


1-1-2014

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Recommended Citation

Charity Scott, Ethics Consultations and Conflict Engagement in Health Care, 15 Cardozo J. Conflict Resol. 363 (2014).

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ARTICLES

ETHICS CONSULTATIONS AND CONFLICT ENGAGEMENT IN HEALTH CARE

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This article explores the intersection of two professional fields—bioethics and clinical ethics consultation in health care on one hand, and alternative dispute resolution (“ADR”) and conflict management on the other—which until recent years remained relatively unknown to each other. It marries the literatures and lessons of these two fields in order to promote the quality of ethics consultations in hospitals and other health care organizations.

Increasingly, health care ethics committees and consultants acknowledge the need to employ the frameworks, approaches, and tools of good conflict management to do their work effectively. Similarly, conflict specialists and ADR professionals are becoming increasingly interested in adapting their skills and expertise to health care organizations, yet they may be largely unfamiliar with the unique cultures and operations of these organizations that impact the nature of the conflicts that arise and the practicalities of their management. This article is intended to provide the common ground for professional understanding across these two fields and a framework for adapting the core principles and insights of the conflict-management field to the particular context of health care ethics consultation. The ultimate goal of improving ethics committees’ and consultants’ abilities to engage effectively with the conflicts that are referred to them is to improve the quality of patient care.

I. BACKGROUND

Most hospitals today—as well as many other institutional health care providers—have an ethics committee, a team of ethics

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consultants, or an individual consultant who engages in clinical case consultations involving ethical questions or other value-laden conflicts over patient care. Health care ethics committees and consultants may undertake a wide variety of activities, including education and policy-making, as well as consultation on individual patient cases. This article focuses on ethics consultations in individual patient cases, which may be requested when a concern or conflict has arisen over the appropriate course of health care for a patient or over which treatments may be in a patient's best interests.

Health care ethics committees became increasingly prevalent in hospitals and other institutional health care providers after a 1976 New Jersey court case involving Karen Ann Quinlan.¹ Quinlan was a young woman in a persistent vegetative state whose father requested removal of a respirator that was assisting her breathing in the belief that his daughter would not have wanted to be kept alive by that technology if there were no hope of her recovery to a cognitive state. A devout Catholic, the father had first sought to confirm the moral rightness of his request by consulting Catholic clergy. At trial, his request was also supported by a formal statement of the Roman Catholic Church, which did not require the continuation of his daughter's unconscious life by this extraordinary means. Her treating physicians, however, declined to withdraw the respirator because it conflicted with their professional judgment under then-prevailing medical standards, practice, and ethics. Quoting a 1975 law review article, the judges in the case endorsed the concept of a hospital-based ethics committee to share responsibility for this kind of challenging decision-making involving ethical issues and conflicts about the appropriate course of patient care:

Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, . . . which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally . . . their official status is more that of an advisory body than of an enforcing body.²

Since the *Quinlan* decision, ethics committees and other institutional processes for the review of ethical dilemmas and conflicts over patient care have been widely endorsed by professional socie-

¹ In the Matter of Karen Quinlan, 355 A.2d 647 (N.J. 1976).

² *Id.* at 668.

ties and organizations. The Joint Commission requires its accredited hospitals to have “a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.”³ The American Medical Association in its Code of Medical Ethics provides that “[a]ll hospitals and other health care institutions should provide access to ethics consultation services,” which may be undertaken through an ethics committee, a subset of the committee, consultation teams, or individual consultants.⁴

Ethics consultation services have grown over the years. A 2007 study found that 95% of hospitals had or were forming ethics committees,⁵ a dramatic increase from an estimated 1% in 1983.⁶ As ethics committees and consultants have increased in numbers over the decades, so too have their roles and activities multiplied, from classical ethical analysis to a broad range of activities aimed at addressing or resolving uncertainty or conflicts over patient care that may arise from differences in values broadly construed, including personal, professional, ethical, legal, spiritual, community, and cultural values.

The American Society for Bioethics and Humanities, in its recently released second edition of *Core Competencies for Healthcare Ethics Consultation* (hereinafter *ASBH Core Competencies*), has offered a broad definition of health care ethics consultation as “a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care.”⁷ Similarly reflecting the role of ethics consultation in ad-

³ The Joint Commission, *Hospital Accreditation Standards* (2012), LD.04.02.03, Element of Performance 1.

