deficient in dealing with these life and death decisions.⁵

One response to these troubling cases has been the establishment by many hospitals of ethics committees. These committees are multidisciplinary in composition typically including physicians, nurses, social workers, clergy, and in some cases, ethicists, lawyers and community representatives. Health care providers, patients or their families may consult the committee when they have a concern about withholding or withdrawing life support or some other

had heard at least one case involving termination of life sustaining medical treatment and that overall they had heard over 7,000 such cases. Thomas Hafemeister et al., *The Judicial Role in Life-Sustaining Medical Treatment Decisions*, 7 ISSUES IN L. & MED. 53 (1991).

2. More recently, states have enacted statutes on advance directives and surrogate decision-making. See, e.g., COLO. REV. STAT. §§15-18-101 to 15-18-113 (1987 and Supp. 1993) (providing that a proxy decision-maker for a patient incapable of making his or her own decision may make medical decisions for the patient expressly including refusal of artificial nutrition and hydration – the family member with a close relationship and with the best knowledge of the patient's current wishes is preferred as proxy under the statute). See also VA. CODE ANN. §§54.1-2981 to 54.1-2993 (Michie 1993) (allowing a physician to withhold or withdraw most medical treatments from an incapacitated patient with the consent of the highest ranking surrogate on the statutory list specifies).

3. See, e.g., *Mack v. Mack*, 618 A.2d 744 (Md. 1993) (dispute between spouse and father of 30 year old patient who had been in a persistent vegetative state for eight years over removal of a feeding tube); *Couture v. Couture*, 549 N.E.2d 571 (Ohio Ct. App. 1989) (dispute between a divorced couple over the continuation of life support for their 29 year old son); *In re E.L.K.*, 11 Pa. Fiduc. Rep.2d 78 (Orphans' Court, Berks County, 1991) (dispute between brother and sister over termination of life support for their elderly mother).

4. See, e.g., *In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co., July, 1991).

5. See, e.g., *In re A.C.*, 573 A.2d 1235, 1264 n.2 (D.C. 1990) ("Because judgment in [life and death cases] involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment -- through legislation or otherwise -- of another tribunal to make these decisions, with limited opportunity for judicial review."); *In re Guardianship of Browning*, 568 So.2d 4, 15 (Fla. 1990) ("[W]e are loath to impose a cumbersome legal proceeding at such a delicate time in those many cases where the patient neither needs nor desires additional protection."). This is particularly true of appellate courts where the "vast majority" of opinions make it clear that these decisions should be made by patients, families and health care providers based on statutory guidelines. David H. Miller, *Right to Die Damage Actions: Developments in the Law*, 65 DENV. U. L. REV. 181, 183 (1988). A study of trial court judges indicates that they are more ambivalent on this issue. See Thomas L. Hafemeister & Donna M. Robinson, *The Views of the Judiciary Regarding Life-Sustaining Medical Treatment Decisions*, 18 LAW AND PSYCHOL. REV. 189 (1994).

treatment decision.⁶ In many cases, parties seeking the committee's assistance are not in dispute, but simply want assurances that they are "doing the right thing." In other cases, there are actual disputes between family members or between family members and health care providers over what is the appropriate ethical or legal response or who has decision-making authority. In most cases, these ethics committees have acted as advisors or consultants, or when a dispute exists, as quasi-adjudicatory bodies, providing a recommendation to the parties as to what the committee believes is the appropriate course of treatment for the patient.⁷

With some of these cases being handled by ethics committees rather than the courts, the cases have been taken out of what is to lawyers the safe, familiar, and well-defined structure of adjudication and put into the obscurities of ethics committee deliberations. Although ethics committees may borrow a few of the procedural elements of adjudication, for the most part, they try to avoid them. They are much less formal than courts and administrative decision-making bodies and usually not well attuned to the process they are using. In some ways their process is a hybrid of the medical consultation process and an informal adjudication process.⁸ The committees seem outright uncomfortable with formalities, and in spite of some criticisms of their lack of due process, they seem more or less oblivious to the criticism and continue to approach cases procedurally in a rather ad hoc way.⁹

Given the general level of malaise that many of the parties in the health care setting seem to have with courts and more formal ways of dealing with termination of treatment issues, some have proposed that these disputes might better be dealt with through a mediation process.¹⁰ Mediation differs from adjudication and the process used by most ethics committees in that rather than

6. Cf., Ronald Cranford & A. Edward Doudera, *The Emergence of Institutional Ethics Committees*, in *INSTITUTIONAL ETHICAL COMMITTEES AND HEALTH CARE DECISIONMAKING 5* (Ronald Cranford & A. Edward Doudera, eds. 1984) (defining an ethics committee as "a multidisciplinary group of health care professionals within a health care institution that has been specifically established to address the ethical dilemmas that occur within the institution").

7. There are some committees, however, that simply provide a list of alternatives and analyze the pros and cons of each rather than arriving at a single recommendation. Ross describes three models of ethics committee consultations: (1) the traditional medical consultation model in which the committee acts as a consultant or expert and is expected to recommend a specific course of action; (2) the case conference model in which the focus is on hearing all points of view and discussing the pros and cons of various options without making a specific recommendation; and (3) the quasi-judicial model in which emphasis is placed on conflict resolution and due process issues. Judith W. Ross, *When Cases Sometimes Go Wrong*, 19 *HASTINGS CENTER REP.* 22-23 (1989).

8. See Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 *MD. L. REV.* 798, 820 (1991). (Ethics committees "partake of both [the Adjudicatory and the Consultation Model] pursuing sometimes one, and sometimes the other. Indeed, a single committee can alternate between the two. One minute the members will see the group as a committee advising caregivers; the next minute they will see it as a body resolving or actually deciding treatment disputes. A close look at ethics committees shows that they have no single clear identity, but rather have a double identity, with the capacity to alternate. [I]t is rather like an Escher print — one minute fish and the next minute fowl.")

9. Wolf remarks that despite the lack of attention to process issues, "there is no hue and cry" for reform. "[I]nstead, there is a widespread sense that ethics committees are fine as they are, without the cumbersome requirements of due process." *Id.* at 804.

10. See, e.g., Mary Beth West & Joan M. Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 *CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS* 63 (1992).

having their dispute decided, or in the case of an ethics committee, having a recommendation made by a third party, the disputing parties themselves decide the issue with third party facilitation. Although mediation has been tried in some types of disputes in health care settings,¹¹ it has as yet to be formally adopted by most health care institutions in these types of cases.¹² Yet signs of some adoption of the idea are appearing as recent conferences on ethics committees include mediation techniques,¹³ as demonstration projects are being established to test the effectiveness of mediation in bioethical disputes, and as a number of mediation training centers are expanding to include bioethics conflicts.¹⁴ Also, some lawyers are trying mediation as an alternative to court resolution of these disputes.¹⁵

Although practically the technique may have something to offer ethics committees, health care providers and patients, the theoretical justification for the application of the technique in termination of life support cases has not been

11. See, e.g., David Holthaus, *Hospital Eases Conflict Through Mediation*, HOSPITALS, Sept. 20, 1988, at 38; Karl A. Slaikou, *Designing Dispute Resolution Systems in the Health Care Industry*, 5 NEGOTIATION JOURNAL 395 (1989) (describing work of Austin, Texas-based Center for Conflict Management with St. David's Community Hospital on a pilot project to develop a hospital wide system for identifying and resolving disputes through mediation). Mediation has also been tried in malpractice cases but with little success. See Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMPORARY PROB. 195 (1991).

12. This appears to be true even in New York state where there is a statutory provision that contemplates the use of mediation in some types of disputes over patient care. New York's statute establishing procedures and standards for Do Not Resuscitate Orders provides that "Each hospital [in the state] shall establish a mediation system for the purpose of mediating disputes regarding the issuance of orders not to resuscitate....The dispute mediation system shall be described in writing and adopted by the hospital's governing authority. It may utilize existing hospital resources, such as a patient advocate's office or hospital chaplain's office or it may utilize a body created specifically for this purpose...." N.Y. PUBLIC HEALTH LAW §2972 (McKinney 1993). There is no evidence that the process has been institutionalized in individual hospitals. *But see* NANCY NEVELOFF DUBLER AND LEONARD J. MARCUS, *MEDIATING BIOETHICAL DISPUTES* (1994) (describing Montefiore Medical Center's Bioethics Mediation Project).

13. See, e.g., Conference on Ethical Decision-Making in Health Care: Ethics Committees and Conflict Resolution Techniques, sponsored by Public Responsibility in Medicine and Research (PRIMR), Boston, MA (Sept. 30-Oct. 1, 1991); Mediation and Medical Ethics Teleconference, sponsored by Center for Health Law and Ethics, University of New Mexico, Albuquerque, NM (June 26, 1992); Conference on Negotiation and Conflict Resolution for Medicine, sponsored by the Boston University School of Public Health Program for Health Care Negotiation and Conflict Resolution, Boston, MA (Apr. 1, 1993); Mediation and Medical Ethics National Conference, sponsored by Decision Resources, Inc. and the Center for Health Law and Ethics, University of New Mexico, Albuquerque, NM (June 2-4, 1994).

14. In 1992 and 1993, a demonstration project training hospital ethics committee members in mediation techniques was undertaken at Montefiore and Beth Israel Medical Centers in New York. See DUBLER AND MARCUS, *supra* note 12. Currently, the American Bar Association's Commission on Legal Problems of the Elderly is conducting a demonstration project training members of nursing home ethics committees in the Washington, D.C. area in mediation techniques. Telephone conversation with Naomi Karp, Associate Staff Director, ABA, October 17, 1994. In 1992, the first Center focusing exclusively on mediation of ethical disputes was established in San Diego, California. Introducing Mediation to Hospital Ethics, CAL. LAWYER, Dec. 1992, at 69. The Center for Medical Ethics and Mediation has trained over 300 people in mediation techniques. Approximately two-thirds of those individuals are members of ethics committees. Telephone interview with Robert Wagener, Director, Center for Medical Ethics and Mediation (Oct. 27, 1993).

15. For example, mediation was tried in the Maryland case of *Mack v. Mack*, 618 A.2d 744 (Md. 1993). Telephone interview with Rachel Wohl, attorney for Deanna Mack (Oct. 27, 1993).

fully articulated or explored. The adjudication process used by the courts and adopted, to some extent, by many ethics committees is based on the premises that (1) there is a single, "best" or authoritative answer to the question posed; (2) there should be some consistency of process and predictability of results in these cases; (3) the state, the institution and the community have an interest in these life and death decisions and therefore should have a role in deciding the outcome; (4) a resolution of the dispute can be achieved by application of ethical and/or legal norms; and (5) the parties will accept the recommendation of the court or committee. In contrast, mediation is based upon the assumptions that (1) there are a variety of solutions to the issues raised all of which are potentially acceptable to the disputants (neither disputant has to lose, both, in fact, can win); (2) each case is different and any resolution must take into account its unique contextual features; (3) these are private issues and are best decided by norms established by the parties involved, fine-tuned to their particular relationship; (4) these cases must include a process for emotional settlement not simply resolution of the "legal" or "ethical" issues; and (5) the parties will be much more likely to comply with the resolution of the case if they determine the outcome.¹⁶

Perhaps the greatest concern about mediation in cases involving termination of life support is that while mediation may lead the parties to a mutually satisfactory solution, it may not lead to an ethical or "just" result. Other difficulties arise with applying the practice of mediation to these types of disputes. For one, there may be cases in which no one is representing the interests of the patient. Also, there may be power imbalances between patients or their family members and health care providers. In these circumstances, critics have pointed out that "traditional mediator neutrality may undermine protection of the weaker party's legal rights."¹⁷

In this article, I examine the theoretical foundations for the use of mediation in termination of life support disputes. In doing so I touch on the usefulness of mediation as an alternative to the courts but focus considerably more attention on the use of mediation as an alternative to the traditional informal consultative/adjudicative process used by ethics committees. I do this for several reasons. First, a number of authors have already described the deficiencies of the courts in dealing with these cases and detailed the advantage of something like an ethics committee for resolving these disputes.¹⁸ Second, to

16. See generally, Robert A. Baruch Bush, *Defining Quality in Dispute Resolution: Taxonomies and Anti-Taxonomies of Quality Arguments*, 66 DENV. U. L. REV. 335 (1989); ROGER FISHER & WILLIAM URY, *GETTING TO YES* (1981); JAY FOLBERG & ALISON TAYLOR, *MEDIATION* (1984); Lon Fuller, *Mediation -- Its Forms and Functions*, 44 S. CAL. L. REV. 305 (1971).

17. Judith L. Maute, *Public Values and Private Justice: A Case for Mediator Accountability*, 4 GEO. J. LEGAL ETHICS 503 (1991).

18. See, e.g., Janet E. Fleetwood et al., *Giving Answers or Raising Questions? The Problematic Role of Institutional Ethics Committees*, 15 J. MED. ETHICS 137, 138 (1989) (asserting that "the judicial system's bureaucratic, adversarial approach is not designed to address humanely the emotional issues faced by patients and health care professionals struggling with life threatening issues"); John J. Paris & Frank E. Reardon, *Ethics Committees in Critical Care*, 2 CRITICAL CARE CLINICS 111, 113 (1986) ("When asked to make actual treatment decisions, the courts are acutely aware of their limitations and lack of clinical experience."); See also, Bernard Lo, Fenella Rouse & Laurie Dornbrand, *Family Decision-Making on Trial*, 322 NEW. ENG. J. MED. 1228 (1990) (arguing that appellate courts are limited in their ability to consider the most up to date information on the case); PRESIDENT'S COMMISSION FOR THE

the extent that mediation is introduced in these types of cases it is likely to be through ethics committees. Third, no one has as yet critically examined the appropriateness of mediation as a process to be used by ethics committees.¹⁹ Fourth, once we determine that courts may not be the appropriate or "best" forum for resolving these disputes, that does not help us determine the best process to use in an out-of-court forum.

As a preface to this examination, Part Two of the article describes the nature of the disputes that arise in termination of life support cases while Parts Three and Four focus on how these disputes are currently dealt with in the courts and by ethics committees. In Part Five, I describe the nature of mediation—its theoretical basis, why it has gained popularity, and why more recently, some scholars have criticized its application to some types of disputes. In Part Six, I analyze the appropriateness of the application of mediation to disputes regarding termination of life support by setting out the characteristics of a paradigm case for mediation and how the types of cases that come to ethics committees, or more broadly involve disputes about the termination or withholding of life sustaining treatment, compare to the paradigm case. In this analysis I ask: Is there anything that mediation has to offer disputants in these cases? How far are termination of life support cases from the "paradigm" case for mediation? To the extent that mediation is adopted by ethics committees for resolving these disputes, are there certain cases that are more likely to be appropriate than others for mediation? What, if any, procedural or substantive safeguards should be adopted to protect the parties as well as relevant societal/state interests if termination of life support cases are mediated? The analysis draws on literature from somewhat analogous applications of mediation, in particular, mediation in family disputes, in speculating about the potential benefits and risks of the process in the context of life and death decision-making.

In general, I conclude that there is reason to be cautious about the application of mediation to termination of life support cases, especially those involving disagreements between physicians and patients or other surrogates. Yet, I concede that there may be a small number of cases where mediation is appropriate, in particular, disputes between relatives of an incapacitated patient. I also advocate that to the extent mediation is adopted by ethics committees, some alteration of the traditional mediation model is necessary. Where there are significant concerns about power imbalances, I propose either a model where the mediator is a member of the ethics committee and plays an active role in educating the parties as to the relevant ethical norms and in reviewing any agreement for consistency with these norms or a model where committee members do not serve as mediator but participate as parties to the mediation itself giving them an opportunity to have input into the resolution but not to dictate it.

STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 169 (1983) [hereinafter PRESIDENT'S COMMISSION] (arguing that ethics committees can be more efficient and more sensitive than a judicial body).

19. *But see* West and Gibson who have identified similarities between mediation and ethics committee process and have advocated that ethics committees might learn from mediation techniques in doing case consultations. West & Gibson, *supra* note 10 at 6.

II. THE NATURE OF DISPUTES IN LIFE AND DEATH DECISION-MAKING

Although termination of life support cases are factually distinct there seem to be some common themes running through them. In general, the cases involve patients who are incompetent or lack decision-making capacity. Admittedly, there are cases where a competent patient disagrees with his or her physician about the withholding or withdrawal of some type of life sustaining treatment,²⁰ yet these disputes seem less common than those involving incapacitated patients.²¹ This is perhaps true in part because it is much more difficult to ignore the stated preferences of a competent person or argue with the patient that they are mistaken about what they really want; and, second, because the law is rather clear in cases involving competent patients. In virtually all such cases, the courts have stated that a competent patient has a right to bodily integrity and to be free of unwanted bodily invasion including medical treatment.²²

The large majority of cases occur in an institutional setting, where the institutional framework for decision-making predominates. When a patient is receiving care at home, the pressures of high tech medicine or concerns about legal liability are largely absent.²³ Moreover, if a patient is receiving care at home, there has probably already been some kind of agreement between the patient and/or the patient's family and the treating physician that extensive efforts to save the patient's life are not going to be attempted. Thus, most disputes over life and death decisions occur in a hospital or nursing home.

A third characteristic of these cases is that for the most part the patients have one of the following medical conditions: they are either (1) terminally ill, (2) permanently unconscious; or (3) suffering from multiple chronic problems, significant debilitation, dementia and some pain.²⁴ Other types of cases that

20. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Ct. App. 1986), *review den'd* (Cal. June 5, 1986); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Ct. App. 1984).

21. A study of state and federal court cases addressing the initiation, maintenance, or removal of life sustaining treatment from 1976-1992 lists only 16 out of 102 cases (16%) as involving a competent patient. GUIDELINES, *supra* note 1, at Appendix A.

22. The exception being a few cases involving blood transfusions for adult Jehovahs' Witnesses who are otherwise healthy and have minor children. See, e.g., *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964) (the state, as *parens patriae*, would not permit a mother to abandon her seven month old child by refusing a life-saving blood transfusion). *But see* *Public Health Trust of Dade County, Fla. v. Wong*, 541 So.2d 96 (Fla. 1989) (patient's minor children's right to be reared by two loving parents was not sufficient to override patient's constitutional rights of privacy and religion); *Norwood Hospital v. Munoz*, 564 N.E.2d 1017 (Mass. 1991) (mother of minor child had right to refuse life-sustaining treatment; issue of child abandonment did not apply where minor child's father planned to care for him); *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1989) (parent of a newborn infant had the right to refuse a life-saving blood transfusion).

23. *But see*, *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (involving competent quadriplegic patient living at home who sought court order permitting the removal of his ventilator, allowing administration of pain relief and immunizing anyone providing assistance from civil or criminal liability).

24. The survey by the National Center for State Courts of state and federal court cases involving termination or continuation of life support between 1976 and 1992 listed 86 cases as involving incompetent patients or patients of questionable competence. Of those 86 cases, 19 (or 22%) involved terminally ill patients; 42 (or 49%) involved permanently unconscious patients; and 12 (or 14%) involved patients with multiple, chronic, debilitating problems. See GUIDELINES, *supra* note 1, at Appendix A.

come up, although somewhat less frequently, include very young patients, often newborns, with multiple chronic problems, significant neurological impairment with no hope of physical or cognitive improvement so that they might experience meaningful interaction with others and disputes over whether a patient is brain dead. These cases also seem to involve disputes over a few specific types of life sustaining treatment, most often ventilatory support and artificial nutrition and hydration.²⁵ Although other types of treatment are often at issue, e.g., antibiotic therapy, CPR (cardiopulmonary resuscitation), kidney dialysis, surgery, chemotherapy, they seem to be either a subset of these predominant treatment issues or to comprise a much smaller group of cases.

A. *Types of Disputes*

At the outset, it seems important to state that many times what are labeled as disputes in this context are really not disputes at all, that is, real differences of opinion or belief about what the right course of treatment should be. Rather, they are false disputes or misunderstandings about the facts or about "required" actions. In many cases, the "disputes" result from a lack of communication on the part of the so-called disputing parties.²⁶ This lack of communication or failure to communicate seems to permeate treatment of patients by many physicians.²⁷ It can be explained, in part, by the specialization inherent in modern medicine as well as physicians' demanding schedules,²⁸ but is perhaps best understood as a relic of earlier medical training which did not emphasize the need for communication with the patient.²⁹ In other cases, these false

25. The study by the National Center for State Courts listed 15 cases out of 86 (or 18%) involved disputes over ventilatory support alone; 35 (or 41%) involved artificial nutrition and hydration alone; and 10 (or 12%) involved both. *See id.* Of the 200 cases involving termination of life support identified by Choice in Dying, 43% involved artificial feeding. Choice in Dying, *supra* note 1.

