BIOETHICS MEDIATION & THE END OF CLINICAL ETHICS AS WE KNOW IT

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I. INTRODUCTION

“Bioethics mediation” entered the collective clinical ethics vernacular through a widely read treatise of the same name by Nancy Dubler and Carol Liebman, now in its second edition. In Bioethics Mediation, Dubler and Liebman articulated a new vision for how clinical ethics consultations could be conducted that would offer stakeholders in a bedside conflict a way to craft a shared resolution to a seemingly intractable ethical impasse. They argued that a mediated resolution to a bioethics conflict, as in legal mediation, would avoid the pitfalls of the win-lose verdicts conventionally leveled by ethics committees or consultants in tough, recalcitrant cases.

While the field of clinical ethics was quick to acknowledge the value of mediation as one skill in a large arsenal of clinical ethics tools, bioethics mediation has not been widely adopted as the central method of clinical ethics consultation, a fact lamented by its supporters. Verdict-based consultation is still the predominant approach to bedside conflicts that are addressed by ethics consult services (ECS).

In this Article, I will not only argue that bioethics mediation is a superior approach for resolving ethics conflicts, but I will also defend the controversial position that it is the only ethically justifi-

able method for resolving values-based conflicts in a pluralistic society. Although it has so far been relegated to the status of mere handmaiden to conventional consultation, bioethics mediation—as its detractors have surmised—has the potential to end clinical ethics consultation as we know it.

II. WHAT DO CLINICAL ETHICS CONFLICTS LOOK LIKE?

Imagine the following case that effectively illustrates a classic bedside ethical conflict:

John Roberts is a 73-year-old man who presented to the hospital with respiratory distress. He required intubation and mechanical ventilation upon arrival. Subsequently, he underwent a battery of tests that diagnosed metastatic lung cancer. His hospitalization has been complicated by pneumothorax, venous thromboembolism, cardiac arrhythmias, anemia, pneumonia and severe malnutrition. He has undergone multiple procedures including a tracheostomy and feeding tube placement. One month into his course of treatment, he has persistent respiratory failure and remains ventilator dependent. Additionally, he has now developed acute renal failure which requires renal replacement therapy to sustain life. He is otherwise hemodynamically stable. Mr. Roberts has no advance directive or living will and has never communicated his explicit wishes to his family. His wife has medical power of attorney. During previous conversations, both his wife and daughter have verbalized a strong desire to continue aggressive therapy and indicated that their best understanding of the patient’s wishes would be to continue with aggressive therapy indefinitely. The medical team feels that hemodialysis will not alter the patient’s prognosis. He has metastatic cancer and is too unstable to safely receive even palliative chemotherapy. His life expectancy is weeks, and while withholding this life sustaining treatment could hasten his demise, it will not change the outcome of certain death as a direct result of complications from his lung cancer. Therefore, the medical team is refusing the dialysis.5

At issue here is a clash of values between the patient’s wife (who has legal decision-making power) and daughter, who both believe that Mr. Roberts deserves everything medically to be done to keep his body alive, and the MICU physicians and nurses, who believe that continuing aggressive care is not only a futile squandering of

5 I wish to thank Dr. Joshua Kayser for the construction of this fictional case.
scarce resources, but also a constant assault on a dying man. In contrast, Mr. Roberts’ wife and daughter see withdrawal of care (removing his breath, food, and water) as the assault, tantamount even to murder. To settle this dispute, imagine an ethics consultation is requested from the hospital’s ECS.

III. The Conventional Consult Model, Legitimacy, and the Problem of Win-Lose

Although clinical ethics consultants are loathe to admit that the end result of a case consultation is a “verdict,” because it sounds more authoritarian than they like to portray their work as being, that is de facto what ensues at the conclusion of most consults. In a case like Mr. Roberts’, the ECS would determine the best course of action, and they would make a recommendation to the treating MICU physician either to continue aggressive care or to refuse the family’s request for dialysis. The term used by ECSs to describe what they provide is a “recommendation,” because the decision of an ECS is not legally binding, but in practice, hospital administrators and personnel usually implement what the ECS suggests. After all, their advice was sought because those involved in the ethics conflict did not know how to proceed.