⁴ AMA CODE OF MEDICAL ETHICS, Opinion 9.115 - Ethics Consultations, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9115.page>.

⁵ Ellen Fox, Sarah Myers & Robert A. Pearlman, *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J. BIOETHICS, 13, 15 (2007).

⁶ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, DC: U.S. Government Printing Office, 1983), Appendix F, at p. 446, available at http://bioethics.georgetown.edu/pcber/reports/past_commissions/deciding_to_forego_tx.pdf.

⁷ AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES, CORE COMPETENCIES FOR HEALTHCARE ETHICS CONSULTATION 2 (2d ed. 2011) [hereinafter *ASBH CORE COMPETENCIES*]. For an updated review of this publication, see generally Anita J. Tarzian, *Health Care Ethics Consultation: An Update – Core Competencies and Emerging Standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force*, 13 AM. J. BIOETHICS 3 (2013).

addressing value-laden conflicts, the American College of Healthcare Executives, in its Code of Ethics, provides that health care executives should "[w]ork to ensure that there is a process in place to facilitate the resolution of conflicts that may arise when values of patients and their families differ from those of employees and physicians."⁸ As we will see, this broad role requires ethics committees and ethics consultants (collectively referred to hereafter as "ECs") to have skills not only in ethical analysis but also in communication, interpersonal relationships, and conflict management.

II. THE COMPOSITION AND ETHICS WORK OF ECs

Who are members of ethics committees, and who becomes an ethics consultant? ECs have come from a wide variety of multidisciplinary educational backgrounds, including philosophy, medicine, law, theology, nursing, social sciences, social work, public health, and health administration.⁹ They may be employed by the health care facility specifically to provide clinical case consultations and other ethics services, or they may be employees whose primary work responsibilities lie elsewhere (such as physicians, nurses, social workers, and chaplains) and who volunteer to serve on an ethics committee. Other ECs are independent contractors who are hired by a health care facility to provide these services. Some ECs may provide case consultation services to the entire facility; others may provide their services to a specific unit or team within the facility.¹⁰

What do ECs do? Among other roles discussed later, ECs address ethical concerns in patient care. The *ASBH Core Competencies* states that the general goal of ethics consultation "is to improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns."¹¹ It defines

⁸ *Code of Ethics, § II (D), The Healthcare Executive's Responsibilities to Patients or Others Served*, AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES, available at http://www.ache.org/abt_ache/code.cfm#patients.

⁹ *ASBH Task Force Report on Ethics Consultation Liability*, AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES 1, 10 (2004), available at <http://web.archive.org/web/20060214174618/http://www.asbh.org/resources/taskforce/pdf/Ethics%20Consultation%20Liability%20Report.pdf> [hereinafter *ASBH Liability Report*]. See also Fox et al., *supra* note 5, at 17 (national survey found that most individuals who provide ethics consultation services were physicians (34%), nurses (31%), social workers (11%), chaplains (10%) or administrators (9%); fewer than 4% were philosophers, theologians, lawyers, other health care providers, or laypersons).

¹⁰ *ASBH Liability Report*, *supra* note 9, at 10–11.

¹¹ *ASBH CORE COMPETENCIES*, *supra* note 7, at 3. See also Tarzian, *supra* note 7, at 4.

ethical concerns as “uncertainty or conflict about values,”¹² and while it does not define “values,” it acknowledges that values can be embedded in individual personal conceptions of the good, professional practices, morals, and law.¹³ ECs also facilitate the resolution of conflicts among the people who are grappling with such ethical concerns, who can include the individual patient, the health care team providing care to the patient, the patient’s family or other loved ones, interested parties in the patient’s religious or other community, and the patient’s surrogate if the patient is not mentally competent to participate in her treatment.

Since the 1970s, the ethics concerns that ECs address have tended to fall into subject-matter patterns. Because they frequently have involved matters of life and death, and untested questions in medical practice as technology has advanced, these ethics concerns have simultaneously raised legal concerns. Either through court cases or by legislative enactments, states have tried to clarify the legal boundaries within which these recurring ethical questions can be resolved. Examples of typical patient-care issues and questions for ethics case consultation are provided in Figure 1. Many of the principles and norms that have gained consensus for the resolution of cases involving these issues have been developed through an extensive ethical literature, numerous court opinions, and state and federal laws and regulations.