26. *See* JUDITH W. ROSS ET AL., HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 57 (1986) [hereinafter HANDBOOK] ("[M]any problems that [an ethics] committee might consider are not basically ethical problems, although they may have minor ethical components. Problems brought to the committee may be matters of faulty or non-existent communication, or of misunderstandings about policies and guidelines."). *See also*, Gail J. Povar, *Evaluating Ethics Committees: What Do We Mean by Success?* 50 MD. L. REV. 904, 912 (1991) (stating that at George Washington University Medical Center, where Povar chairs the ethics committee, and at other institutions that she is familiar with, "many consults arise more from failures of communication than from clear ethical discomfort").

27. According to Robert Zussman, there is an "extraordinary and methodologically diverse body of research on doctor-patient communication outside the hospital." He states that this "research has consistently demonstrated patients' dissatisfaction with physicians' instructions, documenting both the techniques used by physicians to maintain interactional domination and (sometimes) how these failures of communication affect the patient's compliance with medically prescribed regimes." Robert Zussman, *Life in the Hospital: A Review*, 71 THE MILBANK QUARTERLY 167, 171 (1993). For a series of articles on physician-patient communication, see ENCOUNTERS BETWEEN PATIENTS AND DOCTORS: AN ANTHOLOGY (John D. Stoeckle, ed. 1987).

28. *See* Ann J. Kellett, Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 MO. J. OF DISP. RES. 111, 119 ("Physicians are not only professionals, the majority of them are entrepreneurs. In addition to dispensing medical care, they must deal with the management of a business and attend to billing, insurance forms and employee relations. They must also interact with and coordinate the activities of other medical specialists and a host of health care workers. They must be available for emergencies. They must remain current with burgeoning medical literature and become proficient with new technology. The popular image of the 'harried doctor' is far too often real.").

29. *See, e.g.*, RENÉE C. FOX, THE SOCIOLOGY OF MEDICINE (1989) (describing

disputes may be a result of a misunderstanding of what the law requires. In some cases, physicians or other health care providers may fear criminal prosecution or civil liability for certain actions, even if they think that morally their actions are justified.³⁰ Thus, they seek assurances that what the patient or his surrogate wants is not "illegal" or "unethical."³¹

Generally, when there are real disputes, they seem to fall into one of two categories: (1) disputes between an incapacitated patient's family members and the patient's treating physician or (2) disputes between family members of such patients.³² This distinction may have real significance in determining the applicability of mediation to these types of disputes. The nature of the disputes in these two contexts is sufficiently different to warrant further discussion and examination. Below are two cases that I will refer to at later points in this article that illustrate the different scenarios.

CASE # 1: Dispute Between Family Members and Physician

Michael M., a 2 year old boy who had been HIV positive since birth, was admitted to the hospital for a lump on his back. The lump turned out to be a malignant tumor. Surgery was performed and all gross tumor removed; however, there was a strong possibility that microscopic residual tumor remained. Further studies also demonstrated evidence of metastasis to the lungs and bone. According to the oncologist, Michael has no chance of survival without chemotherapy. With chemotherapy, there is a 40% chance that the cancer will be eliminated. The chemotherapy consists of cycles of three different drugs given intravenously for a period of about 4-1/2 months. The side effects of the drugs are nausea, vomiting, hair loss, hemorrhage and the possible need for transfusion, and depression of the bone marrow which could lead to increased risk of infection.

Michael's physician wants to begin the treatment as soon as possible but Michael's parents will not consent. Although he is asymptomatic for AIDS, they

training for detached concern as part of medical education and socialization in the 1950s). Jay Katz documents this inattention to patient communication on the part of physicians in his classic work. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1964). Zussman challenges whether physician education today is any better. He points to numerous recent accounts of medical training which consistently state that "a good part of medical training consists of teaching students and house staff to manage their emotions, to concentrate on technical matters, and to ignore the social and psychological aspects both of disease and of the patient who suffers from the disease." Zussman, *supra* note 27, at 173-74.

30. See Mildred S. Solomon et al., *Decisions Near the End of Life: Professional Views on Life Sustaining Treatment*, 83(1) *AMERICAN J. OF PUB. HEALTH* 14 (1993), reviewed by Jane E. Brody, *Doctors Admit Ignoring Dying Patients' Wishes*, *N.Y. TIMES* (Jan. 14, 1993) (study of 1400 doctors and nurses found that doctors and nurses "often violate their own personal beliefs and ignore requests from patients to withhold life support in cases of terminal illness").

31. See, e.g., *Corbett v. D'Alessandro*, 487 So.2d 368 (Fla. Dist. Ct. App.), review denied, 492 So.2d 1331 (Fla. 1986) (although treating physicians in agreement that Mrs. Corbett's tubal feeding should be stopped, they were uncertain about the legality of doing so, forcing Mr. Corbett to take the case to court); *In re Jane Doe*, 16 Phila. 229 (Pa. Ct. Com. Pl., Philadelphia Co. 1987) (physician and hospital, including its ethics committee, decided that while willing to accede to the competent patient's wishes to be removed from a ventilator, they would not do so without a court order).

32. There may also be disputes between health care providers, for example, between physicians and physicians, or nurses and physicians or between institutional administrators and patients or their families, but these cases seem to surface much less frequently.

are heavily influenced by the fact that their son is HIV positive and will only have a relatively short life span in any case, and they wish to make that life as comfortable as possible. A close family friend recently died of breast cancer after a long and difficult course of chemotherapy. They do not want Michael to suffer in this way and then not be cured. They believe it is their decision to make and not the physician's. The physician feels that it is worth trying to save Michael as HIV infected children can live for several years. The physician is frustrated with the parents as he does not believe they "understand" the medical issues and wants the ethics committee to review the case. He personally is overextended and does not feel he has the time to educate the parents about the issues.

The parents are young — the mother is 19 years old and the father is 20. Neither completed high school. Michael contracted the HIV virus from his mother while she was pregnant with him. Her own health at this time is stable. She has no symptoms of AIDS.³³

CASE # 2: Dispute Between Family Members

Joseph R. is a 75 year old male with a history of chronic emphysema who suffered a massive stroke while hospitalized for breathing difficulties. As a result of the stroke, he was initially unable to breathe on his own and experienced considerable loss of brain function. He was supported on a ventilator, underwent surgical drainage of intraventricular cerebrospinal fluid and then placement of a permanent shunt, was weaned from the ventilator but required a tracheostomy tube. He developed a pneumonia and was being given IV (intravenous) antibiotics to treat the infection. His other medical conditions included diabetes, hypertension, and chronic bronchitis.

The patient's family, his 49 year old son, who is an engineer, and his 42 year old daughter, who is a nurse, disagree about the appropriate course of treatment for him. The daughter wants the attending physician to stop treating the patient with antibiotics and wants only tube feeding and hydration administered. The son disagrees. He bases his decision on the attending physician's remarks that the pneumonia is reversible and would routinely be treated. If the antibiotics are discontinued the patient will likely die from the pneumonia. If the pneumonia is treated, the patient may live more than six months, although he will suffer from the residual effects of the stroke, i.e., diminished mental capacity, and from his other chronic conditions.

In an interview with the chair of the institution's ethics committee, the patient's daughter stated that it seemed to her that the patient was only going "downhill all the way." In particular, she remembered her 19 year old nephew who twice suffered a cardiac arrest and each time was "saved" only to become "blind, demented, and comatose." That, the daughter related, was thought by the patient to be a terrible outcome and something that he wanted to avoid for himself. The patient's son, however, remembered that when their mother died, their father did everything to keep her alive despite the fact that she was bedridden and senile.

33. This case was taken and modified for purposes of illustration from a case that appeared in the MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER (Institutional Ethics Committee Resource Network, Baltimore, MD), Spring, 1993, at 6-7.

The daughter had cared for the father during the previous year in her home and felt that she should make this decision. The son, although close to his father as a younger man, had not seen his father much during the past six years as he had moved across the country to take a new job.³⁴

B. Disputes Between Physicians and Family Members

In disputes between physicians and family members, the basis for the dispute can arise from a variety of sources. One common reason is a difference in belief about what the patient wanted or meant by certain statements — written or oral. For example, many living will forms state that the patient does not want life sustaining treatment if the patient is terminally ill and there is no hope of recovery.³⁵ Although these documents were intended to resolve dilemmas about the application of life sustaining treatments for severely ill and incapacitated patients, in some instances they have not been effective in doing so, because a debate arises as to what is meant by “terminal illness” and “no hope of recovery.” Statutes in most states define terminal illness, yet the statutory definitions provide little guidance and leave a great deal of discretion to the patient’s physician.³⁶

Whether there is any hope for recovery may also be a point of disagreement. Neither living will forms nor state statutes specify a statistical probability of success below which certain treatments will not be given,³⁷ and physicians and family members may view statistical probabilities quite differently. The physician’s prognosis for the patient may be rejected by the family for other reasons. For example, the patient’s family may not completely trust the physician³⁸ or may have a more broadly based distrust toward the “medical establishment.” Alternatively, rejection of a physician’s prognosis may be based on a disbelief of scientific accuracy or a different understanding of the probabilities of success of a given intervention.³⁹ A family member’s religious

34. This case was taken and modified for purposes of confidentiality and illustration from a case that came to the Ethical Advisory Committee at the University of Maryland Medical System, Baltimore, MD.

35. See NORMAN L. CANTOR, *ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY* 35 (1993).

36. See, e.g., COLO. REV. STAT. §15-18-103(10) (1993) (“‘Terminal condition’ means an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death.”); MO. REV. STAT. §45.9.010(6) (1993) (“‘Terminal condition’ means an incurable or irreversible condition which, in the opinion of the attending physician, is such that death will occur within a short time regardless of the application of medical procedures.”).

37. See *Letter from Christine Cassel*, ASLME BRIEFINGS (American Society of Law, Medicine and Ethics, Boston, MA), Spring 1993, at 4.

38. See RUTH MACKLIN, *MORTAL CHOICES: BIOETHICS IN TODAY’S WORLD* 47 (1987) (describing why physicians might not engender trust, she states, trust is not likely to be forthcoming or confidence instilled by people who “speak brusquely, who are always hurried in their communications, and who are evasive in their answers”).

39. Statisticians have pointed out that many individuals have difficulty evaluating probabilistic events. See, e.g., Richard Zeckhauser, *Procedures for Valuing Lives*, 23 PUBLIC POLICY 441 (1975) (arguing that “we have a great deal of difficulty thinking about very small probability levels”); Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, in *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* 3, 3 (Daniel Kahneman et al., eds., 1982) (asserting that in assessing the probability of an uncertain event “people rely on a limited number of heuristic principles which reduce the complex tasks of assessing probabilities and predicting values to simpler judgmental operations. In general, these heuristics are quite useful, but sometimes they lead to severe and systematic errors.”).

convictions may cause them to doubt the physician's judgment. The family member may believe more strongly in the strength of prayer and God's will than in the power of medicine. The case of Baby Rena is illustrative on this point.

Baby Rena, [a 16 month old with AIDS] was in such constant, agonizing pain that her doctors kept her heavily sedated. She wasn't able to eat or breathe on her own. Her doctors believed further treatment was futile and perhaps even cruel. The doctors wanted to take her off the respirator and let her die if she couldn't make it on her own, as they expected. But the hospital's policy prevented Rena's physicians from acting without approval of a parent or guardian.⁴⁰

Because Rena's mother had abandoned her at birth, she had been placed in a foster home. Her foster parents were evangelical Christian. At an ethics committee meeting about the case, for nearly thirty minutes, Rena's foster father, explained the couple's view that the decisions made in Rena's case "should be motivated by a spiritual sense of obedience to God. It's most important to find out what God desires or what God wills for Rena," he said, "because the one who gives life should ultimately be the one who allows life to be taken. God has not given man the authority to serve as God."⁴¹

Other reasons for an unwillingness to accept the physician's prognosis may be a lack of understanding of scientific principles related to disease processes and treatments, or an appropriate understanding of the uncertainty inherent in the practice of medicine. A significant body of literature supports this latter rationale. In her book, *Mortal Choices*, Ruth Macklin points out,

There is considerable evidence that physicians' ability to estimate benefits in terms of probability of a favorable outcome is limited by the state of medical knowledge. Uncertainty stems from the fact that medicine is still an imprecise science, and the detailed course of many critical illnesses has not been fully described. There is also a lack of hard data documenting the effectiveness of many diagnostic and therapeutic procedures.⁴²

In some cases, families report previous experiences with the medical profession where the physician's prognosis turned out to be entirely inaccurate. Such experiences make families skeptical of medical estimates the next time around.

An alternative source of contention between physicians and family members may be their relative views of the benefits and burdens of the proposed treatment. Family members may view the pain and suffering associated with a proposed course of treatment as too onerous given a minimal chance of recovery from the patient's condition, especially if they believe the patient would not have wanted to take those odds and prolong a life already

40. Benjamin Weiser, *The Case of Baby Rena: Who Decides When Care Is Futile?*, WASH. POST, July 15, 1991, at A1.

41. *Id.*

42. Macklin, *supra* note 38, at 155. See also Renée C. Fox, *Training for Uncertainty*, in A SOCIOLOGY OF MEDICAL PRACTICE 87 (Caroline Cox and Adrienne Mead, eds., 1975) (describing the training of physicians in dealing with uncertainty).

fraught with disabilities and physical and emotional pain.

Related to this possible source of disagreement is a difference in attitudes towards the quality of life in various conditions.⁴³ Physicians, in some cases, may appear insensitive to quality of life issues when their focus is on the immediate medical decision to be made. They may not have to deal with the patient again if the patient leaves the intensive care unit or returns home. Family members, on the other hand, will continue to have to see the patient in a persistent vegetative state or in the advanced stages of Alzheimer's disease or some other progressive, debilitating disease, and suffer the anguish of watching the patient deteriorate or continue to survive with a questionably human existence. For this reason family members may feel that continued life is not in the patient's interest. Alternatively, some family members may believe that life, no matter what its quality, is sacred and worth living,⁴⁴ whereas the treating physician may personally believe that in some cases, the quality of a life makes that life not worth saving.⁴⁵

Nurses may also have strong opinions about the benefits and burdens of a proposed treatment and about quality of life issues and may enter into the dispute. Often nurses seem to take the side of the family seeking termination of life support, perhaps because they are the health care provider who sees the patient most frequently, who must suction him, change his dressings, turn him, and observe his suffering.⁴⁶

These two disagreements, over the perceived benefits and burdens of the proposed treatment and the value of life in certain states, are illustrated by the case of Michael M. In that case, the physician likely considers the burdens of the proposed treatment, i.e., chemotherapy, as minimal, for significant benefits — elimination of the cancer. The patient's parents, on the other hand, no doubt see the burdens of the treatment as significant (nausea, vomiting, hair loss, etc.) and the benefits of the treatment as minimal. This latter perception is undoubtedly related to the probability of success (40%) and the patient's life expectancy, even if his cancer is cured, due to his HIV status. The physician and the parents may also have different assessments of the quality of life of a child with AIDS. The fact that the parents will have to observe the child's suffering and care for him during that time may also color their views of the quality of his life.

Differences may also arise over the interpretation of legal standards, in cases where physicians and family members are aware of the law. Alternatively, the legal standards themselves may create conflicts. In many states, statutes authorize family members to make decisions regarding the application of life sustaining treatment for an incapacitated patient. However,

43. Physicians and patients aside, even social scientists who study "quality of life" are unable to agree on a clear measurement. See LINDA K. GEORGE & LUCILLE B. BEARON, *QUALITY OF LIFE IN OLDER PERSONS* 200 (1980).

44. A moral stance based on sanctity of life as opposed to one based on quality of life has been associated with orthodox religions such as Roman Catholicism and Orthodox Judaism. Macklin, *supra* note 38, at 123.

45. See, e.g., *In Re Conservatorship of Wangle*, No. PX-91-283 (Minn. Dist. Ct., Hennepin Co., July, 1991).

46. But see Weiser, *supra* note 40 at A6. In that case, the nurses sided with the treating physician. "Every day that Rena spent in the intensive care unit was a day of torture, [according to her treating physician,] and his nursing staff sometimes viewed themselves as the torturers." *Id.*

often these statutes limit a family's authority to withhold or withdraw life support to certain conditions and it is the physician who determines if these conditions are met. For example, in all states permitting family decision-making, the patient must lack decision-making capacity. In some cases, physicians and family members may disagree about whether the patient has the requisite capacity to make an informed decision. Families, who often have greater contact with a patient than the patient's treating physician, may have observed things about the patient's behavior that the physician has not and therefore believe they have a better basis for determining the patient's decision-making capacity than does the physician.

Also, in a number of states, families may not make a decision regarding the withholding or withdrawal of life support unless the patient is terminally ill.⁴⁷ Although there may be differences between the parties over whether the patient fits this statutory category, family members in most cases will not be in a position to challenge the physician's determination that the patient's condition is or is not terminal. However, they may resent or think illogical the narrow definition of the term and the resulting limits of their authority. In such cases, the family's argument is, in reality, with the law that defines the term, rather than with the physician who feels compelled to follow the law.

In some states, a physician need not comply with the instruction of a family member or surrogate if to do so is contrary to the physician's conscience⁴⁸ or the surrogate's decision is not consistent with generally accepted standards of patient care.⁴⁹ Such statutory standards that provide significant discretion on the part of physicians or take decision-making authority away from family members can also lead to disputes.

In cases involving infants, in states that have adopted the federal "Baby Doe Rules",⁵⁰ decision-making authority for the withholding or withdrawal of life support is given largely to the physician and there are narrow circumstances under which such withholding or withdrawal is permitted.⁵¹

47. See, e.g., IOWA CODE ANN. §144A.7 (West Supp. 1992) (life sustaining procedures may be withheld or withdrawn from a patient who is in a terminal condition and who is incapable of communication); LA. REV. STAT. ANN. §40:1299.58.5-6 (West 1992) (surrogate may make a declaration to withhold or withdraw life sustaining treatment if a patient is terminally ill and has an irreversible condition; surrogate may refuse life sustaining treatment on behalf of a minor if child is terminally ill).

48. See, e.g., ARIZ. REV. STAT. ANN. §36-3205(C)(1) (1993); FLA. STAT. ANN. §765.308 (West 1993); ILL. REV. STAT. ch. 755 para. 40/35 (Smith-Hurd 1992).

49. MD HEALTH GEN. CODE ANN. §5-612(a), Uniform Health Care Decisions Act, §13(d) (1993).

50. 45 C.F.R. §1340 (1990). The regulations require that as a condition of receiving state grants under the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5101-5107 (1988), states must establish programs and/or procedures within their child protective service systems to respond to reports of medical neglect, including reports of the withholding of medically indicated treatment for disabled infants with life-threatening conditions. See 45 C.F.R. §1340.14. "Withholding of medically indicated treatment" is defined as the failure to respond to an infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions. 45 C.F.R. §1340.15(2).

51. Exceptions to the requirement to provide medical treatment (but not the requirement to provide appropriate nutrition, hydration, and medication) may be made only in cases in which "(1) the infant is chronically and irreversibly comatose; (2) the provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-

Parents of such infants may resent this shift of decision-making authority especially when they will be saddled with the emotional, physical and financial burdens of keeping the baby alive.

A conflict over who has decision-making authority may also arise in the context of treatment deemed futile by some physicians. The law provides that a physician need not provide treatment that is of no medical benefit,⁵² but debate arises over what constitutes no medical benefit and who determines whether a treatment with a very small probability of success is warranted, especially when the treatment is very costly or may cause the patient additional suffering or pain.