The majority of consults conclude with such a recommendation. In the most comprehensive study of ECSs to date, Fox et al found that 65% of ECSs always make a recommendation and the overwhelming majority (82% of ECS) makes a recommendation in at least 80% of their cases.\(^6\) A single best course of action—as opposed to a range of acceptable options—is recommended in almost half (46%) of the cases.\(^7\) The data from this study don’t provide the percentage of ECS recommendations that are rejected by their respective hospitals, though if such rejections were commonplace, this issue would likely have surfaced in the study as a data-point on the efficacy of ECS. If rejection of the recommendations of ECSs is not commonplace—and there is no data, formal or anecdotal, to suggest otherwise—then ECSs are self-deceived in defining their work as mere “suggestion” or “advice.” In practice on the ground, their work is more akin to “mandate” or “rendered judgment.”

There are two serious problems with ECSs’ rendering of judgments about clinical ethics conflicts: first, they lack any legitimate

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\(^6\) Fox et al, supra note 4, at 18, Table 4.

\(^7\) Id. at 18.
right to this kind of power; and, second, this approach creates clear “winners” and “losers” in an arena where non-polarizing resolutions are eminently achievable.

The first problem is the absence of a robust justification for ECSs to have the authority to determine the course of action in an ethics conflict that will have a dramatic impact on strangers with possibly very different values and priorities from their own. Clinical ethics conflicts routinely involve genuine ethical ambiguity in which there is more than one applicable moral principle, the relevant moral principles often conflict, and more than one ethically justified option exists as a legitimate outcome of the conflict. Such ethics disputes involve a clash between incommensurate moral considerations, values, or principles. The philosophical term for this state of moral ambiguity is *aporia*, a term employed by Ancient Greek philosophers meaning a “state of perplexity.” In *aporia*, there is no consensus among all of the parties involved about the morally appropriate course of action, and various stakeholders utilize the principles that support their own preferred outcomes. When an external body like an ECS makes a recommendation in a situation of *aporia*, it intentionally or unwittingly privileges one set of values over another: it takes a side.8 But “taking sides” in a normative dispute in which multiple principles are in play is no more legitimate than rolling the dice with someone’s else life, priorities, deeply held values, or religious convictions.

If there are valid moral principles on both sides of an issue, then making a recommendation amounts to a judgment of a set of self-appointed decision-makers (most ECSs are comprised of volunteers) who have weighed the arguments by their own lights and decided which are most compelling. But what would give us confidence that this judgment is the ethically correct one? To be the arbiter between these competing principles, the ECS must have ethical knowledge and expertise superior to any of the actual stakeholders in the dispute. What would lead us to believe that an ECS possesses a comparable level of moral expertise? It certainly is not its members’ training. The same national survey cited above found, for example, that only one consultant in twenty had any formal ethics training and only 50% had any apprentice-based training.9 In *aporetic* cases, it is unclear what level of training would be adequate to adjudicate between valid moral considerations, but

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8 Fiester 2011, supra note 3, at 363–72.
9 Fox et al, supra note 4, at 13–25.
these levels are surely insufficient. Once the moral expertise to make such choices is in question, there can be little basis for moral confidence about the verdicts or judgments made in those ethics consultations.

The fact that nearly half of all ECSs choose voting as the process used to determine the ethically correct course of action intensifies the concern about the moral legitimacy of the ECSs’ decisions. Fox et al. found that it is not at all unusual for ECSs to vote on these momentous decisions: 49% of ECSs vote in at least some cases, with 20% of ECSs voting “at least half of the time.”\textsuperscript{10} If a case requires voting as a procedure to reach a decision, then there must be considerable disagreement, dissent, and uncertainty within the ECS surrounding the case. The need to vote signposts the core ethical uncertainty at issue in \textit{aporia}: in these cases, the ECS does not have consensus even among its own members—otherwise, they would not need to vote. The internal conflict indicates the absence of the kind of ethical confidence that might warrant the issuing of a recommendation, especially one with the weight of a mandate. If a vote needs to be taken in the context of an ethical dilemma, the recommendation is not justified. It is tantamount to an ethical “best guess,” which provides an insufficient underpinning to dictate the course of action for a patient or the patient’s family.