FIGURE 1
TYPICAL ISSUES ARISING IN ETHICS CONSULTATIONS

<i>Category</i>	<i>Overview</i>	<i>Examples of issues faced by ECs</i>
Informed consent for a competent adult patient	Supported by the ethics principle of autonomy and by law, a competent patient has a right to be adequately informed of the material benefits and risks of any proposed treatment before consenting to it; which factors are material and must be disclosed can be controversial.	<ul style="list-style-type: none">• Which risk factors, including those arising from the clinicians themselves, are material and must be disclosed?• Should providers disclose that medical negligence may have played a role in unanticipated outcomes of the patient’s care, and if so, how?• Does the patient have the cognitive capacity (competency) to make health care decisions?

¹² *Id.* at 13.

¹³ *Id.* at 2, n. 2.

Refusals of treatment by a competent adult patient	The corollary to the right to informed consent is the right to refuse treatment. The right of a competent adult patient to refuse medical treatment, even life-saving treatment, has been upheld legally.	<ul style="list-style-type: none"> • How should the health care team respond when a patient refuses treatment deemed in his or her best medical interests by the providers? • Should a patient's refusal of treatment be honored when other third-party interests are affected, such as the refusal of a pregnant woman to consent to caesarean section surgery deemed to be in best interests of her fetus? • How should providers' moral distress be handled when honoring a refusal seems to them to be assisting in a patient's suicide?
Consent to and refusals of treatment for minors	Guardians and parents must act in the best interests of their minor children. Views of what is "best" may differ, particularly when the parents or guardians come from different cultural backgrounds from the caregivers.	<ul style="list-style-type: none"> • How should the health care team respond when the parents are refusing treatment that the providers believe is in the child's best interests? • When should a young child's assent to treatment be required? • When are adolescent children mature enough to provide consent to or to refuse medical treatment for themselves?
Decision-making for incompetent patients	When patients lack the ability to make or communicate health care decisions for themselves, they have a right to have a surrogate make those decisions. They may designate by a written advance directive for health care who they desire to make such surrogate decisions during their incompetency and according to what criteria they wish such decisions to be made. In the absence of a written advance directive, often called a living will or durable power of attorney, the state may by statute list who is the legal surrogate decision-maker, usually based on closeness of familial relationship.	<ul style="list-style-type: none"> • How should ECs handle family dynamics that can challenge the legal surrogate's authority to make decisions as a practical matter? • How should ECs handle situations when family members disagree with the health care team's recommendations? • How should ECs deal with lack of clarity over what standards the surrogate should use to decide: (a) a subjective substituted-judgment standard (what the patient would have wanted, if it could be determined), or (b) an objective best-interests standard (what is thought to be in the patient's best interest)? • To what extent should quality-of-life concerns affect decision-making? • How should advance directives be interpreted in individual cases?

End-of-life care	Beyond determining who the surrogate should be for a terminally ill or permanently incompetent patient, other ethics concerns can arise over the appropriate goals of care and how much treatment should be offered to pursue those goals when the patient cannot be cured and may be in the process of dying. Depending on how sick the patient is and how close to death, conflicts can arise over how aggressive the treatment should be.	<ul style="list-style-type: none"> • When should a terminally ill patient be provided artificial respiration (e.g., through a ventilator), artificial nutrition and hydration (e.g., through feeding tubes), or resuscitation (CPR in the event of a cardiac arrest)? • How should ECs handle divergent views of the health care team, surrogate, and family over the relative benefits or futility of further treatment for the patient and the point at which treatment should shift to palliative care? • Where should the line be drawn between relieving a patient's pain through adequate administration of pain-relief drugs and hastening the patient's death, raising the ethics concern of double effect? • How should it be determined when the patient is dead, or when there is sufficient evidence of death, involving the cessation of cardiac, respiratory, and/or brain function?
Reproduction and beginning-of-life care	The moral status of the embryo or fetus in a pregnant woman is one of the most controversial topics in our country, with people holding widely differing views on abortion, sterilization, and artificial reproductive technologies. Views may differ between parents and the health care team over how much and what kind of treatment to offer a newborn baby who is born at the cusp of viability (e.g., 22 weeks gestation) or is born otherwise seriously ill or severely impaired.	<ul style="list-style-type: none"> • May individual health care providers ethically and legally withhold providing medical procedures to which they conscientiously object, such as contraception and abortion services, or must they provide such services despite their conscientious objections? • How should ECs handle the different values that parents and the health care team may place on the chances of a premature newborn's survival and the risks projected for long-term physical or cognitive impairments?
Confidentiality	Patients are entitled under federal and state laws to have the privacy of their health care information protected and not disclosed to others.	<ul style="list-style-type: none"> • To what extent should patient privacy be protected when the patient's health condition poses a risk of harm to others? • How should genetic information and genetic privacy be handled, including whether incidental findings from genetic tests should be disclosed to the patient or others (e.g., when genetic tests show a lack of genetic relationship between a minor child and purported biological father)?