In many of the disputes between physicians and family members there is a notable difference in the discourse of health care providers and family members. Physicians, as a result of their training, rely on precise scientific terms, and statistical probabilities. Family members, however, use a discourse that is often emotional and sometimes spiritual. As mentioned above, there may also be a significant amount of distrust between these two parties. In part, this may be a result of the different languages each appears to speak.⁵³ In addition, there may be differences in values because the parties may be of different socioeconomic classes, different ethnic groups, or have different cultural and educational backgrounds.⁵⁴

In disputes between family members and physicians it is important to understand the environment within which the parties are acting as well as the particular pressures they are operating under. The environment, as stated above, is typically either a hospital or a nursing home. In the hospital, it is often a "high tech" setting, e.g., an intensive care unit or shock trauma center. These are cold, sterile, technical environments filled with hardware, bright lights and precise, fast-paced, movements. Patients and family members can easily feel out of place in such settings.⁵⁵ Movements in the nursing home may be somewhat slower but to many such facilities still seem cold and sterile. They are institutions, sometimes bureaucratic and often preoccupied with licensing standards and regulations. In the nursing home, nursing home administrators seem to take the place of physicians. In both institutions families often feel powerless and ill at ease.

When these disputes arise, families are often influenced by the difficult emotions surrounding the possible death of a loved one. Such emotions may include intense grief, anxiety, fear, uncertainty, anger and guilt.⁵⁶ Anger may be felt towards the institution, the staff, the physician, the patient or other

threatening conditions, or otherwise be futile in terms of the survival of the infant; or (3) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane." 45 C.F.R. §1340.15.

52. See, e.g., *In re Dinnerstein*, 380 N.E.2d 134 (Mass. Ct. App. 1978) (concluding that the decision to withhold cardiac resuscitation belongs to the physician when the intervention would offer no benefit to the patient).

53. See generally ENCOUNTERS BETWEEN PATIENTS AND DOCTORS, *supra* note 27.

54. See, e.g., Eliot Friedson, *Dilemmas in the Doctor/Patient Relationship*, in A SOCIOLOGY OF MEDICAL PRACTICE, *supra* note 42, at 291 (arguing that routinely conflict between patients and physicians is due to a "clash of culture or education").

55. For a thorough description of the hospital as a social and cultural microcosm, see RENÉE C. FOX, *THE SOCIOLOGY OF MEDICINE: A PARTICIPANT OBSERVERS VIEW* 142-180 (1989).

56. See Macklin, *supra* note 38, at 138.

family members. Family members may also feel guilty at not having done more for their ill relative, for not having cared for them at home, for even thinking about ending the patient's life, or for thinking about "inappropriate" financial and emotional burdens that keeping the patient alive will cause the family. During this time, family dynamics may place stress on certain individuals. Some individuals may become closer as a family unit; some may rely heavily on spiritual strength and/or pastoral counselors.

Factors influencing the physician's behavior may include demands of other patients, fear of legal liability,⁵⁷ and in some cases concern over the use of limited resources.⁵⁸ A physician's training also may have left a paternalistic imprint.⁵⁹ The paternalistic instinct may create conflicts where the physician is of the view that the family member doesn't really know what the patient would have wanted or doesn't really understand the medical facts.⁶⁰ The physician also has significant control over the care of the patient. She has access to necessary information, the expertise to understand it and the authority to garner the resources necessary to treat the patient.

C. Family Disputes

In the case of family disputes, disputing parties can include spouses,⁶¹ adult children where the patient has more than one child,⁶² a spouse and a

57. See *id.* at 11 ("Fear of legal liability frequently drives medical decision-making, thus contaminating the process by introducing considerations that are not patient-centered."). See also Kellett, *supra* note 28, at 119 (Physicians have a "generalized fear and mistrust of patients, fueled by the 'malpractice crisis'. In the back of the physician's mind lurks the worry that the patient may be a potential adversary. This concern may color the physician's approach to the patient on both interpersonal and professional levels.").

58. See, e.g., *Case Consultation in a Maryland Hospital*, MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER (Institutional Ethics Committee Resource Network, Baltimore, MD), Winter 1993, at 6 (A 58 year old woman with a history of chronic alcohol abuse, was admitted to the hospital with upper G.I. bleeding and liver failure. She bled severely and continued to bleed until she was taken to surgery for a total gastrectomy and pyloroplasty. Following surgery, the patient developed Adult Respiratory Distress Syndrome (ARDS) and Disseminated Intravascular Coagulopathy (DIC). She was mechanically ventilated for six weeks. During this time, she was treated for almost continuous bleeding problems requiring 196 units of blood products. The patient required ICU care since regular medical and surgical floors could not handle rapid blood replacement. The patient was resuscitated numerous times. The attending physician requested an ethics committee consult six weeks after the patient was admitted to the hospital to determine whether the patient should continue to be treated aggressively. He was concerned about the rapid use of blood product and the drain on the local community's supply of blood. The continued request for blood was depleting the institution's supply as well as that of the local Red Cross.).

59. Macklin emphasizes this point when she states, "[in] order to act in what they believe to be their patients' best interest, and based on their own superior medical knowledge, many doctors claim that a certain amount of paternalism is necessary for the proper practice of medicine." Macklin, *supra* note 38, at 43. See also Katz, *supra* note 29, at 88, who asserts that because of their expert knowledge, physicians often insist on "complete authority" over their patient's medical needs.

60. Some physicians actually believe that patients or their family members are not capable of giving informed consent because they have not been to medical school. See Macklin, *supra* note 38, at 44.

61. *Couture v. Couture*, 549 N.E.2d 571 (Ohio Ct. App. 1989) (dispute between divorced parents of 29 year old son in persistent vegetative state over withdrawal of tube feeding).

62. *In re E.L.K.*, 11 Pa. Fiduc. Rep. 2d 78 (Orphans' Ct., Berks County, 1991) (dispute between son and daughter of 76 year old patient over whether a DNR order should be written for the patient).

child,⁶³ a spouse and a parent,⁶⁴ a parent and a sibling, some other combination of individuals related to the patient, or disputes between blood relatives and domestic partners.⁶⁵

Disputes between family members can have some of the same characteristics as disputes between physicians and family members. For example, family members may disagree about what it is that the patient would have wanted. This may be because family members spoke to the patient about the issue at different times and interpreted the patient's remarks differently. Or, alternatively, the patient may have said nothing specifically about what he would want done in the current circumstances, but family members may interpret the patient's values and prior behavior differently. This may lead them to different conclusions about the patient's preferences.

Family members may also disagree among themselves as to what is best for the patient. Just as in disputes between providers and family members, this can be due to differences among family members in (1) their ability to understand important medical concepts; (2) the weight they attach to small probabilities and their relative views on risk taking and risk avoidance;⁶⁶ (3) their views of the benefits and burdens attached to specific treatments; (4) their views about quality of life; or (5) their trust in the medical profession. These differences can be due to different levels of education and life experiences.

What makes disputes among family members unique is the historical relationship of those individuals. Family disputes often come "wrapped in a thick gauze of past relationships."⁶⁷ These relationships also tend to be ongoing and are often interdependent.⁶⁸ Each family is unique but typically has an established pattern of relating wherein the individuals take on certain roles. These roles, in terms of dominance and dependence are likely to play themselves out in the context of health care decision-making.

For example, there may be power issues at play. Certain family members may have dominated family life years ago and want to continue in that role, e.g., "mom would have wanted me to speak for her, not you." Others may now resent that domination and attempt to assert their more recent status within the family or relationship with the patient, e.g., "I was a better daughter than you, I cared more about mom, you were never good to mom, you never visited mom while she was in the nursing home," etc. The case of Joseph R. has some of

63. *In re* Guardianship of Stone, No. 90-5867 (Fla. Cir. Ct. Broward County, June 24, 1991) (dispute between second wife of patient and patient's son over termination of life support. The patient's son said that his step-mother wanted to prolong Mr. Stone's life so that she would gain more monies under an anti-nuptial agreement.).

64. *Mack v. Mack*, 618 A.2d 744 (Md. 1993) (dispute between spouse and father of 30 year old man who had been in a persistent vegetative state for 8 years over withdrawal of feeding tube).

65. Laws in some states provide a priority ranking of who has decision-making authority in these cases as well as a mechanism for resolution of disputes between family members of equal authority such as "majority rule," *see, e.g.*, VA. CODE §54.1-2986 (Supp. 1993). However, health care providers and institutions are often reluctant to terminate life support when family members are in disagreement for fear of a law suit by the disgruntled family member.

66. *See supra* text accompanying note 39.

67. ROBERT COULSON, *FIGHTING FAIR: FAMILY MEDIATION WILL WORK FOR YOU 5* (1983).

68. *See* Frank A. Sander, *Towards a Functional Analysis of Family Process, in THE RESOLUTION OF FAMILY CONFLICT: COMPARATIVE LEGAL PERSPECTIVES* at xii (John M. Eekelaar & Sanford N. Katz, eds., 1984).

these elements. The patient's daughter seems resentful of the fact that her brother has not participated much in the care of their father or even visited him much during the past six years and now wants to participate in the decision about their father's treatment.

In *Mack v. Mack*,⁶⁹ the patient's wife and father argued over whether the patient, Ronnie Mack, who had been in a persistent vegetative state for over eight years, should be taken off of artificial nutrition and hydration. The dispute included disagreement over the interpretation of past remarks made by the patient and whether they were clear indications of what the patient would want done⁷⁰ as well as allegations that each was "unfit" to act as the patient's guardian and make the decision.⁷¹

As in the case of physician/family member disputes, disputes between family members will involve feelings of deep emotions related to dealing with a life and death situation. These emotional pressures will be handled differently by different individuals in the family.

III. WAYS IN WHICH THESE DISPUTES ARE CURRENTLY HANDLED IN THE COURTS

Over 80 cases involving termination of life support have reached either the state courts of appeal or supreme courts. A handful have reached federal district courts and one has reached the U.S. Supreme Court.⁷² An estimated 7,000 have reached state trial courts although a complete and accurate number of these cases is unavailable due to the number of unreported decisions at this

69. 618 A.2d 744 (Md. 1993).

70. The patient's wife related two stories which she believed conveyed the patient's desire not to be kept alive via feeding tubes. The first involved remarks made by Ronnie Mack after a visit to his grandmother who was living in a nursing home. At the time of the visit, his grandmother was aged, senile and unable to care for herself. During the visit, his grandmother was sitting up in bed having lunch. She was unable to feed herself and required assistance. Ronnie Mack fed her jello which kept dribbling down her face. After the visit, Ronnie acted unusually quiet and thoughtful. He told his wife, that if he ever got to the point where he "could not do for himself" he did not want to live. Brief for Appellant at 10-11, *Mack v. Mack*, 618 A.2d 744 (Md. 1993) (No. 99). The second example involved a statement made after Ronnie witnessed the accidental shooting of his close friend. Ronnie was sitting next to his friend when the friend was shot in the throat. The young man died quickly. Shortly after learning that his friend died, Ronnie told his wife that even though he was sorry his friend was dead, he was glad that he died quickly rather than "go through anything like being paralyzed or not being able to ever talk, not be able to play ball." *Id.* at 11. Ronnie's wife also inferred from his intense dislike of hospitals, love of sports and weightlifting, *id.* at 11-12, that he never would have wanted to be kept alive in this way. *Id.* at 10.

On the other side, Ronnie's father related a story about the death of Ronnie's mother. The boy's mother died of a stroke when he was 10 years old. At the time of the stroke, however, Ronnie's father was told that there was a small chance that his wife could be kept alive with surgery, but that she would in all likelihood be an "80% vegetable." The father chose to have the surgery performed, but his wife died before anything could be done. A few years later, the young boy thanked his father for considering the surgery. The father believed that this demonstrated Ronnie's desire to be kept alive, even though his quality of life was minimal. Brief for Petitioner at 7-8, *In re Mack*, No. 91T103 (Baltimore Co. Cir. Ct., Mar. 10, 1992).

71. Ronnie's wife argued that his father was an alcoholic and historically abused his son. Brief for Cross-Petitioner at 2, *In re Mack*, No. 91T103 (Baltimore Co. Cir. Ct., Mar. 10, 1992). Ronnie's father argued that Ronnie's wife should not be given the status of a wife for medical decision-making purposes as she was living with another man. Brief for Petitioner at 12, *In re Mack*, No. 91T103 (Baltimore Co. Cir. Ct., Mar. 10, 1992).

72. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

level.⁷³

Although a "relatively large number of judges" at the trial court level have been asked to resolve disputes over termination of life support, these cases tend "to appear relatively infrequently on a court's docket, allowing judges little opportunity either to establish standard procedures or to develop expertise to address the complex issues placed before them."⁷⁴

Despite the cost and emotional trauma of these cases, once these cases come to court, alternatives to formal litigation are rarely considered, nor is an out of court settlement likely.⁷⁵ According to a survey of trial court judges, when asked what alternatives to formal litigation were considered, "22.9% of the judges said a pre-trial settlement conference was considered, 1.8% said mediation was considered, 1.8% said arbitration was considered, 16.3% said the appointment of a surrogate decision-maker was considered, and 7.7% said submission to a hospital ethics committee, prognosis committee, or an ethics consultation service was considered."⁷⁶

When these cases come to court they are rarely dismissed⁷⁷ and courts are asked to articulate who has decision-making authority and standards for decision-making.⁷⁸ When courts decide the issue they rely on precedent which has established a framework within which these cases should be decided. Briefly, the framework provides that a patient has a constitutional liberty

73. See Hafemeister, *supra* note 1. A study by the National Center for State Courts characterized the cases occurring between 1976 and 1992 as follows:

The nature of these cases varied widely. For example, the cases addressed issues ranging from the substantive question of whether LSMT [life sustaining medical treatment] should be foregone to whether attorneys' or guardian-ad-litem's fees should be awarded. Both civil and criminal actions were filed. Some cases discussed whether an individual could forgo LSMT, while other cases focused on the ability of a substitute decision-maker to make that decision. The age of the individual for whom it was proposed to forgo LSMT ranged from infancy, to more than 90 years-of-age. Numerous types of treatment were at issue, although more recent cases focused on artificial nutrition and hydration. The individual's medical condition, cognitive capacity/competence, and expression of treatment wishes all varied considerably.

GUIDELINES, *supra* note 1, at 6-7.

74. Hafemeister & Robinson, *supra* note 5, at 4.

75. Hafemeister and Robinson attributed this to the need for promptness in deciding the cases. *Id.* at 20.

76. *Id.* at 21.

77. *Id.* at 20.

78. Many cases come to the courts in the posture of guardianship, i.e., the patient lacks decision-making capacity and either has no family, the family is not legally authorized to make the decision at issue, or for some reason the family is not the appropriate decisionmaker, and someone must be appointed by the court to consent to the proposed treatment. In some cases, the courts go no further than this, giving the guardian complete authority to make the decision. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (Ariz. 1987); *In re Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (July 28, 1988), *cert. denied sub nom.* *Drabick v. Drabick*, 488 U.S. 958 (1988), *reh'g denied*, 488 U.S. 1024 (1989). In other cases, the court will not relinquish authority over a life and death decision to the guardian and instead, makes the decision itself. See, e.g., *In re Greenspan*, 558 N.E.2d 1194, *remanded*, No. 88P8726 (Cir. Ct. Cook Co., Oct. 3, 1990); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989) (In both cases the Illinois Supreme Court required judicial approval for removal of artificial nutrition and hydration.) See also *Superintendent of Belchertown State School v. Sarkewicz*, 370 N.E.2d 417, 435 (Mass. 1977) (The Massachusetts Supreme Court stated that "questions of life and death" require the process of a "detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created.").

interest in refusing unwanted medical treatment.⁷⁹ If a patient lacks decision-making capacity an effort must be made to determine what the patient would have wanted with respect to the receipt of various medical treatments. This is referred to as the substituted judgment test. In applying the test, courts have considered such factors as expressed preferences of the patient regarding the provision of, or the withholding or withdrawal of the life-sustaining treatment at issue or life-sustaining treatments more generally as well as "the patient's general values regarding health care, life extension, and overall manner of living."⁸⁰

In applying the standard, courts have struggled with deciding what evidence is credible and what level of evidence is sufficient.⁸¹ As regards the appropriate evidentiary standard, although in many early decisions appellate courts seemed comfortable with a preponderance of the evidence test,⁸² more recent decisions seem to be embracing a clear and convincing evidence test.⁸³

In a number of cases, the courts were unable to decide the case using a substituted judgment test and relied on a best interest test⁸⁴ or a combination of both tests.⁸⁵ The best interest test has been articulated in numerous ways but in general courts have considered or required the surrogate decision maker to consider

evidence about the patient's present level of physical, sensory, emotional and cognitive functioning, the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment options; and the risks, side effects, and benefits of each of those options.⁸⁶

The subjectivity of the standard leaves much space for interpretation and

79. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

80. See GUIDELINES, *supra* note 1, at 78.

81. At the trial court level, judges seem to have had particular difficulty in (1) evaluating prior statements of the patient; (2) evaluating the testimony of witnesses reporting prior statements of the patient; (3) deciding what weight to give the opinions of family and friends of the patient; and (4) determining whether the patient's expressed choice had been altered by time or intervening events. Hafemeister & Robinson, *supra* note 5, at 28.

82. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626 (Mass. 1986); *In re Jobes*, 529 A.2d 434 (N.J. 1987); *Newman v. William Beaumont Army Medical Center*, No. EP-86-CA-276 (W.D. Tex. Oct. 30, 1986).

83. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990); *In re Guardianship of Crabtree*, No. 86-0031 (Hawaii Fam. Ct., 1st Cir., April 26, 1990); *In re Greenspan*, 558 N.E.2d 1194, *remanded*, No. 88P8726 (Cir. Ct. Cook Co., Oct. 3, 1990); *Mack v. Mack*, 618 A.2d 744 (Md. 1993); *In re Westchester Co. Medical Center (O'Connor)*, 531 N.E.2d 607 (N.Y. Ct. App. 1988).

84. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *In re Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *cert. denied sub nom.*, *Drabick v. Drabick*, 488 U.S. 958 (1988); *In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988); *In re Guardianship of Hamlin*, 689 P.2d 1372 (Wash. 1984); *In re Guardianship of L.W.*, 482 N.W.2d 60 (Wis. 1992).

85. See, e.g., *Foody v. Manchester Memorial Hospital*, 482 A.2d 713 (Conn. Super. Ct. 1984); *In re Torres*, 357 N.W.2d 332 (Minn. 1984).

86. GUIDELINES, *supra* note 1, at 74.

for drawing different conclusions from the same set of facts.⁸⁷ The parameters of the test have not been well defined. For example, there is some disagreement as to whether the test should apply at all to patients in a persistent vegetative state.⁸⁸

These two standards have generally governed cases involving termination of life support for incapacitated adults.⁸⁹ In cases involving young children, courts look to constitutional and common law precedent which gives parents considerable latitude in deciding the best course of medical treatment for their children.⁹⁰ The cases, however, place limits upon parental decision-making when the life of the child would be threatened by the parents' actions.⁹¹ In these cases, the issue often comes to the court on the allegation that the parents have violated the state statute prohibiting child medical neglect. In some states these statutes can form the basis for a criminal prosecution.⁹² The statutes in general leave a great deal of discretion to judges in deciding whether neglect has occurred.⁹³

No matter which standard is applied, judges, at least at the trial court level, have significant difficulty with the medical issues involved in these cases, in particular, determining the patient's likelihood of recovery or improvement.⁹⁴

87. See *id.* at 75 ("applying the best interests standard involves a very subjective process, precluding the application of a pat formula that dictates what the surrogate's decision will be").

88. See, e.g., *Mack v. Mack*, 618 A.2d 744 (Md. 1993).

89. In spite of their widespread adoption by the judicial system, the standards are not without critics. See, e.g., Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988). Rhoden argues that the substituted judgment test,

which requires the family to provide clear proof that termination of treatment is what the incompetent would have chosen, is often unworkable because a patient's character traits, and even her prior statements about medical treatment, seldom rise to the evidentiary level that courts purport to require. Similarly, she argues that the [best interest] test, which requires the family to prove that the burdens of the patient's life, measured in terms of pain and suffering, clearly and markedly outweigh its benefits, dehumanizes patients by suggesting that only their present, physical sensations count.

Id. at 375.