The preceding argument naturally raises the following objection: we allow judges to vote on weighty legal matters and we consider their verdicts legitimate, so why is voting on moral matters not equally legitimate? There are two responses to this important objection. First, unlike ethical disputes, legal disputes have at their foundation a set of laws or legal rulings, and although interpretations of those laws can differ, the fact of those laws’ existence is not in dispute. In ethical dilemmas, we do not have a bedrock of agreed-upon and codified rules that anchor our deliberations, so the debates are much more nebulous and amorphous. But, second, as a society, we imbue judges with this type of authority because of our conviction that they have a superior command of the pertinent laws. There is a vetting process for judges that grants them the authority to make judgment calls on controversial and ambiguous cases. There is no vetting process for ECS “judges.” As indicated before, most hospitals have a completely volunteer-comprised, unpaid ethics committee populated by hospital staff who are well-meaning but lacking in formal training in ethics.

\textsuperscript{10} Id.
The American Society for Bioethics and Humanities, a national bioethics organization, is equally wary of ethics consultants *qua* judges. In their *Core Competencies for Healthcare Ethics Consultation*, they warn ECSs that they must not “impose their values”¹¹ in an “authoritarian model” of ethics consultation.¹² In fact, mirroring the above argument, they warn that ECSs shouldn’t produce “a single ‘correct’ solution” but a “range of ethically acceptable options.”¹³ Despite these directives from the professional organization, however, clinical ethics consultation in the US still follows the single-recommendation/verdict-based model.

A second serious problem with ECSs rendering judgments—beyond the *legitimacy* of their rendering verdicts—is that the conventional approach to ethics consults creates clear “winners” and “losers,” with devastating effects on the stakeholders with the losing hand. In ECSs that deem one option as being preferable to other defensible positions, the stakeholders advocating for or preferring the alternatives are significantly disadvantaged in the consult and may experience potent after-effects and stressors.¹⁴ In a piece about ethics conflicts at the end of life, legal scholar and physician M. Gregg Bloche argued, “Answers dictated . . . yield clear winners and losers, heightening long-term resentments and inviting further strife.”¹⁵

Conventional ethics consultation is flawed in both concept and potentially negative consequences.

**IV. Mediation and the Prospect of Win-Win**

In contrast to conventional consultation, bioethics mediation provides the best prospects for achieving the proverbial “win-win” for conflicting parties in a bedside conflict. Bioethics mediation avoids privileging one stakeholder over another, or prioritizing one principle over others. The goal of the bioethics mediator is to craft a shared solution between parties. Again Bloche: “A large literature suggests that solutions crafted by the parties to a conflict come

¹² *Id.*
with a sense of shared ownership that dampens discord.” Mediation builds a consensus about outcome even if there is no consensus about the values or beliefs surrounding the case. It refuses to take a stand on which moral principles or claims ought to trump other valid principles; therefore, its ethical reach does not exceed its grasp. The effect is a leveling of the moral “playing field” in an arena with clear power and status differentials.

To achieve a shared resolution that meets the needs of all stakeholders, the mediator engages in what I call “moral archeology” and then takes the stance of universal, “ecumenical advocacy.” The former process is a mediator-led diagnostic of the values, issues, concerns, interests, and needs at play in the conflict. In this first moment, the mediator is like a midwife, assisting the parties in articulating what matters to them and why, so that they can use that information to generate solutions that will work for them. Richard Zaner, criticizing conventional consultants for misconstruing their proper role, argues, “[T]he consultant’s job is to help individuals whose situation it is think through their circumstances as thoroughly as possible, then help them understand what must be decided and what aftermaths can be expected.” The bioethics mediator performs a “moral archaeology” on the conflict: a systematic uncovering of the moral values, interests, principles, and laws pertinent to the ethics dispute.