Allocation of resources	Distributive justice concerns can arise when a patient lacks insurance or other financial means to pay for care, and when there is an absolute scarcity of health care resources. The dilemmas over who should receive or forego the limited resources raise ethical questions of equitable access to limited health care resources that cannot be provided to everyone who needs them.	<ul style="list-style-type: none"> • May providers decline to provide services to uninsured patients or patients on Medicaid or Medicare? • In public health emergencies, how should intensive care unit beds and or other scarce equipment be triaged or rationed? • Who should receive scarce organs and tissues for transplantation?
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When so much is at stake, an ethics concern or uncertainty can ripen into full-fledged interpersonal conflict. As a general proposition, “[b]ioethics conflict is almost always about the ‘proper’ or ‘appropriate’ plan for future care.”¹⁴ Nevertheless, not every question over patient care that comes to an EC raises ethics concerns or reflects value-laden conflicts. Some conflicts may reflect simple miscommunication or misunderstanding between the health care team and the patient or the family, which can be cleared up by better efforts at interpersonal communication and rapport building. Some requests for ethics consultation may be better handled by another unit within the institution, such as chaplaincy, social work, or human resources. Even if there is an ethical dimension to a patient’s course of care, the question may need to be referred to the legal affairs department or risk management. ECs can be helpful by identifying at the outset of a referral whether they or another department are the appropriate forum for addressing the concern or conflict.

The emotional, psychological, and physical toll on health care providers, patients, and families during times of intense, challenging health crises can be heavy. The stakes are high when life-and-death decisions and professional reputations are on the line, and when inevitably different personalities, vulnerabilities, and worldviews are present. Sorting out what is understandable interpersonal tension among the parties, what raises ethics concerns, and how to facilitate resolution of a conflict are demanding responsibilities of health care ECs.

¹⁴ NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, *BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS* 15 (Vanderbilt University Press rev. ed. 2011).

III. THE MULTIPLE ROLES OF ECs

How do ECs address the concerns or conflicts that come before them? To date, there is not one model of the EC's role in a case consultation that has been agreed upon in the literature or among ECs in practice.

The ECs' own educational backgrounds and disciplines of origin can affect how they view their roles and how they comport themselves when doing an ethics consultation. For example, researchers have observed that ECs who are physicians tend to focus a consultation on clinical issues and be most responsive to physician-initiated requests, while non-physician ethicists tend to be more open to exploring non-clinical issues and to the involvement of patients and families.¹⁵ ECs who are lawyers, reflecting law's emphasis on process, may tend to advance a procedurally-oriented role for ECs, such as mediation of the parties' problem.¹⁶

Some commentators have advocated that an EC, at least one with an educational background in ethics and philosophy, should serve as a moral expert for choosing the right course of action and take a direct approach to the ultimate decision-making in case consultations.¹⁷ In this view, the ethicists are moral experts who are consulted to make a recommendation as to the best ethical choice based on their moral expertise, much as medical specialists are consulted for an opinion as to the right or best medical course of action based on their medical expertise. Whether or not health care ethicists have such moral expertise in individual cases is hotly de-

¹⁵ Diane E. Hoffmann & Anita J. Tarzian, *The Role and Legal Status of Health Care Ethics Committees in the United States*, in *LEGAL PERSPECTIVES IN BIOETHICS* 49 (Ana S. Iltis, Sandra H. Johnson, and Barbara Hinze eds., Routledge 2008) (citing Bryn Williams-Jones, *A Review of Recent Ethics Literature on Clinical Case Consultations* (Dec. 2000)); Susan E. Kelly, Patricia A. Marshall, Lee M. Sanders, Thomas A. Raffin & Barbara A. Koenig, *Understanding the Practice of Ethics Consultation: Results of an Ethnographic Multi-Site Study*, 8 *J. CLINICAL ETHICS*, 136, 140 (1997).