90. Under the 14th amendment, parents have a liberty interest in raising their children free from undue state interference and in maintaining the integrity of the family unit. See *Hodgson v. Minnesota*, 497 U.S. 417 (1990); *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974); *Prince v. Mass.*, 321 U.S. 158 (1944); *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

91. See *Parham v. J.R.*, 442 U.S. 584 (1979).

92. See, e.g., MD COURTS & JUD. PROC. ART, § 3 - 831.

93. Some of the statutes have actually been struck down as unconstitutionally void for vagueness. See, e.g., *Alsager v. District Court of Polk City, Iowa*, 406 F. Supp. 10 (S.D. Iowa, 1975) (an Iowa statute authorizing termination of relationship between parent and child if court found that "the parents have substantially and continuously or repeatedly refused to give the child necessary parental care and protection" was held to be unconstitutionally vague). See also *Davis v. Smith*, 583 S.W. 2d 37 (Ark. 1979) (term "proper home" held impermissibly vague); *Roe v. Conn*, 417 F.Supp. 769 (N.D. Ala. 1976) (definition of "neglected child" struck down for vagueness).

94. See *Hafemeister & Robinson*, *supra* note 5, at 36. Other medical issues noted as problematic for judges surveyed by *Hafemeister and Robinson* included determining (1) whether the patient was terminally ill or in a persistent vegetative state; (2) what constitutes life sustaining medical treatment, (3) whether the patient had the required capacity to make the decision in question, and (4) whether the patient was dead/brain dead. *Id.* at 37.

IV. HOW THESE CASES ARE HANDLED BY ETHICS COMMITTEES

Although a number of disputes involving termination of life support have reached the courts most have not, and efforts are made to resolve these disagreements in some other fashion. Ethics committees have emerged as one mechanism to deal with these disputes at an institutional level. These multidisciplinary committees generally have a majority or plurality of physician members, and almost all include nurses and social workers.⁹⁵ Although called ethics committees, not all include an ethicist or someone with formal training in ethics.⁹⁶ Committee size varies considerably with some committees having as few as three members and others having over thirty.⁹⁷

The establishment of committees in many cases was motivated by a desire on the part of health care providers to have a better mechanism by which to deal with cases involving termination of life support. Efforts were also endorsed by the Baby Doe guidelines,⁹⁸ the President's Commission Report on Termination of Life Support⁹⁹ and several professional associations including the American Medical Association,¹⁰⁰ the American Hospital Association,¹⁰¹ the Catholic Hospital Association¹⁰² and the American Academy of Pediatrics.¹⁰³ As of 1985, over 60% of hospitals in the country with over 200 beds had established an ethics committee,¹⁰⁴ and at least one state has statutorily mandated that all hospitals and nursing homes establish such a committee.¹⁰⁵ However, use of the committees by health care providers and patients and their families varies widely from institution to institution. In some institutions, committees are consulted regularly;¹⁰⁶ in other institutions, the committees are infrequently used or have never been consulted.¹⁰⁷ Large hospitals and teaching hospitals are more likely to have committees, and it is more likely that their

95. HANDBOOK, *supra* note 26, at 38.

96. See Diane E. Hoffmann, *Does Legislating Hospital Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in Maryland, the District of Columbia and Virginia*, 19 LAW, MEDICINE & HEALTH CARE 105, 108 (1991) (finding that overall, less than half (46%) of committees in Maryland, the District of Columbia, and Virginia included a formally trained ethicist).

97. *Id.* at 107.

98. 45 C.F.C. §1340 (1993).

99. PRESIDENT'S COMMISSION, *supra* note 18. In that report the Commission concluded that in order to protect the interests of patients who lack decision-making capacity and to assure their well-being and self-determination, health care institutions "should explore and evaluate ... various administrative arrangements for review and consultation, such as 'ethics committees' particularly for decisions that have life or death consequences...." *Id.* at 5.

100. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, GUIDELINES FOR ETHICS COMMITTEES IN HEALTH CARE INSTITUTIONS, 253 JAMA 2698 (1985).

101. AMERICAN HOSPITAL ASSOCIATION, GUIDELINES: HOSPITAL COMMITTEES ON BIOMEDICAL ETHICS (1984).

102. ROBERT P. CRAIG ET AL., CATHOLIC HOSPITAL ASSOCIATION, ETHICS COMMITTEES: A PRACTICAL APPROACH (1986).

103. Alan R. Fleishman, *Bioethical Review Committees in Perinatology*, 14 CLINICAL PERINATOL 379 (1987).

104. *Ethics Committees Double Since '83 Survey*, 59 HOSPITALS 60 (1985).

105. MD. HEALTH-GEN. CODE ANN. §§ 19-370 to 19-374 (1990 & Supp. 1993).

106. See Henry Perkins & Bunnie Saathoff, *Impact of Medical Ethics Consultations on Physicians: An Exploratory Study*, 85 AMER. J. OF MED. 761 (1988).

107. See Hoffmann, *supra* note 96, at 110.

committees are used for consultation purposes.¹⁰⁸ While many authors have argued that patient protection should be the mission of ethics committees¹⁰⁹ and some committees have articulated that goal as their purpose, other committees have not been as clear about their role and seem to act more as neutral advisors, weighing the interests of all the relevant parties in arriving at a recommendation in a case consult.

Most often it is physicians who initiate the request for committee review of a case in which they are involved.¹¹⁰ As a result, most of the cases involve physician concerns about the care of a patient and whether the physician can ethically or legally do what she wants to do. Sometimes, requests for committee review involve disputes between the physician and the patient's family. A smaller number of cases involve disputes between family members and a few between health care providers, i.e., between physicians or between nurses and physicians.

For the most part, committees report to the medical staff or to the institution's administrator.¹¹¹ In many facilities, ethics committees are still establishing themselves within the institution, attempting to let health care providers know of their existence and gain their trust. For the most part, the reputation of the committees is advanced by word of mouth. To gain acceptance within the institution committees must prove themselves by showing how they can assist health care providers with difficult cases.¹¹²

A. Ethics Committee Process

The process used by committees to deal with these cases is not well documented and varies considerably from committee to committee. Based on an informal study of twenty-eight "representative ethics committee members from health care institutions around the country," Cohen describes three "basic structural models" that committees appear to use in case consultation. They include review by (1) the committee as a whole; (2) a consult team derived from the committee members; or (3) a single ethics consultant.¹¹³

108. *Id.* at 107.

109. *See, e.g.,* HANDBOOK, *supra* note 26, at x, which states:

ethics committees should exist primarily to serve patients and to protect their interests. The temptation to protect the hospital, hospital employees, and physicians will be felt frequently. In many situations, the interests of hospital, health care workers, and patients and families will be united; in other situations the patients' interests may appear obscure or uncertain; in yet others, the patients' preferences may lie in sharp contrast with the values of the hospital or of the health care professionals. It will be difficult to always keep the patients' interests uppermost and, in some cases, it will be impossible. If it were easy, ethics committees would not be needed.

110. Hoffmann, *supra* note 96, at 110.

111. However, there are some committees that report to both and others that report to neither. *See* Diane E. Hoffmann, *Regulating Ethics Committees in Health Care Institutions—Is it Time?*, 50 MD. L. REV. 746, 765 (1991).

112. *See* Povar, *supra* note 26.

113. Cynthia B. Cohen, *Avoiding 'Clouduckooland' in Ethics Committee Case Review: Matching Models to Issues and Concerns*, 20 LAW, MEDICINE & HEALTH CARE 294 (1992). In a study of 20 committees from across the country West and Gibson found similar approaches:

Some invite all committee members to consultations and hold them in the committee meeting room, sometimes only during regularly scheduled committee meeting times. Others have permanently constituted or rotating consultation subcommittees of three to six members who may hold consultations in the

In some institutions, before actually discussing the case, the committees engage in a process of information gathering. Often this is done by a single member or a few members of the committee. During this phase of the consult the designated committee member(s) may talk to the physician, the nurse, and the patient and/or the patient's family members or may simply talk with the physician who referred the case to obtain their views.¹¹⁴ Sometimes the information gathering is done by phone, other times it is done in person.

In some cases, this information is then taken back to a larger group/committee to discuss and arrive at a recommendation. In other cases, whether or not the initial information gathering was done, the ethics committee meets and some or all of the relevant parties are invited to attend the meeting. If the latter process is adopted, the committee may meet with the relevant parties all at the same time or may meet with them sequentially — e.g., first the family members and then the health care providers. If the parties are met with simultaneously they are usually given an opportunity to state their concerns or position on the case and to ask questions of each other. When the committee meets with the parties sequentially, the parties do not have an opportunity for face to face interaction.¹¹⁵ Whichever approach is used, committee members generally ask the parties questions in order to clarify the issues and obtain additional information. The information sought typically includes the medical facts, the views of the various parties regarding what should be done for the patient, and relevant legal and administrative information.¹¹⁶

patient's unit or even at bedside. One committee reported that consultations had originally been handled by two committee members --both physicians -- until the committee recognized that this was not the best model and constituted an ad hoc task force to service consultation requests.

West & Gibson, *supra* note 10, at 68.

114. West and Gibson analogize this type of process, where the committee consults exclusively with the physician, to the traditional model of medical consults. West & Gibson, *supra* note 10, at 68.

115. This description is largely based on my own experience with a number of ethics committees, but others have described similar procedures. *See, e.g., id.* at 69.

116. For incompetent patients, Ross et al. suggest the following specific questions be asked:

Medical facts

- What is the patient's current medical status?
- Are there other contributing medical conditions?
- What is the diagnosis? The prognosis? How reliable are these?
- Has a second opinion been obtained? Would it be helpful?
- Are there other tests that could help clarify the situation?
- What treatments are possible?
- What is the probable life expectancy and what will be the general condition if treatment is given?
- What are the risks and side effects of the treatment?
- What is the probability that treatment will benefit the patient?
- What benefits will treatment provide?

Patient preference

- [Is the patient] expected to regain competence?
- [Did the patient] ever make a clear statement that would indicate what his or her wishes would be in these circumstances?
- Has the patient prepared a written statement regarding his or her wishes?
- Has the patient signed a durable power of attorney for health care? a living will? a natural death act?
- How physically and emotionally healthy was the patient before

B. Arriving at a Recommendation — Application of Norms

In most cases, the ethics committee members deliberate among themselves and arrive at a recommendation.¹¹⁷ Committees generally do not view themselves as arbitrators deciding who is “right” between adversarial parties but rather as independent consulting bodies trying to arrive at the “best” solution to the problem after gathering all of the facts. In an effort to arrive at a recommendation, typically the committee chair or consultation subcommittee chair facilitates a discussion about the case. The discourse of the committee members often shifts from medical concerns to ethical concerns to legal concerns to psychotherapeutic concerns in no particular order. Committee members often use the rhetoric of bioethics: the principles of autonomy, beneficence, nonmaleficence and justice. These principles, along with relevant legal precedent, basically serve as guidelines or norms for the committees’

this current situation?

- If the patient has made no clear statement, is there information from anyone regarding what the patient might have wanted or might reasonably be assumed to have wanted?

Views of family and friends

- Are there family members and/or friends? Who are they?
- Do they fully understand the patient’s condition?
- What are their positions?
- Do they agree with one another?
- Are there any reasons to question their motives?
- Has one person been identified as having the primary responsibility for communication and decision making?
- Does anyone have legal custody of the patient (guardianship or conservatorship)?
- If the patient is a minor and the parent(s) are the legal guardians, are they choosing a course of action that is clearly in the child’s best interests?
- If there are problems in communicating with family and/or friends, can someone be found (a minister, for example) who could be helpful?

Views of the care givers

- Are the care givers fully apprised of the facts?
- What are their views?
- Why do they hold those views?
- If the care givers disagree, what accounts for the disagreements? Can they be resolved?

Legal, administrative, and external factors

- Are there state statutes or case law that apply to this situation?
- What potential liability might be present with respect to the hospital, to the providers, and to the parent or guardian?
- Are there hospital policies or guidelines that apply?
- Are there other persons (in or outside the institution) who should be given information or asked for an opinion?
- Would it help to consult the literature for any aspect of this case?
- Is expense to the patient and/or family a factor in this case?

HANDBOOK, *supra* note 26, at 25 -26.

117. West and Gibson describe committees that take this approach, i.e., deciding the issue themselves, as viewing their role as educational with certain expertise to offer. West & Gibson, *supra* note 10, at 69. They assert that committees that view their role more broadly may see their function as “helping the persons involved actually reach consensus on how to proceed.” *Id.* at 68.

deliberations.¹¹⁸

Ethics committees for the most part have adopted a fairly legalistic or norm-centered approach to the cases that come to them.¹¹⁹ In some cases the norms are definitive and provide a resolution of the issues. In other cases, the principles and precedents may be in conflict. In these cases, the norms simply serve as guidelines or boundaries for the committee's recommendation and the values of the committee members themselves as well as the committee's dynamics and personalities may be determinative of the committee's recommendation.¹²⁰ The committee members typically arrive at a recommendation by reaching a consensus on the case.¹²¹ The resulting advice then usually reflects a combination of "expert" thinking on the issues from a number of disciplines, consistent with relevant ethical and legal norms, as well as a democratic process where all those in attendance have a say in the outcome.

The committee's recommendation is routinely conveyed to the health care provider involved in the case and, in some cases, is included in the medical record.¹²² A few committees also provide a written response to the patient or patient's family setting forth their recommendation and the reason for it. The committee's recommendation is considered to be advisory only, not binding, yet in most cases it is given considerable weight, especially by the health care provider.¹²³

C. Criticisms of Ethics Committees

While ethics committees have been in existence now in many institutions for more than a decade, there has been little empirical study of them and few efforts at evaluation. To the extent that studies have been done they have focused on the satisfaction of physicians and health care providers and have indicated that those users have generally found the committees helpful to their

118. Throughout the article I lump together ethical and legal norms treating them as basically the same. Although I am certain that some bioethicists will take issue with this and argue that ethics committees do not apply legal norms, my own experience is that the committees are very cognizant of legal norms and apply them regularly. For the most part, I would also argue that those legal norms are consistent with the relevant bioethics "principles" that the committees apply.

119. See John D. Golenski, *Measuring Institutional Change: a Yardstick for Ethics Committees*, American Hospital Association Resource Center (May/June 1990) (education of ethics committee members typically focuses on "ethical principles, precedential jurisprudence, and generally accepted norms within the professions").

120. A study of ethics committee members in Maryland, the District of Columbia and Virginia indicated that certain professionals often dominate the committee's discussions. When ethics committee members were asked which individuals most influence the outcome of the committee's discussions, overall, 60% said physicians were most influential, 23% said lawyers and 17% said ethicists. Hoffmann, *supra* note 96, at 111.

121. See HANDBOOK, *supra* note 26, at 27; see also, Hoffmann, *supra* note 96, at 111; Jonathan D. Moreno, *What Means This Consensus? Ethics Committees and Philosophic Tradition*, 1 J. OF CLINICAL ETHICS 38 (1990).

122. See Hoffmann, *supra* note 96, at 110 (finding that 66% of ethics committees in Maryland, the District of Columbia, and Virginia include their recommendation in the patient's medical record).

123. See Wolf, *supra* note 8, at 808 (arguing that committee's conclusions "may have a substantial impact" given that the committee's advice may have a psychological effect on the disputants, may be the last word in a case especially if a family does not have the financial means to pursue judicial review, and that courts, in some cases, have given weight to ethics committee recommendations).

dilemmas.¹²⁴ Few, if any, studies have looked at the views of patients and family members who have used the committees. Despite the lack of empirical research, there have been numerous articles raising concerns about the committees and their operations. For the most part these criticisms are based on structural or process issues. Substantive critiques have not focused directly on ethics committees but more generally on traditional bioethics theory.

1. Structural Concerns

A number of authors have criticized ethics committees for their membership, in particular, their institutional protectionism¹²⁵ or professional bias.¹²⁶ Virtually all committees are composed almost entirely of hospital or nursing home staff.¹²⁷ Some committees include community representatives but this is often a token gesture — typically one such person sits on the committee, rarely two or more. As a result, committees may be perceived not only as lacking neutrality and objectivity but as “provider-focused.”

Some committees may also lack expertise in bioethics and relevant legal norms. Members need not go through any training. Often members are simply interested individuals without any special expertise or perspective.

2. Process Concerns

In terms of process, ethics committees have been criticized for their lack of due process protections and their internal deliberative process. Although most authors agree that as a matter of constitutional law most ethics committees need not apply due process protections, some have argued that as a matter of justice ethics committees should incorporate them into their procedures. Due process concerns have been raised primarily by Susan Wolf who has argued that the committees do not consistently provide patients or their surrogates with such basic protections “as notice, an opportunity to be heard, a chance to confront those in opposition, receipt of a written determination and a statement of reasons, and an opportunity to challenge that determination.”¹²⁸ She criticizes the committees stating that they “seek the decisive power of the Adjudicatory Model, while using the processes of the Consultation Model.”¹²⁹ She argues that “[t]his is the worst of both worlds—the committee wields great influence over the treatment decision but accords no protections for the

124. A survey of over 500 physicians, nurses and social workers at five Maryland hospitals with long-standing ethics committees found that of those that had had some experience with the committees, two-thirds found the committees helpful to their decision-making, while one-third did not. Hoffmann, *supra* note 96, at 114.

125. See, e.g., Cynthia B. Cohen, *The Social Transformation of Some American Ethics Committees*, 19 HASTINGS CENTER REP. 21 (1989) (“The structure of some committees has been designed to protect institutional interests: a few are chaired by legal counsel for the institution; others are composed almost entirely of members of the board who ‘have an interest in ethics.’”).

126. See, e.g., Bernard Lo, *Sounding Board: Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 NEW ENG. J. MED. 46, 47 (1987) (“The composition of ethics committees may not reassure patients that their wishes and interests are represented ... patients or surrogates who disagree with the committee’s recommendations may say that the composition of the committee was biased against them.”).

127. Hoffmann, *supra* note 96, at 108.

128. Wolf, *supra* note 8, at 831.

129. *Id.*

patient's rights."¹³⁰ Although some have argued with the adoption of full blown due process measures by ethics committees,¹³¹ most agree that at a minimum the patient or patient surrogate should be notified and consulted about the case.

The second concern about these committees goes to committee dynamics and their deliberative process. In at least some cases, committee dynamics are dominated by certain members, often the chair or physician members. This means that there is further potential for bias in the outcome. Not only are patient concerns potentially suppressed but the concerns of other professionals, such as nurses, social workers and clergy are not well represented.

3. Substantive Concerns

There have been few substantive criticisms focused directly at ethics committees, i.e. criticisms focused on the quality of the recommendation, however, there has been a great deal of criticism about the principles that they appear to apply. In making recommendations, most physicians, nurses, ethics committees, and the courts seem to base their decisions on "contract theory, on secular-based theory of human rights, and on liberal theories of justice."¹³² The ethical theories of justice have led to the application of the bioethical principles of beneficence, nonmaleficence, autonomy and justice in medical decision-making.¹³³ In recent years, there have been a number of scholarly articles critical of the use of "Principlism"—the application of abstract principles to resolve real cases.¹³⁴ These criticisms have been based on the perception that the application of these abstract principles not only are nondeterminative but also are "missing an emphasis on care and relationship"; "ignoring the interests of the family"; and failing "to meet the needs of nursing, family medicine, or clinical medicine."¹³⁵ These scholars advocate instead a theory based on care and relationship. Although some ethics committee members may intuitively rely on such a theory, their training in ethics, if any, more than likely focused on the principles of bioethics.

V. NATURE OF MEDIATION

Mediation is a *process* whereby a neutral third party assists disputing parties reach a mutually acceptable agreement. Although generally the process is voluntary, in some jurisdictions, certain types of disputes must go through mediation before going to court.¹³⁶ Unlike a private arbitrator or judge a

130. *Id.*

131. See, e.g., Vicki Michel, *Ethics Committee Procedure: Due Process or Good Process?*, ETHICAL CURRENTS 6 (June 1992).

132. Vangie Bergum, *Beyond Rights: The Ethical Challenge*, 10 PHENOMENOLOGY + PEDAGOGY 75, 77 (1992).

133. These principles were largely derived from the moral theories of Kant, Rawls, and Mills and have been adopted and widely disseminated by Tom L. Beachamp and James F. Childress in their book, PRINCIPLES OF BIOMEDICAL ETHICS (1989).