As the process of moral diagnosis unfolds, the bioethics mediator assumes the position of “ecumenical advocate,” a position of investment in the dialogue that seeks to ensure that each and every voice is adequately heard and protected. Unlike patient-advocacy, which singularly promotes the interests of the patient (prioritizing the patient’s voice over others’ in an attempt to bolster it), ecumenical advocacy makes no a priori assumptions about the weakest or most vulnerable stakeholder in a conversation. Whenever individuals need help protecting their interests and/or values, the mediator needs to support those individuals’ voices. It is the moral obligation of a facilitator in a conversation to safeguard the vulnerable, but there are others besides patients who can be vulnerable. Thus, the patient should not be the presumptive ward of

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16 Id.
17 Fiester 2013, supra note 14.
18 Id.
20 Fiester 2013, supra note 14.
21 Fiester 2012, supra note 3.
the consultant because power differentials rear their heads in a multitude of unpredictable ways, and, in some circumstances, the patient has full voice and most of the control. The mediator must be vigilant about any and all moments of marginalization and voicelessness in the conversation—not only those involving patients—and the mediator then takes steps to redress them. If one party has no conversational space in the dialogue, the mediation and the mediator have failed. Mediation, then, is a kind of constant and revolving advocacy, protecting any and all parties struggling to have their positions articulated and clearly heard.

That ecumenical advocacy applies not only to the parties in the conflict, but also to the positions they take in the conversation. Although always bound by the constraints of the law and well-worn ethical norms, bioethics mediators refrain from recommending any course of action over other feasible, defensible courses. To “recommend,” after all, is to “endorse,” “push towards,” or “commend.” But on what grounds would a mediator make a “recommendation” that does not, at the very same time, “impose values” on the participants? Ecumenical advocacy is the flip-side of mediator-neutrality. To defend every acceptable option that surfaces in the conversation is to be neutral about which option the group should choose as best for them. Bioethics mediation employs a neutrality with regard to outcome, while being quite partisan about process. While highly invested in how the process is conducted, they are disinterested in what resolution the parties agree to—again, within the constraints of law and established societal norms. In fact, being agnostic on outcome is one of the reasons why mediators are less likely to be co-opted into being the handmaiden of their institution’s own specific interests, financial or otherwise.

V. FAILURE TO ACHIEVE THE WIN-WIN: THE POPE AND WALDMAN OBJECTION

In an important critique of bioethics mediation, Pope and Waldman despair that mediation—at least in end-of-life disputes—will fail to bring about any resolution at all, let alone one that is

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22 NANCY NEVOLLOFF DUBLER & CAROL LIEMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS (2004).
23 Fiester 2013, supra note 14.
“win-win.”24 Their concern is that the deck is so significantly stacked in favor of surrogate decision-makers, who want “everything done,” and against providers, who often define aggressive care as “futile,” that the typical outcome of an ethics consult, even a mediated one, is that the surrogates get what they want against the clinical team’s strong views that care should be withheld or withdrawn. They reason that if a clinical ethics dispute always ends up going one way—if one class of disputants is always the victor—then mediation merely mirrors the same “win-lose” as conventional consultation, with surrogates consistently in the “win” column and medical providers in the “lose.”

The first problem with this objection is that there is so little bioethics mediation being tried in American hospitals that any claim of defeat is wildly premature. The to-date failure of bioethics mediation is that it is not even being attempted—not that its attempts have not succeeded in bringing about satisfactory shared resolutions. It is simply a false premise that mediation always results in continued care or a stalemate. There simply is not enough data to prove or disprove this gloomy claim since so few ECSs actually employ mediation rather than a traditional consult model.