¹⁶ For example, the authors of DUBLER & LIEBMAN, *supra* note 14, are attorneys.

¹⁷ CHRISTOPHER MEYERS, *A PRACTICAL GUIDE TO ETHICS CONSULTING: EXPERTISE, ETHOS, AND POWER* 12 (Rowman & Littlefield Publishers, Inc. 2007). See also David M. Adams, *Ethics Consultation and "Facilitated" Consensus*, 20 *J. CLINICAL ETHICS* 44, 53 (2009) (arguing in unsettled cases, "the goal of ethics consultation should move from facilitating *consensus within the constraints* to enabling *moral inquiry about the constraints*."); Albert R. Jonsen, *Commentary on "Consensus, Clinical Decision Making, and Unsettled Cases"*, 22 *J. CLINICAL ETHICS* 354, 356 (2011) ("[C]linical ethics consultants should approach every case with their own formulated probable opinion as the grounding of the consultation.").

bated.¹⁸ Nevertheless, under this view the EC is an advocate not for the patient, physician, or hospital, but for the best ethical outcome.¹⁹

In contrast to this role of expert moral advisor, others have promoted the role of the EC as patient advocate, protecting and defending the rights of patients.²⁰ Other roles that have been suggested include “ethical analyst” applying a range of ethical theories to a case while remaining neutral; “ethical adversary” asking probing questions and forcing the parties to think more deeply; an “educator”; and a “counselor” who “adopts a catharsis role allowing others to unburden themselves to someone who will simply reflect, accept, and be nonjudgmental.”²¹ The role of the EC has also been described as a case manager in difficult cases; a professional colleague who helps physicians to make clinical judgments; and as a negotiator, mediator, or arbitrator to help parties in conflict reach

¹⁸ Mark P. Aulisio & Robert M. Arnold, *Ethics Consultation: In the Service of Practice*, 14 J. CLINICAL ETHICS 276, 279 (2003) (“[A]pproximating moral truth . . . should not be the goal of ethics consultation.”); Gary Belkin, *Impact and Accountability: Improvement as a Competency Challenges the Purposes of Bioethics*, 13 AM. J. BIOETHICS 14, 15 (2013) (positing that ECs are “an interest group, rather than an expert group, whose historical narrative may more accurately be described as an attempt to leverage some insights and commitments into a claim of unique, provable knowledge.”); Craig M. Klugman, *As Advisors, Nondirectional Consultation Is Best*, 5 AM. J. BIOETHICS 56, 56 (2005) (“[T]here are no claims to moral expertise, just to a process of thought and a set of knowledge.”). *But see* David M. Adams, *Ethics Expertise and Moral Authority*, 13 AM. J. BIOETHICS 27, 28 (2013) (“To insist that HCECs possess ethics expertise and expert moral knowledge but not moral authority is on the face of it a puzzling claim.”). *See generally* Lisa M. Rasmussen, *An Ethics Expertise for Clinical Ethics Consultation*, 39 J. LAW, MED. & ETHICS 649 (2011). *See also* *infra* notes 90–97 and accompanying text.

¹⁹ MEYERS, *supra* note 17, at 17.

²⁰ William Lawrence Allen & Ray Edward Moseley, *Will the Last Health Care Professional to Forgo Patient Advocacy Please Call an Ethics Consult?*, 12 AM. J. BIOETHICS 19 (2012) (arguing that patient advocacy should be a role of all who provide care to patients, including ECs); Ashley Bassel, *Order at the End of Life: Establishing a Clear and Fair Mechanism for the Resolution of Futility Disputes*, 63 VAND. L. REV. 491, 517 (2010) (observing that “numerous experts believe that patient protection should be the primary purpose of ethics committees”); Andrea Frolic & Paula Chidwick, *A Pilot Qualitative Study of “Conflicts of Interests and/or Conflicting Interests” among Canadian Bioethicists. Part 1: Five Cases, Experiences and Lessons Learned*, 22 HEC FORUM 5, 14 (2010) (discussing “a model of advocacy which characterizes the bioethicist as a tenacious champion for wrongs to be righted and justice to be done, even at significant personal cost.”). *But see* Autumn Fiester, *Mediation and Advocacy*, 12 AM. J. BIOETHICS, 10, 10 (2012) (“Patient advocacy, therefore, should be morally proscribed. . . . [M]ediation demands universal advocacy for all of the stakeholders’ interests, not just the patient’s.”). *See generally* Lisa M. Rasmussen, *Advocacy Through a Prism: A Response to Commentaries on “Patient Advocacy in Clinical Ethics Consultation”*, 12 AM. J. BIOETHICS W1, W1 (2012) (reviewing a series of articles in this issue on patient advocacy by ECs and observing that “[i]mmediate responses to the question of whether consultants can be patient advocates have ranged from ‘clearly not’ to ‘clearly they must,’ and points in between.”).