134. See, e.g., K. Danner Clouser & Bernard Gert, *A Critique of Principlism*, 15 J. MED. & PHIL. 219 (1990).

135. Bergum, *supra* note 132, at 77. Bergum cites S. RUDDICK, MATERNAL THINKING, TOWARD A POLITICS OF PEACE (1989); John Hardwig, *What About the Family?*, 20(2) HASTINGS CENTER REPORT 5-10; Sara T. Fry, *The Role of Caring in a Theory of Nursing Ethics*, 4(2) HYPATIA 88-103; R. J. CHRISTIE & C. B. HOFFMASTER, ETHICAL ISSUES IN FAMILY MEDICINE (1986); and R. ZANER, ETHICS AND THE CLINICAL ENCOUNTER (1988) respectively for these assertions.

136. At present, courts in many states operate under a statutory requirement that, for

mediator does not have the power to impose a solution on the parties, even in cases of mandatory mediation. The process differs from adjudication in that "the emphasis is not on who is right or wrong or who wins and who loses, but rather upon establishing a workable solution that meets the participants' unique needs."¹³⁷ Or, put another way, it "rejects an objectivist approach to conflict resolution, and promises to consider disputes in terms of relationships and responsibility."¹³⁸ Parties are given a chance to "vent their feelings" and "tell their stories" so "that they feel heard and understood."¹³⁹ The focus on relationships and context as opposed to principles has led some to refer to mediation as a more feminine approach to conflict resolution than the hierarchical, rule-oriented court system.¹⁴⁰

A theoretical underpinning of mediation is that it enhances the autonomy and self determination of the participants — they become the decision makers and responsible for the outcome. According to Folberg and Taylor, experts in the field:

The ultimate authority in mediation belongs to the participants themselves, and they may fashion a unique solution that will work for them without being strictly governed by precedent or being unduly concerned with the precedent they may set for others. They may, with the help of their mediator, consider a comprehensive mix of their needs, interests, and whatever else they deem relevant regardless of rules of evidence or strict adherence to substantive law.¹⁴¹

The mediator plays the role of facilitator, helping the parties to reach an agreement but does not interject his or her views into the dispute. A significant tenet of traditional mediation is the neutrality of the mediator. The mediator must be impartial to the parties and their positions—

Traditional mediators are accepted by the adversaries and exert influence because they are seen as having no interest in the conflict beyond its

certain types of cases, parties to a law suit participate in some type of alternative dispute resolution process prior to a court proceeding. See STEPHEN B. GOLDBERG ET AL., *DISPUTE RESOLUTION: NEGOTIATION, MEDIATION, AND OTHER PROCESSES* 262 (1993). For example, judges may mandate mediation in any civil case in Florida, FLA. STAT. ch. 44.102(1992), or Texas, TEX. CIV. PRAC. & REM. CODE ANN. §§154.021-.023 (West 1992); in domestic relations cases in Alaska, ALASKA STAT. §25.20.080 (1983), California, CAL. CIV. CODE §4607 (West 1983 & Supp. 1993), Colorado, COLO. REV. STAT. §14-10-129.5 (1993); Louisiana, LA. REV. STAT. ANN. §9:351 (West Supp. 1992), and Maine, ME. REV. STAT. ANN. tit. 19 §§636, 665, 752 (West Supp. 1992); in personal injury cases in Michigan, MICH. COMP. LAWS ANN. §600.4951 (West 1992); in workers' compensation cases in Montana, MONT. CODE ANN. §39-71-2401 (1993); and in medical malpractice cases in Hawaii, HAWAII REV. STAT. §671-5, 671-16.5 (1993) and Wisconsin, WIS. STAT. ANN. §655.42 (Supp. 1991-92).

137. FOLBERG & TAYLOR, *supra* note 16, at 10.

138. Tina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545, 1548 (1991).

139. NANCY ROGERS & RICHARD SALEM, *A STUDENT'S GUIDE TO MEDIATION AND THE LAW* 10 (1987).

140. See Janet Rifkin, *Mediation from a Feminist Perspective: Promises and Problems*, 2 LAW & INEQ. J. 21, 23 (1984). According to Grillo, "[t]he female mode is characterized by an 'ethic of care' which emphasizes nurturance, connection with others, and contextual thinking. The male mode is characterized by an 'ethic of justice' which emphasizes individualism, the use of rules to resolve moral dilemmas, and equality." Grillo, *supra* note 138, at 1601.

141. FOLBERG & TAYLOR, *supra* note 16, at 10.

peaceful resolution. Indifference toward the parties' positions permits the mediator to consider each in a detached fashion and to explore alternatives that the parties' own confrontational postures would not allow. It also permits the mediator to represent each party's interests to the other with greater credibility than either would have through direct contact since, of the three parties, only the mediator has no direct stake in the outcome.¹⁴²

Mediation gained considerable popularity in the 1970s and 1980s in large part due to practical concerns about the legal system.¹⁴³ The insensitivity of the legal system, its costs and inefficiencies, as well as dissatisfaction with lawyers probably pushed more parties to try mediation than the intrinsic value of mediation itself. Mediation has been described as "amicable, conciliatory, nonadversarial, cheaper, and eliminating the winner-loser roles, while the legal process is seen as acrimonious, litigious, adversarial, expensive, and producing a definite winner and loser."¹⁴⁴

Another advantage of mediation for many parties is that it is more flexible than the courts. Meetings are arranged by the parties at their own convenience rather than rigidly fixed by the court. In addition, the privacy afforded by mediation and the opportunity to "avoid the psychologically traumatic experiences of court confrontation"¹⁴⁵ is attractive to many.¹⁴⁶ Studies of participants in mediation have generally found that they have been satisfied with the process.¹⁴⁷

A. *The Mediation Process*

Although mediation may appear to some as a free ranging discussion with little intervention by the mediator, the mediator plays a significant role in shaping the debate and the discourse. First, she establishes a "constructive ambiance for negotiation"¹⁴⁸ including "maintaining rules of civilized debate, acting as a neutral discussion leader, helping to set [an] agenda, suggesting processes for negotiations, smoothing out interpersonal conflicts, [and] giving

142. William P. Smith, *Effectiveness of the Biased Mediator*, 1 NEGOTIATION J. 363, 364 (1985).

143. Historically limited primarily to labor and international disputes, mediation is now used as a mechanism for the resolution of environmental and community disputes, between merchants and buyers in consumer disputes, in the school system to settle differences between students and between parents and school administrators, and perhaps most often in divorce and family disagreements. See, e.g., STEPHEN B. GOLDBERG ET AL., DISPUTE RESOLUTION 92 (1985).

144. Ruth R. Budd, *Divorce Mediation: Some Reservations*, BOSTON BAR J. May-June 1984, at 33, 33-34.

145. Sanford N. Katz, *Mediation is Coming of Age*, NAT'L L.J., Aug. 6, 1984, at 25.

146. The courts themselves have also encouraged mediation in order to reduce their overcrowded dockets and in some states mediation has become mandatory. That is, prior to going to court the parties must attempt to reach an agreement via mediation. If mediation fails, the parties may still go to court, but they must first go through the mediation process. See *supra* text accompanying note 136.

147. See FOLBERG & TAYLOR, *supra* note 16, at 12 ("Most of those who use divorce mediation services are pleased with the process."). Although some have argued that men are generally more satisfied with mediation than women, see, e.g., Grillo, *supra* note 138, there is some controversy on this point. See, e.g., Ellen Waldman, *The Role of Legal Norms in the Divorce Mediation: An Argument for Inclusion*, 1 VA. J. OF SOC. POL'Y & THE L. 87, 114 (1993) (arguing that a number of studies do not bear this out).

148. HOWARD RAIFFA, THE ART AND SCIENCE OF NEGOTIATION 108 (1982).

reticent people a chance to speak."¹⁴⁹ Second, she helps parties to clarify their values and interests.¹⁵⁰ Third, she deflates unreasonable claims (such as "if this goes to court there is no question that I will win") and loosens commitments, i.e., reduces excessive posturing.¹⁵¹ Fourth, she seeks joint gains by "devis[ing] new compromises and encourag[ing] bargainers to be more creative in their search for a solution."¹⁵² Fifth, she articulates the rationale for agreement, if one is reached.¹⁵³

In carrying out these tasks the mediator has been referred to as a "catalyst, an educator, a translator, an expander of resources, a bearer of bad news, an agent of reality, and a scapegoat."¹⁵⁴ As an educator, the mediator may have to explain certain technical issues to the parties or certain statutory provisions that bear on the dispute.¹⁵⁵ As a translator, "[t]he mediator's role is to convey each party's proposal in a language that is both faithful to the desired objectives of the party and formulated to insure the highest degree of receptivity by the listener."¹⁵⁶

The techniques used by mediators to assist parties in reaching an agreement vary from mediator to mediator and from session to session for a single mediator. Yet, most mediation process follows a similar progression. Prior to the actual mediation session there is often an intake process at which time some initial information is obtained from the disputing parties and a decision is made as to whether the case is appropriate for mediation. If so, the form the mediation should take, i.e., single mediator, co-mediators, and need for experts, must also be decided. At the mediation session, there is typically an introductory stage in which the mediator creates some structure and establishes trust with the parties.¹⁵⁷ During this stage, the mediator introduces herself, assesses the participants' attitudes about mediation and their readiness for the process, gathers relevant information about the participants' perceptions of the conflict, their goals and expectations, and the conflict situation. She then explains the mediation process including the fact that everything said will be confidential, that she may caucus separately with each party, how long each session will be, the opportunity for legal input and review of any agreement reached, the opportunity to revise the document, and options if an agreement is not reached.

The second phase of the mediation process is usually referred to as fact-finding and isolation of issues.¹⁵⁸ One of the priorities of a mediator at this stage is to get the parties to articulate their goals and interests in an effort to identify common ground and move them away from positional bargaining. In this stage the mediator may meet with the parties together or separately, but the mediator stresses that all parties will have an opportunity to speak uninterrupted by others. During this phase, the mediator may allow the parties

149. *Id.*

150. *Id.*

151. *Id.* at 109.

152. *Id.*

153. *Id.*

154. GOLDBERG ET AL., *supra* note 143, at 92, summarizing Joseph Stulberg, *The Theory and Practice of Mediation: A Reply to Professor Suskind*, 6 VT. L. REV. 85 (1981).

155. Stulberg, *supra* note 154, at 92.

156. *Id.*

157. FOLBERG & TAYLOR, *supra* note 16, at 38.

158. *Id.* at 47.

to vent their anger so that they can move on and approach their conflict more rationally.¹⁵⁹ Part of the challenge for the mediator at this stage is making sure that all of the issues are out on the table and that none are lurking in the background to pop out unexpectedly later. This requires that the parties have some trust in and a willingness to share intimate issues with the mediator.

The third phase typically involves the creation of options and alternatives.¹⁶⁰ This includes a recognition of the “[n]eeds of the parties and others who will be affected by the decision[; p]rojections of the past into the future...; [g]eneral economic and social forecasts that may affect an option [; identification of] roadblocks and limitations[; and] new people and situations that are anticipated.”¹⁶¹

The fourth phase is often called negotiation and decision-making.¹⁶² At this stage the mediator attempts to get the parties to agree to a set of objective criteria by which to evaluate the alternatives arrived at in phase three and to move them away from their fixed bargaining positions. During each phase, but perhaps more importantly here, it is necessary that the mediator maintain some sort of equality in communication so that more talkative participants do not dominate the session.

In the final stages of the process, if an agreement is reached, the mediator assists the participants in drafting an agreement and provides them with opportunities to review the document, suggest revisions, and have it reviewed by an attorney or another party.¹⁶³

B. The Role of Norms in Mediation

There is some controversy in the mediation field over the “appropriate” role of third party norms. The “traditional” view of mediation is that it is often directed “not toward achieving conformity to [legal or societal] norms, but toward the creation of the relevant norms themselves.”¹⁶⁴ In mediation, the parties create the norms and as a result “person-oriented norms” may win out over “legal norms.”¹⁶⁵ However, there are mediators and scholars who view at least one goal of mediation as the protection of rights of the parties.¹⁶⁶ Those

159. ROGERS & SALEM, *supra* note 139, at 23.

160. FOLBERG & TAYLOR, *supra* note 16, at 49.

161. *Id.* at 50.

162. *Id.* at 53.

163. *Id.* at 60-65.

164. Fuller, *supra* note 16, at 308.

165. FOLBERG & TAYLOR, *supra* note 16, at 245.

166. See, e.g., Robert A. Baruch Bush, *Efficiency and Protection, or Empowerment and Recognition?: The Mediator's Role and Ethical Standards in Mediation*, 41 FLA. L. REV. 253, 260-61 (1989):

[t]he protection-of-rights conception holds that the mediator's primary role, and the main value of the mediation process, is to safeguard the rights of the disputing parties and potentially affected third parties by imposing various checks for procedural and substantive fairness on an otherwise unconstrained bargaining process... the protection of rights conception usually engenders a focus on mediator duties, especially on the duty to advise and urge parties to obtain independent legal counsel and the duty to terminate a mediation that threatens to produce an unreasonably unfair agreement.

Bush contrasts the protection-of-rights conception of mediation with the “efficiency” and “empowerment and recognition” conceptions. He argues that both the efficiency and protection of rights views are flawed and should be replaced by a empowerment and

practitioners and writers believe that mediators should play a more active role in assuring that parties are, at a minimum, aware of "outside" norms and in some cases, that decisions are made consistent with them.¹⁶⁷

The debate has been particularly vital with respect to lawyer mediators. Riskin writes, "[f]or some, the substance of the law and the respective rights of the participants form the foundation for decision-making. For others, the law plays a supporting role to the participants' own sense of fairness."¹⁶⁸ Many lawyer mediators don't believe it is their role to provide any information about the relevant law.¹⁶⁹ Others may not believe it appropriate to disclose substantive legal norms but might indicate that they think one or both of the parties have an inaccurate understanding of the law and should consult a lawyer to clarify their legal rights.¹⁷⁰

Waldman claims that there has been a trend in mediation practice, particularly in divorce mediation, to reject legal norms:

Most early theorists incorporated established legal doctrines into their chrysalid formulations of the divorce mediation process, but sought to reshape the manner in which these doctrines were introduced and applied. They assumed that knowledge of legal norms would be an essential and useful component of the mediator's conflict resolution skills. Later writings, however, betray a hostile attitude toward judicial processes and results. These discussions of alternative dispute processes and goals portray the law as extrinsic to the mediation enterprise, suggesting a diminished requirement for mediator familiarity with essential family law concepts.¹⁷¹

She further asserts that "[w]hereas the pioneers of mediation invested third party neutrals with the task of evaluating each agreement against accepted notions of equity, second-wave theorists and practitioners increasingly delegate that task to an outside reviewer."¹⁷² Waldman argues that this trend is a "wrong turn" in the development of mediation practice.

While mediators differ to the extent they reveal or encourage the adoption of legal or societal norms, parties who know the relevant norms often rely on them, especially if they would benefit that party.¹⁷³ Thus, in some cases,

recognition view. *Id.*

167. See, e.g., Waldman, *supra* note 147.

168. Leonard L. Riskin, *Toward New Standards for the Neutral Lawyer in Mediation*, 26 ARIZ. L. REV. 329, 335 (1984).

169. In a number of jurisdictions, lawyer mediators are reluctant to provide legal information for fear of disciplinary action or malpractice suits. The ABA Standing Committee on Dispute Resolution concluded that "since the line between advice and information is so gray, an attorney-mediator should be exceedingly cautious in providing legal information." Waldman, *supra* note 147, at 146 n.217, citing ABA Standing Comm. on Dispute Resolution, Report to the House of Delegates: Recommendation — Ethical Considerations for Attorney-Mediator (Tentative Draft 1991).

170. Riskin argues that "[a] major benefit of using a lawyer as mediator is his ability to tell the participants what the law provides and what a court would likely do with their case." Riskin, *supra* note 168, at 351. On the other hand, he states, "such neutral lawyering is unusual, problematical, and perhaps even dangerous if not conducted carefully." *Id.*

171. Waldman, *supra* note 147, at 90.

172. *Id.* at 90-91.

173. Edward Brunet, *Questioning the Quality of Alternative Dispute Resolution* 62 TUL. L. REV. 1, 27 (1987).

relevant legal and societal norms may frame the dispute.¹⁷⁴

C. Criticisms of Mediation

During the seventies most commentators were "unabashedly" enthusiastic about mediation, but during its second decade serious questions began to be raised about mediation generally and the appropriateness of its application to certain types of disputes.¹⁷⁵ Criticisms focused primarily on mediation as compared to formal dispute resolution through the courts and have roughly fallen into two categories: procedural and substantive, although a few structural concerns have also been raised.

1. Structural Concerns

In the family context, which may serve as an analogy for some types of disputes over termination of life support,¹⁷⁶ mediators are typically social workers and/or lawyers.¹⁷⁷ While some mediators have received little or no formal training in the process of mediation, most individuals desiring to be mediators go through some type of brief mediation training.¹⁷⁸ Questions have been raised, however, about the lack of training and quality of services provided by some mediators.¹⁷⁹ This has led a number of authors and professional associations to suggest either standards for mediators or regulation of mediators as a means of quality control.¹⁸⁰

174. As Mnookin and Kornhauser have asserted, parties do not negotiate in a vacuum but rather in "the shadow of the law." Robert H. Mnookin and Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968 (1979). This assumes, however, that parties are aware of the relevant legal norms.

175. See, e.g., GOLDBERG ET AL., *supra* note 143, at 3. See also, ROGER MATTHEWS, *INFORMAL JUSTICE?* 1 (1988).

176. Another potential analogy is mediation of malpractice suits, however, "experience with the use of traditional mediation in malpractice cases is very limited." Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 441 (1992).

177. These professionals may come to mediation with different perspectives. Mediators from a clinical or social work background are likely to emphasize the emotional issues in the case and view mediation as a therapeutic process. See FOLBERG AND TAYLOR, *supra* note 16, at 132. Lawyer mediators tend to focus on the legal issues and to view mediation as a contractual process. *Id.* at 133. In some cases these disputes are co-mediated (mediated by two mediators), often by a social worker and a lawyer mediator. *Id.* at 140-41.

178. There are a number of private non-profit organizations that offer short courses in mediation focusing on role plays and simulations. In the context of family mediation, both the American Arbitration Association and The American Academy of Family Mediators provide basic and advanced seminars for practitioners. See ROBERT COULSON, *supra* note 67, at 125. See also FOLBERG & TAYLOR, *supra* note 16, at 233-242. Some states requiring mandatory mediation have established minimum educational requirements for mediators. See, e.g., CAL. FAM. CODE §3164 (West 1994) (requiring mediators to have a master's degree in behavioral science); OR. REV. STAT. §§107.610, 107.775 (1983) (mediators must have a master's degree in behavioral science or bachelor's degree and one year training in behavioral sciences and two years casework or clinical experience, or behavioral science bachelor's degree and four years case work or clinical experience), cited in Jana B. Singer, *The Privatization of Family Law*, 1992 WIS. L. REV. 1443, 1500 n. 275.

179. Despite a proliferation of mediation courses, "the qualifications of mediators vary widely. For example, a 1988 survey reports that many court-connected mediation programs rely to a significant degree on unpaid volunteers to mediate divorce and custody cases." Singer, *supra* note 178, at 1501. And in some cases, the services provided by such mandatory programs are perceived as "inadequate at best." *Id.*, quoting Grillo, *supra* note 138, at 1553.

180. See, e.g., Thomas A. Bishop, *The Standards of Practice for Family Mediators: An*

2. Procedural Criticisms

The procedural criticisms hurled at mediation include (1) its lack of due process protections; (2) the falsehood of mediator neutrality; and (3) the imbalance of power of the parties, primarily in divorce mediation.