But while the jury is necessarily still out about whether mediation can ultimately achieve better outcomes in end-of-life conflicts than conventional consultations, as Bloche hopes it can,25 the assessment of mediation merely on the one-dimensional axis of continuing care/withdrawing care is too narrow. Mediation is not only the commitment to the open ending, but also a profound optimism about the prospects for an ending with a sense of closure for all parties,26 a “comforting or satisfying sense of finality.”27 To judge a mediated outcome merely by whether it conforms to the typical pattern of certain types of conflicts’ resolution is to miss the tectonic shifts that may have occurred in the mediation on other critical dimensions, such as: mutual respect and understanding, resolution of feelings of resentment and frustration, a renewed or newly established willingness to work together moving forward, etc. Referring to intractable end-of-life conflicts that default to the status quo, Pope and Waldman conclude: “Mediation fails in these

24 Thaddeus Mason Pope & Ellen A. Waldman, Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure, 23 OHIO ST. J. ON DISP. RESOL. 143 (2007).
25 See Bloche, supra note 15.
26 See Fiester 2013, supra note 14.
cases. There is no agreement, only capitulation under coercion.”28 To reduce bioethics mediation to the achievement of an agreed-upon settlement is to be blinded to the myriad ways bioethics mediation is distinct from legal mediation. Legal mediation strives to secure an agreement regardless of whether the parties experience any semblance of good will, catharsis, redemption, or transformation with regard to the others in the conflict. Bioethics mediation seeks to right important relationships—especially between surrogates and the clinical team—that have been derailed by the ethics dispute. The surrogate-provider relationship can be repaired even if the clinicians and the surrogates end up disagreeing about the proper course of treatment or clinical path. To achieve repair even without agreement is still an important type of success. Looked at in a certain light, it may even be a loftier kind of success.

Concretely, Pope and Waldman propose creating what they call a “safe harbor to unilaterally refuse requests for inappropriate treatment.”29 They propose a pure procedural standard for determining appropriate cases of withdrawal and withholding therapy, like the Texas Advance Directive Act (TADA).30 If a provider refuses to grant a family/patient request, then a process is initiated to have a third-party make that decision.31 The idea is that against the backdrop of a fortified clinical authority, mediation can exist on a level playing field, whereas in the current state of affairs, the providers are always one-down. But “unilateral refusal” is the very antithesis of a playing field in which mediation can effectively operate. If providers can merely override patients and their families, mediation is pointless: it is tantamount to mandating a conclusion before the discussion even begins. “Unilateral refusal” undermines ecumenical advocacy because it forces the mediator’s hand to direct the parties to one solution over all others.

In their argument “for empowering providers to refuse inappropriate treatment requests,”32 Pope and Waldman give five supporting reasons: “(1) to protect the integrity of the medical profession, (2) to reduce patient suffering, (3) to avoid instilling false hope, (4) to rationalize the use of scarce resources, and (5) to relieve surrogates of the burden of decision.”33 But while all five

28 Pope & Waldman, supra note 24, at 161.
29 Id. at 143.
31 Pope & Waldman, supra note 24, at 192.
32 Id. at 187.
33 Id.
of these are lofty goals, they do not necessitate the heavy hand of unilateral clinician decision-making. All of this can be accomplished by mediation. Taking their points one by one: (1) Mediation helps articulate why physicians feel their integrity is compromised by aggressive care/interventions in patients they deem futile and enables patients/families to see clinicians as humane and moral. (2) Patient suffering is a lightning-rod issue, a weapon that is often wielded to get families to do what clinicians want. There is no proof that unilateral refusal will accomplish a reduction in patient suffering because most patients at issue in unilateral refusal are highly sedated to mitigate their conscious suffering. We may actually be projecting “suffering” on the unconscious without any data to back up that claim. (3) Mediation is the process in which the true clinical picture can fully be grasped—it is not a venue that engenders false hope. Bioethics mediators spend an inordinate amount of time dissecting the clinical circumstance so that everyone is in possession of what the clinicians deem the medical “facts.” (4) The United States has come to no consensus about the proper use of scarce resources, as the Schiavo debacle strikingly demonstrated. Rationing care on a case-by-case basis is neither morally justified nor legitimate. And, finally, (5) mediation sleuths out whether surrogates want to be relieved of this burden—it does not wrestle the decision out of their hands.