Although mediation generally includes such basic due process provisions as notice and an opportunity to be heard, critics have said that it does not go far enough -- that parties in mediation usually are not accompanied by a lawyer and that mediation lacks evidentiary rules to prevent the introduction of unreliable or even prejudicial evidence.¹⁸¹ The concern about legal representation is most often expressed in those contexts where there is a considerable imbalance of power and where one party could be aided considerably by an advocate. In some cases, mediators have responded to this concern by allowing disputants to bring an attorney or other advocate with them to the mediation session. The lack of evidentiary rules has been defended by mediation enthusiasts who argue that the parties have an opportunity, to the extent they have knowledge, to correct false information and argue about the credibility or authenticity of information presented. The rebuttal is consistent with one of the arguments for mediation, i.e., that the parties have the opportunity to construct their own rules of evidence, if they so desire. Parties in mediation, for example, may decide that something is relevant for the purposes of mediation "because it is emotionally—even though not logically—connected to the proceedings."¹⁸²

The second procedural criticism of mediation is the belief that mediator neutrality will lead to fair outcomes. This criticism actually has two components: (1) a concern that mediators are not, in fact, neutral and that their views and biases may influence the result; and (2) that even if neutral, mediators cannot guarantee fairness, if they cannot enter into the conflict to correct power imbalances. As Bryan points out, "the ethic of neutrality and party empowerment compromises any attempt by the mediator to produce fair ... agreements through power balancing because it denies mediators the opportunity to use the only effective power balancing technique: interference with the substance of [the] agreements."¹⁸³

The third criticism on the procedural side — the relative power of the parties — is the one that has attracted the most attention,¹⁸⁴ particularly in the context of divorce and child custody mediation, although some concerns about power imbalances are more far reaching. For example, Fiss argues that

Individual Interpretation and Comments, 17 FAM. L.Q. 461 (1984); Richard K. Schwartz, *A New Role for the Guardian Ad Litem*, 3 OHIO ST. J. ON DISP. RESOL. 117 (1987) ("Ideally, to rectify the problems of substandard mediation, licensing and regulation of family mediators should be established with severe sanctions for mediator misconduct or incompetence.").

181. See Brunet, *supra* note 173, at 12-13. Brunet also criticizes mediation for its lack of effective discovery procedures. *Id.* at 13.

182. Grillo, *supra* note 138, at 1589.

183. Penelope E. Bryan, *Killing Us Softly: Divorce Mediation and the Politics of Power*, 40 BUFF. L. REV. 515 (1992). Some mediators argue that process techniques alone such as allowing both spouses ample opportunity to speak, etc., allows them to maintain neutrality and generate fair outcomes. Bryan and others challenge this assertion.

184. According to Bryan, "the [mediation] literature [has proven] insensitive to power issues." *Id.* Characteristically, she writes, "a recent book on divorce mediation devotes only sixteen of over four hundred pages to power imbalances. In those sixteen pages the authors deny the existence of power imbalances or suggest that if they exist they do not affect mediation." *Id.* at 499.

disparities in resources between the parties can influence the outcome of mediation because the poorer party "may be less able to amass and analyze the information needed to predict the outcome of the litigation, and thus be disadvantaged in the bargaining process. The poorer party might be forced to [settle] because he does not have the resources to finance the litigation...." ¹⁸⁵ Disparities in income and education may also affect one party's ability to argue persuasively to the other party.¹⁸⁶

Power imbalances may be especially troubling in divorce and custody disputes where participants come to mediation "with long-standing patterns of dominance and submission, deference and competition, dependence and competence....[W]hen decisions need to be made, these long-standing communication patterns emerge as each participant attempts to gain a sense of personal power."¹⁸⁷ Several authors and researchers have concluded that men typically have the upper hand in the bargaining process.¹⁸⁸ Often they are better educated.¹⁸⁹ This means they are better able to understand what goes on in mediation and to generate more alternatives during negotiation. Men may also be more comfortable in a bargaining context because of their work¹⁹⁰ and may be more willing to fight for what they want. Some have argued that men are also less concerned about maintaining personal relationships. Grillo cites several prominent researchers who suggest that, as a general rule, women have a more relational sense of self than do men, as a result they are more likely to be at a disadvantage in a mediated negotiation.¹⁹¹ Finally, men are more apt to use the discourse of law in bargaining than are women.¹⁹² This gives them the upper edge as the discourse of law typically trumps that of morality or therapy.¹⁹³

Delgado et al.¹⁹⁴ have alleged that informal methods of dispute resolution may foster racial and ethnic prejudice. The allegation is based on a number of sociological and psychological studies showing that people who hold prejudicial attitudes are more prone to act on those attitudes in informal rather than formal settings. Delgado and his co-authors suggest that "to protect minorities [alternate dispute resolution] should be reserved for disputes in which parties of comparable status and power confront each other."¹⁹⁵

Concerns based on power imbalances have led to regulation of the mediation process in some jurisdictions. For example, in Hawaii "mediators are directed by court standards to 'promote fairness' and encourage full disclosure of information between parties"¹⁹⁶ and in Iowa "Supreme Court Rules require

185 Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073, 1075 (1984).

186 Linda R. Singer, *Nonjudicial Dispute Resolution Mechanisms: The Effects on Justice for the Poor*, 13 CLEARINGHOUSE REV. 569, 577 (1979).

187 FOLBERG & TAYLOR, *supra* note 16, at 184.

188 See, e.g., Bryan, *supra* note 183; Grillo, *supra* note 138.

189 See Bryan, *supra* note 183, at 450-451, 454.

190 *Id.* at 452.

191 Grillo, *supra* note 138, at 1550.

192 Sally Engle Merry, *The Discourses of Mediation and the Power of Naming*, 2 YALE J.L. & HUMAN. 1, 9 (1990).

193 *Id.* at 5.

194 Richard Delgado et al., *Fairness & Formality: Minimizing the Risk of Prejudice in Alternate Dispute Resolution*, 1985 WIS. L. REV. 1359.

195 *Id.*

196 GOLDBERG ET AL., *supra* note 136, at 160, *citing* Hawaii Supreme Court Standards for Public and Private Mediators, 1986.

family mediators to assure a balanced dialogue."¹⁹⁷ In spite of these regulatory efforts, mediators continue to struggle with how best to rectify power imbalances.

3. Substantive Criticism

The most significant criticism of mediation cuts to its very core: the appropriateness of the absence of societally-imposed norms on some types of private decisions.¹⁹⁸ The fundamental question is "Does the state or society have an interest in these disputes that overrides that of the individual parties to that dispute?" Alternatively, we might ask, "Do we care whether the outcomes of mediated settlements are just?"¹⁹⁹ If the disputes are purely private, such as contract disputes and disagreements between spouses, as opposed to clearly public, where the state has traditionally played a role, e.g., criminal law, areas of governmental regulation, and constitutional law issues, we probably don't care a great deal about the outcome.²⁰⁰ However, in many cases it is not totally clear whether the issue is a purely private or public one. Judge Harry Edwards has argued that

[M]any disputes cannot be easily classified as solely *private* disputes that implicate no constitutional or public law. Many commentators have tried to distinguish 'public' and 'private' disputes, but, in my view, no one has been fully successful in this effort. The problem is that hidden in many seemingly private disputes are often difficult issues of public law.²⁰¹

The question has been debated at length in the context of custody disputes

197. *Id.*, citing Rules Governing Standards of Practice for Lawyer-Mediators in Family Disputes, 1986.

198. Brunet argues that "[a] process that ignores substantive legal rules could (1) frustrate the intent behind substantive legal norms; (2) injure third parties not present as dispute participants; (3) cause existing but ignored substantive norms to atrophy and become inefficacious; and (4) elevate procedural over substantive norms." Brunet, *supra* note 173, at 8. He further states that "[d]ispute processing systems that are predicated upon so-called 'creative' solutions send a false signal to the community that the outcomes dictated by substantive law are unworthy of enforcement...." *Id.* at 18. Furthermore, "[o]nce a citizen loses the predictability of a probably law-constrained court outcome, the benefit of 'law' as signal is lost." *Id.* at 19.

199. Bush points out that there are four fundamental public values at stake in dispute resolution. These include the protection of the civil rights of each of the parties; the pursuit of "substantive or social justice"; the promotion of efficiency, i.e., the greatest good for the greatest number, making the best use of our limited social resources; and the "establishment and articulation of public values that give us a sense of societal solidarity." Robert A. Baruch Bush, *Mediation and Adjudication, Dispute Resolution and Ideology: An Imaginary Conversation*, 3 J. CONTEMP. LEGAL ISSUES 1, 4 (1989-1990). He then asserts that mediation weakens and "undermines every single one of these values" because it fails to generate rules based on these values or any other values. Instead, mediation "rests solely on the expedient of compromise." *Id.* at 4-5. Yet Bush is an ardent advocate of mediation and counters those same deficiencies he so clearly articulates with the argument that mediation promotes an alternative set of public values. Values such as "reconciliation, social harmony, community, interconnection, relationship, and the like." *Id.* at 6. These values are based on a view of mediation as providing "a moral and political education for citizens, in responsibility for themselves and respect for others." *Id.* at 12.

200. See, e.g., Brunet, *supra* note 173, at 44 ("When a dispute involves no clear issue of public importance, leaving the choice of the type of decision maker to the parties should raise little objection.").

201. Harry T. Edwards, *Commentary: Alternative Dispute Resolution: Panacea or Anathema?*, 99 HARV. L. REV. 668, 671 (1986).

in divorce. Although the use of mediation to terminate marriage and allocate property between two adults has raised some concerns about the application of societal norms, most objections to the process have arisen when children are involved. In these cases, many have argued that the state under the doctrine of *parens patriae* has a role in assuring that the child's needs are adequately addressed.²⁰²

In an effort to address concerns about substantive fairness in mediation, some writers have argued for greater mediator accountability,²⁰³ and statutes and court rules in a number of states now require the mediator to play a more "active" substantive role than has traditionally been the case. For example, in California, mediators must ensure that mediated agreements in school disputes are "consistent with the law,"²⁰⁴ and in child custody cases, they must ensure that any agreement makes "[p]rovision for the best interest of the child...."²⁰⁵

The ABA Standards of Practice for Lawyer Mediators in Family Disputes attempt to deal with these concerns by allowing mediators to suspend or terminate mediation whenever continuation of the process would harm one or more of the participants. Also, although requiring mediators to be impartial, the standards state that "[t]he mediator has a duty to ensure that the participants consider fully the best interests of the children...", and that "[i]f the mediator believes that any proposed agreement of the parents does not protect the best interests of the children, the mediator has a duty to inform them of this belief and its basis."²⁰⁶

Although in conflict with the notions of mediator neutrality and the self determination of the parties, these statutory requirements and professional standards are an effort to address the public policy concerns about state interests. An alternative that has been used in a number of jurisdictions in child custody cases is to have mediated agreements reviewed by the courts. Although theoretically this type of review seems to make sense, in fact it is problematic. Not only is it difficult for judges to evaluate fairness after the fact when they have not heard all of the negotiations, in reality judges have not given the review priority.²⁰⁷

VI. APPLICATION OF MEDIATION TO LIFE AND DEATH DECISION-MAKING

A. Appeal of Mediation to Ethics Committees

In spite of the criticisms described, mediation may be appealing to ethics committees for a number of reasons. First of all, the "aura" and language of

202. See, e.g., Mnookin & Kornhauser, *supra* note 174, at 954-55.

203. See Maute, *supra* note 17.

204. CAL. EDUC. CODE § 56500.3(f) (West 1989 & Supp. 1994)); noted in GOLDBERG ET AL., *supra* note 136, at 176.

205. CAL. FAM. CODE § 3162(b)(1) (West 1994).

206. GOLDBERG ET AL., *supra* note 136, at 471.

207. The problem is that in most cases the agreements are simply "rubber stamped" by the reviewing judge. Mnookin & Kornhauser, *supra* note 174 at 956. This is so for several reasons: "The state usually has very limited resources for a thorough and independent investigation of the family's circumstances.... [S]econd, the applicable legal standards are extremely vague and give judges very little guidance as to what circumstances justify overriding a parental decision." *Id.* at 956.

mediation is likely to attract them to the process. Mediation is said to enhance the autonomy and self determination of the parties. These are buzz words for ethics committees and are the principles on which they rely. Yet, ethics committees must not get confused about whose autonomy and self determination they are trying to promote. While mediation is designed to promote the autonomy of the parties to the dispute, it is not clear that this is or should be the goal of ethics committees. Patient protection must be at the forefront of committee concerns. In a typical termination of life support case, the disputing parties do not include the patient because the patient is comatose or otherwise incapacitated. Enhancing the autonomy of the parties, the patient's family members and health care providers, may or may not promote the interests of the patient.

A second reason mediation may be appealing to ethics committees is the subtle shift it allows committees from their role as protector of patient interests to that of neutral arbiter of patient-health care provider disagreements. Although many ethics committees pay "lip service" to patient protection, many seem more comfortable taking a more objective stance in which they balance the interests of all the relevant parties.²⁰⁸ Mediation, which allows all parties to voice their concerns and calls for a neutral facilitator, fits this alternative role that many ethics committees see for themselves.

A third reason ethics committees might be attracted to mediation is its contextual nature. Ethics committee members seem to reject the rigidity of legal standards and rules and seem much more comfortable with the "softer" and more flexible principles of ethics. For example, where the law in some states regarding termination of life support might require clear and convincing evidence of the patient's wishes, members of an ethics committee may determine that something short of clear and convincing evidence is sufficient because they believe that family members with a long term intimate relationship with the patient know what the patient would have wanted. This view is likely to be consistent with that of parties in a mediation session. This element of mediation is also responsive to the criticism of traditional bioethics and its failure to focus on relationships and caring.

In a similar vein, a small but significant number of ethics committees appear to be uncomfortable attempting to arrive at a single best or right answer to a dilemma that comes to them. They are of the opinion that several outcomes may be ethically appropriate and within that range any decision reached by the patient or his surrogate would be acceptable. These committees, for the most part, have adopted what Ross has described as "a case conference model" to resolution of bioethics disputes and see mediation as a next step in that process.²⁰⁹

A fifth attraction that mediation may hold for members of ethics committees is its shifting of the discourse of disputes from that of law to that of therapy and morality. Most of the conflicts that come to mediation are multidimensional and include a legal or technical side as well as an emotional

208. West & Gibson report that in their survey of ethics committees, "[a]t least one committee reported that it had at one time considered itself solely to be a patient advocate, but that it had assumed a more neutral role after criticism from physicians." West & Gibson, *supra* note 10, at 68.

209. Ross, *supra* note 7, at 22-23.

element.²¹⁰ As a result, the discourse of mediation shifts from one realm to another. In a study of court referred community mediation, Merry found "three analytically distinct discourses [in mediation sessions]: that of morality, of legality, and of therapy."²¹¹ In terms of frequency of use, she determined that the dominant discourse in mediation is moral discourse.²¹² She found that mediators "typically encourage[d] the people in conflict to engage in a reconstruction of the conversation from a struggle over 'facts' and legal charges to debates over relationships, fairness, and therapeutic needs...parties [were] pressed to reformulate their problems in terms of morality and help rather than in terms of legal claims, evidence, or complaints."²¹³ Since ethics committees attempt to provide a moral or ethical resolution to an issue, a mechanism whereby a case can be resolved by such discourse would be held in high regard. Also, because many members of ethics committees are nurses and social workers, the discourse of therapy, rather than law, may be more comfortable for them. These ethics committee members may appreciate the "therapy session" feel of some mediation sessions.²¹⁴

Finally, some have espoused mediation as a method for ethics committees because of its attention to process. Although mediation has been criticized for its lack of due process when compared to the courts, mediation is light years ahead of ethics committees in terms of its attention to process and procedures generally. Mediators are trained to pay attention to procedural details that most ethics committees have not thought about. For example, the mediator should not keep people waiting a long time in the waiting room, but should meet the participants in the reception room and escort them to the mediation setting, and greet the participants by name.²¹⁵ The mediator may even think through the seating arrangements for the participants.²¹⁶ More importantly, the mediator has a well thought out introductory statement. The statement typically makes it clear that the mediator does not know either of the parties and knows very little about their dispute. The mediator stresses confidentiality and explains what mediation is and the process that he or she will use, i.e., the number of sessions, whether he or she will caucus with the parties individually, writing the agreement, etc. This type of well planned orchestration makes the participants

210. See FOLBERG & TAYLOR, *supra* note 16, at 140.

211. Merry, *supra* note 192, at 4. Merry describes moral discourse as one of "relationships, of obligations between neighbors, spouses, parents and children." *Id.* at 6. Therapeutic discourse is drawn from the helping professions and speaks of "behavior as environmentally caused rather than based on individual fault." *Id.* at 8. The discourse of law is described as one "of property, of rights, of the protection of one's self and one's goods, of entitlement, of facts and truth." *Id.* at 6. Merry points out that "[l]egal discourse in these terms does not necessarily refer to particular laws or legal doctrines, but may articulate general understandings of legal relations and procedures, notions of contract or property, and of decision-making based on rational discussion and the presentation of evidence in order to determine 'the truth.'" *Id.* at 7.

212. *Id.* at 8.

213. *Id.* at 5. Merry argues that this subtle pressure away from legal discourse, a more powerful discourse than either that of morality or therapy, is disempowering for those parties who initially sought court assistance. *Id.* at 13.

214. For a description of "therapeutic mediation" see FOLBERG AND TAYLOR, *supra* note 16, at 132-133.

215. *Id.* at 101.

216. See West & Gibson, *supra* note 10, at 64 (during the intake stage the mediator considers what "kind of room and arrangement of chairs will be most conducive to communication.").

aware that this is a serious undertaking and deserves their attention. This is in sharp contrast to the relatively ad hoc procedures used by most ethics committees. However, most committees are likely to be more comfortable with mediation procedures than those associated with a more formal adjudicatory approach.²¹⁷

In spite of these attractions, it seems that many life and death decisions may not be well suited to mediation, especially if we examine how well these disputes fit the "paradigm" case for mediation.

B. The Paradigm Case for Mediation

Based on the mediation process itself and the concerns and criticisms directed at it, there are certain characteristics of a dispute that more or less lend it to mediation as opposed to a norm-centered approach. Relevant characteristics that would make a case appropriate for mediation as opposed to the "traditional" approach of an ethics committee²¹⁸ would seem to include the following:

- 1) The parties are motivated to reach an agreement and engage in a bargaining process.
- 2) The parties are "competent" to negotiate.
- 3) The parties have "relatively" equal bargaining power, i.e., they have similar knowledge of the issues in dispute, have relatively equal resources and income at their disposal and have similar ability to express themselves in a semi-private forum. In addition, there is no history of abuse between the parties, either physical or emotional, so that one party is intimidated by the other.
- 4) The interests of all the relevant parties to the disputes will be represented by the participants in the mediation process.
- 5) Parties participating in the process all have a legitimate stake in the outcome.
- 6) The dispute is one which may be framed as having more than two mutually exclusive outcomes.
- 7) The parties to the dispute are likely to have an ongoing relationship.²¹⁹ Negotiation theory provides that parties that are "repeat players" in a negotiation process or that have an ongoing relationship will be more motivated to behave cooperatively and seek agreement than parties in a "one shot" deal. This is one of the common reasons why mediation has been pushed to such a great extent in family disputes.
- 8) The issues in the dispute are not purely of a legal (or ethical)

217. If asked, some ethics committee members may describe what they do as mediation, yet few, if any, follow the formalities of "traditional" mediation.

218. I refer here to the characteristics of a "healthy" "traditional" ethics committee. Such a process would include expertise on the part of committee members in terms of knowledge of the relevant norms, a willingness to apply the relevant norms, an open and thorough deliberative process (no domination by particular members or viewpoints), and a view that their role is, in large part, to look out for the interests of the patient.

219. See JOHN S. MURRAY ET AL., *PROCESS OF DISPUTE RESOLUTION: THE ROLE OF LAWYERS* 287 (Foundation Press 1989).

nature but are of a factual or emotional nature. Again, this has been an argument for the application of mediation in family disputes:

Family disputes are ... well suited to alternative [dispute resolution] forums because the conflicts often involve a complex interplay of emotional and legal complaints ... Thus, there may be a great need for an open-ended, unstructured process that permits the disputants to air their true sentiments.²²⁰

- 9) There is little or no state, societal or institutional interest in the outcome of the dispute — the ramifications of the agreement will be felt only by the disputing parties, there will be no significant externalities to the agreement.²²¹

C. Application of the Paradigm -- Do Termination of Life Support Cases Fit?

1. Parties' Willingness to Negotiate

One of the first determinants of whether a case is suited for mediation is a very pragmatic one — whether the parties are motivated to reach an agreement and participate in a bargaining process. In the case of disputes involving termination of life support, both health care providers and family members typically wish to avoid court proceedings. This may, in large part, be a factor in explaining why some of these cases come to ethics committees. The issue then becomes whether the parties would prefer a process in which they play an active role and attempt to arrive at their own solution in contrast to the fairly passive role they play in the traditional ethics committee process. To some extent this will depend on the individual party. Where physicians are involved I am skeptical about their willingness to engage in a protracted give and take dialogue with the patient's family primarily because of the time potentially involved in the process. Often, ethics committees speak with the physician briefly in person, but, in some cases, may resort to the telephone, to get his or her side of the story. Then the committee solicits the views of the other parties and arrives at a recommendation, all without involving the physician or involving the physician only minimally.