Additionally, while Pope and Waldman are hopeful that there would be happy consequences of “unilateral refusal,” they fail to recognize the potential serious harms that could also ensue—harms that are the very contrast to what bioethics mediation aspires to accomplish. The laundry list of potential harms includes: creating an inherent win-lose situation, with surrogates feeling violated and robbed of the best clinical care for their loved one; turning healthcare decision-making into literal “verdicts” on treatment, rather than collaborations; engendering lingering distrust of medical institutions and physicians; disadvantaging marginalized populations who lack the resources to fight individual institutional processes; maligning the particular hospital in private or even in very public ways; creating guilt in the surrogates for not having been able to achieve what they consider the best care for a loved one; and allowing for feelings of assault by the actions of the providers that removed breath, food, or hydration from a loved one.

The solution of “unilateral refusal” that Pope and Waldman offer is understandably motivated by the recalcitrant problem that we, as a society, have not come to a consensus about the line between sustaining viable life and prolonging an inevitable death. They reason: “Consensus on precise substantive measures of medical inappropriateness has proven unachievable.” They continue:

There exists no general understanding about what sort of life, what sort of existence is worth the deployment of medical resources. We are fundamentally at odds on the question of who gets to decide when enough is enough. Because we are flummoxed by these questions, as a society we are unable to come up with a “real” definition of “futile care.” We are not yet prepared to specify the proper ends of medicine, the acceptable criteria for rationing, or the legitimate restrictions on patient autonomy.

But if that is an accurate portrayal of the American conundrum about these matters—and I think it is—how is a procedural solution not merely going to replace all of the decision-making authority that surrogates now have with unilateral decision-making authority for providers? The judges in these procedurally determined cases like in TADA—e.g., the ethics committee, the providers—are almost universally individuals who are pro-withdrawal. Haven’t we simply exchanged one hegemony for another in this swap? Isn’t it usually healthcare providers and ECS insiders who believe in “futility” as a criterion for withholding/withdrawing life-sustaining therapy? While one might bristle at surrogates’ current holding of all the cards, we are not better off when some other class of actors gains similarly lop-sided power. In both cases, the victor’s values are not the ones proven to be superior, but are merely the ones that happen to momentarily rule the day. This proposal turns bioethics mediation back into conventional clinical ethics consultation precisely in cases that are aporetic—that is, that have no clear “right” answer. Procedural solutions unjustifiably take sides.

Mediation can do better. The failure of bioethics mediation is not that it does not work, but that it has not convinced enough party stalwarts that it should be tried. There are few ethics consultation services that have even attempted a true bioethics mediation model, and the question is, “Why?” My own theory is that the

35 Pope & Waldman, supra note 24, at 192.
36 Id. at 192–3.
37 Bergman, supra note 3.
allure of power in rendering judgments on or recommendations for other people’s lives is too seductive to resist. Furthermore, relinquishing such a power, once one has it, to decide right and wrong is a near impossible feat of self-control and sacrifice. But it is far too early to throw in the towel. While verdict-based consultation is still the predominant method of ECS, there are actually very few consultations being done—and the number does not appear to be climbing. ECSs are a hugely under-utilized service, even in the largest US hospitals. The median number of consults per year is only three, and 90% of all hospitals perform fewer than twenty-five, which is a measly two consults per month.38 The largest hospitals (those with over 500 beds) are only conducting a median of 15 consults a year.39 To put this into perspective, a 500-bed hospital has about 20,000 patient admissions annually.40 If the median number of consults for this size hospital is fifteen, then only 0.075% of patients are involved in clinical ethics consults—not even one-tenth of 1%. That is a drop in the bucket of the number of ethical dilemmas and conflicts that occur each year in an in-patient setting—ask any clinician. So, although bioethics mediation may not be able to claim many successes because it is rarely tried, conventional consultation cannot claim many successes because it has been tried. Conventional ECS has not managed to garner enough institution-wide credibility to be widely employed.

There are powerful reasons for viewing bioethics mediation as a superior approach for resolving bedside ethics conflicts in a pluralistic society. If bioethics mediation does succeed in being widely implemented, it has the potential to end clinical ethics consultation as we know it.

38 Fox et al., supra note 4, at 16.
39 Id.