But the mediation process not only involves a commitment of time on the part of the parties, it involves a commitment of an emotional sort — a willingness to engage in what may be an emotionally heated debate. This may be uncomfortable for some physicians who wish to avoid conflict and prefer to have someone else arrive at a solution for them or be their intermediary.

A third “threatening” aspect of mediation for physicians may be its “equalizing effect” on the parties. Some mediators, for example, attempt to

220. GOLDBERG ET AL., *supra* note 143, at 313.

221. There are other factors that make mediation a viable alternative to a norm centered approach but these involve a comparison of mediation with the courts. For example, where there is no precedential value in the resolution of the dispute and where mediation would not deter “large scale changes in political and societal institutions that only court adjudication can accomplish” the process may be appropriate. *Id.* at 14.

have all parties referred to by their first names. This would mean Dr. Smith, might be referred to as simply "Bob" or "Jane", stripping the doctor of his or her title of expertise and authority.

Finally, I suspect that in many cases, physicians are actually looking for the imprimatur of an "officially constituted body" such as a court or ethics committee, to give them the "o.k." to proceed with their preferred course of treatment. They want to be sure that what they are doing is the right thing morally and legally and that society also supports their action. From this perspective, they may distrust the very underpinnings of mediation.

In contrast, family members may be more willing to engage in a mediation process and might prefer it to having an ethics committee tell them what the committee views as appropriate. Because family members care deeply about the outcome of the case, they may be willing to spend the time to hash out a resolution with a health care provider — the transaction costs for them are less than the emotional costs to them of a bad outcome for the patient. In fact, in many cases they may simply want more time talking directly with the physician to ask questions and "challenge" her assertions. Family members are also more likely to appreciate the equalizing aspects of mediation, as they have more to gain from its effects. Finally, because it is unlikely that they will be "sued" or prosecuted for their decision (except, perhaps in the case of termination of life support for an infant or child) they have less of a concern about the need for the sanction of some other group for their preferred course of action. They are also more likely to view this decision as extremely private and wish that as few "outsiders" as possible be involved in the case.

These comments are based on disputes between family members and health care providers. In disputes between family members themselves, whether or not those family members are willing to engage in face to face negotiation with other family members will depend on the history of the relationship between the family members and their comfort level in confronting one another.

In either type of dispute, family/family or family/health care provider, however, 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 may not be effective. Such individuals may view compromise as an admission of "normative weakness":

Because of the normative inferences which may be drawn from such admissions...some [parties] may choose to court total loss rather than expose themselves to suspicions of a guilty conscience. This attitude may imperceptibly blend with a more genuine moral stubbornness, an unwillingness to bargain about one's moral rights. It may be considered morally wrong, even, to yield without a command from the court.... [Furthermore, g]etting an unpredictable answer from the law may, to the legally naive individual, mean a verification or falsification of important assumptions about his moral worth and standing in the social realm. It may even take on religious overtones, law being in some measure perceived as a manifestation of divine justice. Thus a court proceeding may take on the character of a moral test case for the individual, which the settlement out of court could not have."²²²

The case of Baby Rena, described above, is illustrative of this type of case. This kind of an attitude might also mean that the parties will not be satisfied with the determination of an ethics committee. However, to the extent the committee is viewed as a source of moral authority, it may serve as an effective substitute for the courts.

2. *The Parties Are Competent to Negotiate*

In most cases, the patient him or herself will not be competent to engage in a mediation process or any other interactive process. My concern, however, actually goes to the competence of the patient's family members to negotiate.

The ideal parties to a negotiated agreement are individuals who are acting freely, not under duress, and able to understand the implications of their decision. This is supported in the law of contracts which provides that a contract cannot be enforced against an individual who is incompetent.²²³ Yet, the legal definition of incompetent is quite narrowly defined.²²⁴ Most family members participating in a mediation session over termination of life support would be likely to meet the legal standard for engaging in a contract yet greater safeguards may be necessary in mediation to ensure a fair process when the stakes are "life and death".²²⁵

In the context of divorce mediation, Mnookin has argued that at the time of divorce, individuals are under a great deal of stress which may render them temporarily "incompetent" to think clearly about the issues.²²⁶ It is likely that family members contemplating termination of life support for a loved one are experiencing intense grief over their impending loss. Parents, for example, with a child who was in a serious car accident or husbands or wives whose spouse was stricken suddenly with a heart attack may actually be overcome by their grief and temporarily dysfunctional. Some may be on sedatives or other drugs. In grieving, individuals typically go through a series of stages. Elisabeth Kubler Ross documented such stages for those experiencing a loss such as death as anger, denial, bargaining, withdrawal, and acceptance.²²⁷ Others have proposed a three stage process including shock/denial; anger/depression and

(1967). This factor would also explain why, for example, mediation would not be appropriate in a dispute over abortion between a "staunch" right to life advocate and an unwavering pro-choice proponent.

223. See E. Allan Farnsworth, *CONTRACTS* 214 (1982) ("One whose power is so impaired is said to lack capacity to contract and is subject to special rules that allow him to avoid the contract that he makes in order to protect him from his own improvident acts and from imposition by others.").

224. See Robert H. Mnookin, *Divorce Bargaining: The Limits of Private Ordering*, 18 J. OF LAW REFORM 1015, 1022, n.14 (1985), citing 2 S. WILLISTON, A TREATISE ON THE LAW OF CONTRACTS §256 (1959) ("Ordinary contract principles would require extreme impairment of cognitive capacity before allowing a defense of incompetence. Incompetence traditionally required a showing that a party has childlike abilities, or is mentally disabled in a severe way.").

225. Even more recent contract scholarship "suggests a theory that respects the ideal of individual autonomy and the efficiency of private ordering, and avoids the unfairness of bargains that exploit incapacity." Mnookin, *supra* note 224, at 1022.

226. *Id.* at 1019-24. A study by Campbell and Johnston of 80 divorcing families referred to mediation from family courts and unable to reach a negotiated settlement found that 64% had personality disorders, 27% had personality disorder traits, and 3% were psychotic. Linda E. G. Campbell & Janet R. Johnston, *Impasse-Directed Mediation with High Conflict Families in Custody Disputes*, 4 BEHAVIORAL SCIENCES & THE LAW 217, 224 (1986). The authors attribute these findings at least in part to "stress reactions to the divorce/dispute." *Id.*

227. ELISABETH KUBLER-ROSS, *ON DEATH AND DYING* (1969).

understanding/acceptance.²²⁸

Bryan has pointed out that

Depression has a devastating effect on negotiating ability.... Depressed people's self perceptions increase their reluctance to engage in negotiations. For example, negotiation requires skill, intelligence, common sense, and social sensitivity. Depressed individuals, however, see themselves as helpless in skilled situations, and expect themselves to perform poorly in situations requiring intelligence, common sense, and social adeptness.²²⁹

Folberg and Taylor argue that someone who is in the early stages of this progression will not be emotionally ready to negotiate a mediated settlement.²³⁰

Where the patient, however, has been ill for quite some time and the family has had an opportunity to adjust to the situation and the possibility of death, family members may be adequately prepared to deal with a negotiation process.²³¹

3. *The Parties Have Relatively Equal Bargaining Power*

In the case of disputes between family members and health care providers there is likely to be substantial differences in each party's access to resources. The health care provider not only will often have the resources of the institution behind him or her, but also will have access to technical expertise which is of significant import in this type of negotiation. As regards the institutional resources, the physician is able to tell the nurses how to function, to ask for additional medical consults, to order additional tests, etc. The family, in contrast, has much less "power" in the institution. Although the family may be able to "fire" the physician or move the patient to a different institution, exercising these options is often not a simple matter. And, even if another physician is found, it is still the physician who "controls" the care of the patient. The family cannot order a test, prescribe a drug, or require that a nurse do something different. This is all the domain of the physician.

The technical expertise necessary to bargain effectively in this context is also on the side of the physician. The ability to generate and evaluate options will be difficult for someone without some degree of medical training. The family has little ability, for example, to effectively challenge the physician's estimate of the patient's probability of survival. To negotiate effectively, family members may have to bring their own medical expert to the bargaining table, a potentially costly option.

But not only is the physician likely to have more technical expertise than the patient's family members, he or she is also likely to be better educated, or at least have more years of schooling. At the teaching hospital where I serve on an ethics committee, many of the patients are indigent, inner city residents of color, who have little if any post high school education. This may make it more

228. MELBA COLGROVE ET AL., *HOW TO SURVIVE THE LOSS OF A LOVE: 58 THINGS TO DO WHEN THERE IS NOTHING TO BE DONE* (1976).

229. Bryan, *supra* note 183, at 466-67.

230. FOLBERG & TAYLOR, *supra* note 16, at 97.

231. This is more likely to be the case, for example, when the patient has been in a nursing home for a significant period of time.

difficult for them to engage in a mediation process which requires the ability to articulate persuasive arguments to the other side.²³² The fact that these patients and their families are also of color and most physicians are white may raise concerns about the quality of informal justice articulated by Delgado et al.²³³

In addition to their expertise and educational advantages, physicians are revered in our society.²³⁴ They are treated with a great deal of respect and deference.²³⁵ Some individuals, often elderly patients, are reluctant to challenge a doctor's authority. The fact that most physicians are men may also play into this power imbalance, especially if the family member is a woman. In this type of dynamic, findings of those who have studied divorce mediation and the relative advantage of men in the bargaining process may be relevant.

As regards disputes between family members, much of the literature regarding family disputes may hold true here. Traditional patterns of dominance are likely to play themselves out in mediation just as they have in the real lives of the parties. For example, in *Mack v. Mack*,²³⁶ the dispute was between a young man's spouse and his father. The patient's wife had historically feared her father-in-law, who had in the past allegedly been abusive to his son.²³⁷ In fact, when Deanna Mack had an opportunity, shortly after the car accident which resulted in her husband's condition, to terminate his life support, she declined. Her reasoning was that her father-in-law had threatened that she would be in trouble if she did so. The case was not resolved in mediation and subsequently went to court.

4. *Interests of All Relevant Parties Are Represented*

Perhaps one of the most problematic aspects of the application of mediation to termination of life support cases is that there may be no one officially representing the interests of the patient. One possible scenario comes to mind. A patient's health care provider may argue that it is futile to keep an 80 year old woman in a persistent vegetative state maintained by artificial nutrition and hydration. She will not recover and she is utilizing valuable resources. The patient's spouse, might argue, based on his own religious beliefs, that she should be kept alive — that all life is worth maintaining no matter what its quality. In this debate, no one is looking at what the patient would have wanted. In the ethics committee context, it is typically the committee that takes on the role of looking out for the interests of the patient.

232. As pointed out by Singer, "Once inside a forum, individual parties, particularly low-income parties, may suffer significant disparities in knowledge of the subject matter in dispute and in their ability to argue persuasively to the other party...." Singer, *supra* note 186, at 576.

233. Delgado et al., *supra* note 194.

234. See Kellett, *supra* note 28, at 114-115, who states: "[p]atients, and the public in general, maintain an image of physicians that includes a 'myth of medical perfection.' [Also television programming presents an image of the selfless, warm, sensitive and perfect physician." (quoting Press, *The Presumption to File Claims: The Patient's Perspective*, 12 *Law, Med. & Health Care* 53, 55 (April 1984)).

235. Kellett asserts that "[t]he patient's lack of information, his dependence on and deification of the physician, combined with the physician's expert and professional status contribute to an imbalance of power." Kellett, *supra* note 28, at 114-115.

236. 618 A.2d 744 (Md. 1993). See *supra* note 69 and accompanying text for a discussion of the case.

237. See Brief for Cross-Petitioner, *supra* note 71 and accompanying text.

5. Parties to Process Have a Legitimate Stake in the Outcome

Mediation would seem to provide greater opportunity for parties with a stake or interest in the outcome to have a say in that outcome than they would have in an adjudicatory process. On the other hand, mediation may give parties with little stake in the outcome greater weight than a court or ethics committee thinks is appropriate. Some might argue that some parties to the dispute do not have a legitimate place in mediation or should not have equal bargaining power because their stake in the outcome is minimal. Unlike a court or an ethics committee that can give different weight to different testimony or different points of view, mediation gives all interested parties an opportunity to be heard and to negotiate and potentially veto an agreement. This can be troublesome for those who believe the decision should be made only by certain individuals.

The use of mediation in a dispute between a health care provider and family member may elevate the role of the health care provider in decision-making over what the law provides. In general, courts and statutes in most jurisdictions have made it clear that the patient or his surrogate (most often a family member) has ultimate decision-making authority in questions regarding termination of life support. Although this is what the law says, in practice, the physician holds all the cards, i.e., control over use of drugs, administration of CPR, ventilator, nutrition and hydration. Family members who want to take an action that the patient's doctor disagrees with may have to turn to the courts to force a physician to comply with their wishes. So, from a practical aspect, mediation may not give the physician more authority, but simply maintain the notion of shared decision-making which some physicians and ethicists have argued is appropriate.²³⁸ Among family members, mediation may elevate peripheral family (e.g., brothers-in-law) to the status of core family (spouses) or siblings who have had no contact with the patient with siblings that have been the patient's primary caretakers. Of course, the participants can argue about this among themselves but it is unlikely that a sibling, for example, who has not spent much time with the patient will relinquish decision-making authority to a sibling who has, at least on this issue.

6. The Dispute Is Amenable to Compromise

At first blush, many termination of life support cases would appear to be unsuitable for mediation by virtue of the fact that the object of the dispute — the life of the patient — is indivisible. Where there is only a single issue on the table and no real alternatives, there is a question of the suitability of mediation for the dispute.²³⁹ This argument has also been made in the context of divorce cases where there is only one child and the child is indivisible and in inheritance disputes over material objects, if these are considered to have emotional values which cannot be translated into money. As pointed out by Aubert,

Under such conditions the factual calculations of success chances are often intermingled with moral comparisons (e.g., concerning the relationships between the deceased and the various heirs), thus making bargains and compromise irrelevant. Such conflicts remain in the realm of dichotomous rights and duties, the proper sphere of legal [norm-

238. See, e.g., KATZ, *supra* note 29.

239. See Aubert, *supra* note 222, at 46.

dichotomous rights and duties, the proper sphere of legal [norm-centered] decisions.²⁴⁰

While this may be true in some cases, in fact, there are probably only a very small number of cases where alternative outcomes cannot be negotiated. Even in the case of a divorcing couple with a single child there are options such as joint custody and visitation rights. In termination of life support cases, although there is only one patient and he is either going to live or die as a result of the decision reached, often there are a number of different choices for treatment that are possible — not simply the two extreme positions of the parties.²⁴¹ For example, where artificial nutrition and hydration is at issue, the discussion might include evaluation of a variety of options, e.g., parenteral nutrition, gastric tube, naso-gastric tube, etc. Even disputes over whether the patient should be started on a ventilator can include compromises such as a two week trial period. Also, often a family who is unwilling to consent to removal of a patient from a ventilator or feeding tube might be willing to accept a “Do Not Resuscitate” (DNR) order. Thus, although the final dispute may not be resolved through mediation, parties may be able to come closer together by exploring a number of options.

7. Parties Have an Ongoing Relationship

Satisfaction of this criterion will depend on whether the dispute is between family members or between family members and health care providers. Typically family members will have an ongoing relationship, although not necessarily. Often disputes regarding termination of life support arise between family members who are estranged and never had much of a relationship to begin with. Coming together for a mediation session is unlikely to change that preexisting relationship. As regards disputes between health care providers and family members, these are likely to be singular interactions. In a few cases, a family member may have had a long term relationship with the physician, but in most cases, when these disputes arise in hospitals where specialists prevail, it is unlikely that the physician with whom there is a dispute is the long time family doctor.

Lack of an ongoing relationship does not necessarily mean that a dispute is inappropriate for mediation; it simply means that there may not be as great a motivation for reaching a compromise or a “civil” agreement or for being totally honest and open in the mediation process. Such disputes are also not amenable to one of the hypothesized advantages of mediation — that the parties become educated in how to better communicate with each other in the future. This alleged benefit will have no impact on disputes in which the parties are virtually strangers and are unlikely to have to interact again.²⁴²

8. Dispute Is Not Simply One of a Legal/Ethical Nature

The fact that disputes regarding termination of life support are not simply disputes over legal or ethical issues may be the strongest reason for the

240. *Id.*

241. See HANDBOOK, *supra* note 26, at 27.

242. On the other hand, it may be beneficial to physicians who are likely to encounter this type of dispute again in the future.

application of mediation to life and death decision-making.²⁴³ These disputes are highly emotional and mediation has the potential to address the emotional side of the issue. In mediation, individuals may be given an opportunity to vent their anger and express their grief. Such emotional expression would certainly not be encouraged in court and in most cases there is not an opportunity to vent emotions in a more traditional ethics committee process as parties typically do not meet face to face. Parties, in particular family members, involved in termination of life support disputes, are not only likely to be experiencing some grief but may also have a great deal of anger. This anger is often aimed at "the system" which is preventing them from doing what they think is right for the patient. Often the health care provider represents that system. In a recent ethics committee case in which I was involved, the young parents of a severely and terminally ill infant wanted the child to be taken off a ventilator because they believed the baby to be suffering. They did not understand why the baby's physician would not do as they asked. They were angry at the attending physician for not telling them how seriously ill the baby was and at the nurses for seeming to give them hope that the baby might improve. They felt as if no one was giving them straight answers or information about the condition of their child. They were permitted to vent their anger to the ethics committee, although not to the attending physician herself.

Some claim that in family disputes the failure of the court system to deal with the emotional feelings of the parties leads to the parties taking the law into their own hands. Some termination of life support cases seem to have this characteristic as well, as evidenced by the Linares case, in which a man came to Rush-Presbyterian-St. Luke's Medical Center in Chicago and removed his comatose infant son from a ventilator, "all the while holding off the medical staff with a .357 magnum until the child died."²⁴⁴

9. Neither the State, Society or the Institution Has an Interest in the Outcome of the Case

It appears that this is the basis on which termination of life support cases fall most short of the mediation paradigm. The state, society and health care providers have expressed strong interests in the way these cases are decided from several perspectives. First and foremost, society has expressed an interest in ensuring that an individual's wishes regarding life sustaining treatment for him or herself are followed. This concern has been expressed through courts and legislatures in virtually every state where laws permit (1) a competent individual to refuse life sustaining treatment or to prepare an advance directive,

243. In contrast, this may be a reason why mediation has not been very "successful" in the context of medical malpractice cases. Metzloff argues that mediation might make sense in medical malpractice cases if the litigants commonly had "litigation goals other than to obtain compensation for their injuries" such as obtaining an apology from the physician or hospital or preventing the physician from practicing. In his experience, such cases represent "the clear minority of malpractice disputes. For the large majority of claims, the parties desire a decision on the merits of the negligence claim." Metzloff, *supra* note 176, at 451, n.88. *But see* Meschievitz, *supra* note 11, at 200 ("Increasing evidence suggests that parties [to a malpractice suit] want something in addition to a monetary payment. Plaintiffs may want to know why something happened. They want to be heard and have an opportunity to express their anxieties over what has happened, and at times they want an apology. Occasionally, they just want to know it will never happen again.").

244. John J. Paris, *A Desperate Act, But Not Murder*, CHI. TRIB., May 15, 1989, §1 at C15.

i.e., living will or durable power of attorney for health care; and (2) family members to speak on behalf of an incompetent patient, expressing the patient's preferences on the initiation or continuation of medical treatment. These laws have as their foundation the common law principles of self-determination and informed consent,²⁴⁵ as well as a constitutional basis — each individual has a constitutional liberty interest in refusing unwanted medical intervention.²⁴⁶ Thus, to the extent that mediation results in a patient or family member *ceding* legal rights to a health care provider or institution, it leads to violation of state laws and policy as well as constitutional principles.

This ceding of rights seems most problematic in cases where there is a dispute between health care providers and patients or their surrogates. In those cases, mediation would give authority to health care providers to have input into a decision that the law might otherwise not grant them. The concern would be less in the case of disputing family members, unless a patient has selected one of those family members as his agent under a durable power of attorney for health care. In that case, mediation again would be granting authority for the making of decisions to those that, under the law, have no such right.

A second societal concern expressed by numerous state legislatures is the protection of vulnerable patients who have not expressed a preference regarding termination of life support from premature decisions to stop or withhold the administration of life support. This has been done through statutes that limit family decision making to cases where the patient is terminally ill²⁴⁷ and through court cases and statutes that require families and guardians to make a decision that is consistent with the patients' desires, or in the best interests of the patient. At the far end of the spectrum of these cases, there are also criminal law concerns. There has only been one reported criminal case brought against doctors for the withdrawal of life-sustaining treatment from a terminally ill or comatose patient.²⁴⁸ And that case was ultimately dismissed. Yet criminal charges have been brought against health care providers who have actively hastened a terminally or seriously ill relative's or patient's death.²⁴⁹

In addition to the state and society, health care institutions and health care providers have an interest in how these cases are resolved. In part this interest

245. See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972); *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960). See also *Schloendorff v. Society of the N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body...").

246. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

247. See, e.g., Judith Areen, *Advance Directives Under State Law and Judicial Decisions*, 19 LAW, MED. & HEALTH CARE 91, 98 (1991); CONN. GEN. STAT. §19a-571(a) (1993); FLA. STAT. ANN. §765.305 (West Supp. 1992); IOWA CODE ANN. §144A.7 (West Supp. 1992); LA. REV. STAT. ANN. §40:1299.58.5-6 (West 1992). These statutes appear to reflect the thinking of the New Jersey Supreme Court in the *Quinlan* case on this point. In that case the court stated that the state's interest in preservation of life wanes as the "degree of bodily invasion [associated with the proposed treatment] and the [patient's] prognosis dims." *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

248. *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983).

249. See Deborah A. Wainey, Note, *Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying*, 37 CLEV. ST. L. REV. 645 (1989). See also, Todd Woody, *Was His Act of Mercy Also Murder?*, N.Y. TIMES, November 7, 1988, at A12 (describing case of Dr. Robert Peter Rosier); Ludovic Kennedy, *This Shameful Verdict Advances the Cause of Death with Dignity*, SUNDAY TELEGRAPH, September 20, 1992, at 2 (describing the case of Dr. Nigel Cox).

is based on self protection — they are concerned about legal action against them for certain decisions they render. Health care institutions may also be concerned about the economic costs associated with certain courses of action. Finally, providers, as a group, are concerned that the norms of their profession are followed.²⁵⁰

As stated earlier, ethics committee members, for the most part, appear to apply a norm-centered approach to the cases that come to them. The application of norms by ethics committees serves a number of important functions. First, it provides guidance to health care providers involved in the case as to how similar cases should be decided in the future.²⁵¹ In this regard it is consistent with the educational goal of most ethics committees. Second, it provides some assurances to health care providers, the institution and the family, that the case is being resolved consistently with “community values.” As a result, it may actually prevent litigation.²⁵² Third, and perhaps most important, it is likely to be most consistent with outside or public expectations of the committee. It appears that ethics committees are consulted now, in large part, because they are perceived as sources of moral authority. I suspect that members of the health care community expect that ethics committee recommendations will at the very least “appear to be the product of contemplative, deliberative, cognitive processes”²⁵³ — treated specially, made rationally and chosen carefully and that the procedures used to arrive at a recommendation will be consistent with the import of the issue before the committee.

On the other hand, there are weaknesses associated with the norm centered approach. For example, it assumes that the application of the legal and ethical principles articulated by ethics committees will lead to a clear, singular and “right” answer. The assumption is especially suspect when the norms being applied are rather vague and subjective, or nonexistent.²⁵⁴ An example is the application of the best interest standard. In using the standard, different judges and ethics committees may reach different outcomes on the same set of facts. When the standard is applied, the values of the decision maker and the elements of the decision making process often shape the outcome.

The application by the courts of the best interest standard in child custody cases has led numerous authors to question the superiority of the court's

250. See Alexander M. Capron, *The Burden of Decision*, 20 HASTINGS CENTER REP. 36 (1990).

251. This purpose might be referred to as the “guidance function” of norms. Brunet cites numerous legal philosophers who stress the guidance function of law, e.g., Lon Fuller, Joseph Raz, and H.L.A. Hart. Brunet, *supra* note 173, at 16.

252. See *id.* at 23 (describing how legal norms result in “private ordering” to reduce the risks of litigation).

253. Judith Resnick uses this language when explaining the community's sense of outrage at a judge who flipped a coin to decide whether to incarcerate a convicted defendant for 20 or 30 days. Granted, mediation is not the same as a coin toss, but the example captures some of the concerns about using less formal procedures that do not reflect the application of norms. Judith Resnick, *Tiers*, 57 S. CAL. L. REV. 840, 841 (1984).

254. Brunet, who criticizes alternative dispute resolution, does so in large part on the grounds that it will subvert the “guiding function” of substantive law. But he cites Raz to make the point that to satisfy that purpose, laws must be “relatively simple,” “self-explanatory” and easily understood. Brunet, *supra* note 173, at 16. He states that “not all legal norms are predictable. Ambiguous norms fail to guide citizens and, accordingly, serve a limited legal function.” *Id.* at 19 n.92.

determination. For example, Mnookin and Kornhauser argue that "in child custody disputes, the actual determination of what is in fact in a child's best interest is ordinarily quite indeterminate. It requires predictions beyond the capacity of the behavioral sciences and involves imposition of values about which there is little consensus in our society."²⁵⁵ More fundamentally, they argue,

given the epistemological problems inherent in knowing what is best for a child, there is reason to doubt our capacity to know whether any given decision is a mistake. Therefore, the possibility that negotiated agreements may not be optimal for the child hardly can be a sufficient argument against a preference for private ordering.²⁵⁶

It seems that a similar statement might be made about the application of the "best interest" test in the context of termination of life support.

Given the controversy and indeterminacy of some of the norms developed in this area, the interests of the state and society in these cases is not always clear. Yet, this is in large part the rationale for the development of multidisciplinary, multiperspective ethics committees. The committees, it was envisioned, would represent the divergent views on these issues held by members of society.²⁵⁷ Ethics committees, at least theoretically, would apply the established ethical and legal norms for deciding these cases. Where the norms are not decisive, there would be disagreement among committee members over the application of the norms to the facts of a case but extremes in thought on the issue would likely be moderated by the give and take of the committee and the divergent views presented.²⁵⁸

In sum, it appears that from a societal perspective, there is a range of resolutions to some of these cases that may be appropriate. That is, it may be ethically permissible in some cases either to continue or to stop life support. However, there are certain limits to what is ethically permissible that we, as a society want to enforce. Certainly, where the norms are clear, i.e., competent patients have the right to reject life support, we want them enforced. And, even where the norms are less clear, we want a decision to reflect the boundaries of moral and legal acceptance. With a traditional ethics committee process there is a greater probability that these boundaries will be respected. In a traditional mediation process there is a legitimate concern that they may not be.

In a mediation process, disputants may reject established norms and develop their own. For example, they may decide what is most important is not the best interests of the patient, but the best interests of the patient's spouse or children. Alternatively, they may not develop any norms at all. Mnookin has identified two types of strategic behavior in divorce mediation: (1) norm-free, which is characterized by the exercise of power, "horse-trading, threat, and

255. Mnookin & Kornhauser, *supra* note 174, at 957.

256. *Id.* at 958.

257. Ross states that ethics committees were thought to be a good approach to dealing with ethical dilemmas in patient care as "they had the potential for providing public involvement" and "could be a symbolic reminder that treatment decisions need to be consistent with overall social values." See HANDBOOK, *supra* note 26, at 8.

258. Moreno makes clear that it is by consensus that ethics committees reach their recommendations, not some scientific process that leads to "the truth". Moreno, *supra* note 121, at 40.

bluff", and (2) "norm centered behavior" in which the "parties invoke rules, cite precedents, and engage in reasoned elaboration."²⁵⁹ Often the parties use both models.²⁶⁰ The use of norm-free bargaining in the context of life and death cases raises real cause for concern about the use of mediation in that context.

In deciding whether a case involving termination of life support is ultimately appropriate for mediation it seems that the most difficult question will be whether the outcomes desired by each of the parties fall within the boundaries of moral and legal acceptance. Again, because in a number of cases those boundaries are unclear, this will not be a simple determination. Certainly, cases raising constitutional questions or bumping up against criminal laws against mercy killing, assisted suicide and child neglect, are cause for concern as well as any cases where one party is advocating a course of action that is clearly at odds with what the patient has expressly stated be done. As regards whether some course of action is in the patient's best interests, it is difficult to articulate clear boundaries. Yet cases where the patient's prognosis with treatment is good, the probability of success is high, the treatment is not painful or otherwise burdensome, and one party is calling for nontreatment, should raise significant doubts about the application of mediation.

*D. Analysis of the Cases of Joseph R. and Michael M.*²⁶¹

Based on the criteria discussed above, it appears that the case of Joseph R. would be appropriate for mediation but that the case of Michael M. would not. The case of Joseph R. seems to have most of the attributes of the "paradigm" case for mediation. It is likely that the parties — Joseph's 49 year old son and 42 year old daughter — would be willing to mediate their disagreement and, in fact, may prefer it to the "intervention" of an ethics committee. As brother and sister they have an "ongoing" relationship and they probably see this as a private family matter and may be reluctant to disclose these private matters to the scrutiny of a committee of "strangers." Both parties also seem to be "competent" to negotiate. Although they are both dealing with the possible death of their father, the facts indicate that Joseph has been ill for a number of years — his illness was not sudden. Also, it does not appear that there is a significant power imbalance between the parties. Although the son is older, there is no indication of a history of dominance on his part and although the daughter may be somewhat more knowledgeable of the medical issues, given her nursing background, both parties appear to be well educated. There may be some underlying emotional issues influencing their positions, i.e., guilt on the part of the son for not being around more for his father during his illness, and resentment on the part of the daughter towards her brother, yet neither party appears to have any overriding conflict of interest that would prevent him or her from acting in the best interest of their father. Although it may seem fairly narrowly defined, the resolution of the case also does not necessarily rely on a choice between two mutually exclusive options — treatment with antibiotics or no treatment with antibiotics. The options can be expanded to include other types of treatment, e.g., CPR if the patient has a cardiac arrest, ventilatory

259. Mnookin & Kornhauser, *supra* note 174, at 973.

260. *Id.*

261. *See supra* Section II.A.

support if the pneumonia does not respond to the antibiotics, artificial nutrition and hydration, etc.

As mentioned, the Joseph R. case has a host of emotional issues that need to be addressed between the two parties. It is not a case that is purely ethical or legal. Finally, a norm centered approach to the case will not necessarily lead to a single, best outcome. Both results advocated by the parties, treatment and no treatment, are justifiable on ethical or legal grounds. Both ethical and legal norms would support the son and daughter as appropriate decision-makers in this case and there is evidence to support a conclusion that providing or withholding of the antibiotics is consistent with what the patient would have wanted or is in his best interests.

The application of mediation to the case of Michael M., however, is troubling. In this case, we get some hint that the physician may not be willing or interested in participating in a mediation process. The facts indicate that he is overextended and feels frustrated with the parents. Thus, he may not feel like committing the time necessary for a mediated process. The fact that he has probably not had much of a prior relationship with the parents and will only have a continuing relationship if the parents agree to the chemotherapy (and then only for 4-1/2 months) provides little incentive to mediate. Finally, even if he could personally be persuaded that chemotherapy is not in the child's best interests, he would undoubtedly want some assurance that this non-treatment was appropriate from the perspective of some authoritative body (an ethics committee or court). The case also is problematic in terms of the "competency" of the parties to negotiate. Particularly troubling is the fact that not only are these young parents having to deal with their child's cancer and HIV status, but also that they are having to deal with the mother's HIV status. Not knowing more about the emotional frame of mind of the parents and its impact on their ability to negotiate makes it difficult to determine definitively whether they would be able to participate effectively in a mediation process.

The power imbalance between the physician and the parents is also problematic. The fact that the parents are quite young and have not completed high school may make it difficult for them to argue persuasively with the physician. They may be intimidated by the superior knowledge and status of the physician in the hospital setting and may not feel qualified to challenge his assertions about their child's prognosis.²⁶²

Whether the interests of the child, Michael M., are being adequately represented is also open to question in this case. The parents appear to be concerned with the child's interests but may also have their own interests at stake. Having to care for the child throughout the painful chemotherapy and then, if he survives the cancer, with his AIDS, will be physically all consuming and emotionally devastating. On top of this, the parents may have to cope with the mother's illness. Yet, it is also arguable that the parents are in the best position to represent the child's interests and that their interests and that of

262. On the other hand, the parents have considerably more control of the case than family members often do in disputes with physicians. Often the patient is already receiving the treatment in dispute and the family members are powerless to stop it — they cannot unplug the ventilator. In this case, however, the treatment has not started and the physician needs the parent's consent to begin the chemotherapy. But, the physician is not without leverage. He can threaten to contact child protective services reporting the parents for medical neglect of the child.

Michael are inextricably interwoven. Neither is it clear that the physician is looking out for the "best interests" of the child. He may also have motivations that are based more on his own values than on the interests of his patient.

The case is not problematic from the perspective that there are no alternative solutions. Although at first it might appear that the issue is simply whether or not to start the child on chemotherapy, there may be other options, including a trial period of the therapy to determine how well the child tolerates it.

Finally, the case appears inappropriate for mediation because of the interests of the state, society and the institution in the outcome. Although a norm centered approach is not likely to lead to a clear outcome in this case — ethical and legal arguments can be put forward to support either approach — the question is "close enough" to the boundaries of "unacceptable" behavior that some type of higher scrutiny, such as that of an ethics committee, seems warranted. In this case, the possibility of allegations of child neglect on the part of the parents and related constitutional issues elevating the rights of the parents make the application of mediation to the dispute particularly troublesome.

E. Modification of the Traditional Mediation Model

Although there will be some cases, such as that of Joseph R., that have virtually all of the requisite characteristics for mediation and some that have almost none of them, such as that of Michael M., most cases will fall somewhere in the middle, having some of the paradigmatic characteristics but not all of them. These criteria do not allow us to predict conclusively in a given case whether or not mediation would be successful (i.e., would lead to a resolution of a case) — they only provide some guidance as to the potential effectiveness *and* relative appropriateness of mediation (as compared to a more traditional ethics committee process). The criteria are based on a relatively traditional model of mediation, i.e., a single, non-interventionist mediator without third party review. Modifications to the traditional mediation model that provide additional procedural and/or substantive safeguards, however, may make mediation more broadly applicable to cases involving termination of life support. These safeguards are most important when there are significant power imbalances between the parties, when no party is specifically representing the interests of the patient and when there are concerns that these cases may not otherwise be decided within the boundaries of moral and legal norms.

Several options present themselves as possibilities, although some may "violate" some of the principal tenets of mediation. One option would be to have a neutral party serve as mediator, but to have ethics committee members participate as experts with respect to the medical and ethical issues. The committee members could be of assistance either to the mediator, in framing the questions to ask to the parties and in arriving at alternative solutions to the dispute, or to the parties in clarifying medical facts or ethical norms. This is a technique that has been used successfully in some types of mediation (e.g., business disputes) and would be the least violative of the traditional mediation model.²⁶³

263. Linda R. Singer provides some examples of the use of neutral experts in other contexts: "In a controversy over construction ... the expert may be an engineer, an architect, a

A second option would be to have a neutral party serve as a mediator but to have the ethics committee review the agreement. This option has the potential to weed out "inappropriate" settlements but also has the weaknesses associated with judicial review of child custody cases — it is difficult to evaluate an agreement, without knowing the basis for the agreement, nor having been privy to the negotiation discussions.

A third possibility is to have a member of the ethics committee serve as the mediator and to take an active role in educating the parties as to the relevant ethical norms and to review the outcome to be sure that the result is consistent with relevant ethical principles. By having been present during the negotiations, the mediator will be better able to evaluate the "fairness" of the agreement, than would ethics committee members who did not observe the process. This heavy-handed mediator role, while most injurious to the traditional notion of mediator neutrality, would be most likely to ensure that the interests of the patient are respected. However, it might be difficult for ethics committee members to serve as a mediator if they have strong opinions about the appropriate outcome. To function effectively in this type of role, West and Gibson assert that the committee members should be without independent interests and views concerning the issues.²⁶⁴ Where the committee members are 'interested' participants, it may be difficult for those members to act as facilitators.²⁶⁵

A fourth possibility is to have a neutral party serve as mediator, but to have ethics committee members participate in the process as interested parties. This would mean that they would have to participate in the negotiations, state their views and to "sign on" to any agreement reached. This option would not violate mediator neutrality and, assuming ethics committee members serve this function, would provide a voice for the patient as well as for community interests. This model is also probably closest to the existing ethics committee model, yet is least violative of the tenets of mediation. From the perspective of ethics committee process, it requires ethics committee members to cede their ultimate recommendation-making authority but allows them significant input into the process and outcome. From the perspective of a mediated process, it requires the disputants to share some of their decision-making authority but gives them more decision-making authority than they would have under a traditional ethics committee model.

One or more of these alternatives may be appropriate depending on the specific facts of the case. Options three and four are most "interventionist" and would be most suited for those cases where there is a sense that mediation might be effective but that there is a need for significant safeguards. Options one and two are least intrusive to the traditional mediation model and would be appropriate when there is less of a need for protection of the interests of the parties or the patient.

As regards the case of Joseph R., option one seems most appropriate. In that case, ethics committee members with expertise in the relevant medical

carpenter, or a mason; in a dispute over school desegregation, the expert may be a statistician or an educator." LINDA R. SINGER, *SETTLING DISPUTES: CONFLICT RESOLUTION IN BUSINESS, FAMILIES, AND THE LEGAL SYSTEM* 25-26 (1990). The expert typically "provides parties with an impartial opinion of the facts or applicable standards." *Id.*

264. West & Gibson, *supra* note 10, at 69.

265. *Id.*

issues and ethical norms would probably be most helpful to Joseph's son and daughter as they attempt to reach an agreement on his treatment. The medical expert would be able to give them better information about Joseph's prognosis with and without the antibiotics. The committee member with expertise on ethical norms would be able to tell the parties the norms the ethics committee would consider in arriving at a recommendation, i.e., the patients' preferences, if they can be determined, and, if not, his best interests. This input would likely frame the party's discussions and focus their negotiations.

Where a case might be considered appropriate for mediation but there are concerns about its application, option four may be the most appropriate model. In setting up the mediation, the parties should include three or four members from the ethics committee —someone with expertise in the medical issues, another who is familiar with the relevant ethical norms, and one or two additional members who represent the range of views held by the committee on the case. If the committee is rather like-minded on the case, one member should be sufficient to represent that view, if there are extremes in views on the case, two members would participate who represent those extremes. By including this wide range of expertise and views a full airing of the issues is more likely to take place and an agreement, if one is reached, is likely to reflect relevant ethical norms. In a number of ways the process would mirror the process of consensus building that most ethics committees strive to achieve. The difference would be that the "disputing" parties would be participating as committee members.

VII. CONCLUSION

Discussions of mediation as an option for dealing with termination of life support cases is on the rise. Mediation has some advantages over court resolution for some of these cases. It also has some value for ethics committees that deal with these types of disputes, especially in terms of process. Yet, there are reasons to proceed with caution in applying mediation to these cases. For one thing, no parties to the mediation may see it as their role to represent the interests of the patient. For another, mediation, which is based on consensus, may avoid application of societal standards in reaching an agreement. Finally, using mediation to resolve an issue that comes to an ethics committee may not be consistent with, and may actually undermine, its perception within the health care community as a source of moral authority. For these reasons, the facts of each dispute must be closely analyzed to determine its appropriateness for mediation. Furthermore, if the dispute is found to be appropriate for mediation, a judgment must be made as to the need for modification of the traditional mediation model.