²¹ *ASBH Liability Report*, *supra* note 9, at 12.

ethically acceptable resolutions.²² ECs have also been described as “offensive intruders trying to tell other people how to do their business,”²³ and their role as being “quasi-lawyers giving legal advice, aiding in risk management, and engaging in mediation.”²⁴ Some have decried the indeterminacy of the EC’s role,²⁵ while others seem to have embraced it.²⁶ Reflecting this diversity of roles, one of the most salient findings in a recent study was the sheer complexity inherent in the provision of ethics consultation services.²⁷

The multiplicity of roles that ECs may play is reflected in the multiple goals that have been articulated for ethics consultations. A national survey of hospitals about their ethics consultation services published in 2007 offered the following goals, which the great majority of respondents agreed were either primary (or secondary, in parenthesis) goals:

• Intervening to protect patient rights	94% (5%)
• Resolving real or imagined conflicts	77% (22%)
• Changing patient care to improve quality	75% (19%)
• Increasing patient/family satisfaction	68% (26%)
• Educating staff about ethical issues	59% (37%)
• Preventing ethical problems in the future	59% (36%)
• Meeting a perceived need of staff	50% (35%)
• Providing moral support to staff	47% (47%)

²² John La Puma & David L. Schiedermayer, *Ethics Consultation: Skills, Roles, and Training*, in *BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE* 248–49 (Nancy S. Jecker, Albert R. Jonsen & Robert A. Pearlman eds., Jones & Bartlett Publishers 2d ed. 2007) (describing roles of professional colleague, educator, negotiator, advocate, and case manager); Robert D. Orr & Dennis M. deLeon, *The Role of the Clinical Ethicist in Conflict Resolution*, 11 *J. CLINICAL ETHICS* 21 (2000) (describing the roles of an EC as a negotiator, mediator, or arbitrator depending on the case and context).

²³ Richard M. Zaner, *Listening or Telling? Thoughts on Responsibility in Clinical Ethics Consultation*, 17 *THEORETICAL MED.* 255, 260 (1996). See also Belkin, *supra* note 18, at 15 (citing others for observation that “the success of bioethics hinged on meeting the technocratic purposes of others . . . providing rules of thumb that managed, some argue completely smoothed over, . . . messy questions of purpose, power, and priorities in biomedical culture.”).

²⁴ H. Tristram Engelhardt, Jr., *Core Competencies for Health Care Ethics Consultants: In Search of Professional Status in a Post-Modern World*, 23 *HEC FORUM* 129, 129 (2011).

²⁵ Giles Scofield, *What Is Medical Ethics Consultation?*, 36 *J. L. MED. & ETHICS* 95, 100 (2008); Ruth Shalit, *When We Were Philosopher Kings: The Rise of the Medical Ethicist*, *THE NEW REPUBLIC*, Apr. 28, 1997, at 24–28.

²⁶ George J. Agich, *What Kind of Doing is Clinical Ethics?*, 26 *THEORETICAL MED.* 7 (2005); H. Tristram Engelhardt, Jr., *Credentiaing Strategically Ambiguous and Heterogeneous Social Skills: The Emperor Without Clothes*, 21 *HEC FORUM* 293 (2009); Engelhardt, *supra* note 24.

²⁷ M. D. Godkin, K. Faith, R.E.G. Upshur, et al., *Project Examining Effectiveness in Clinical Ethics (PEECE): Phase 1 – Descriptive Analysis of Nine Clinical Ethics Services*, 31 *J. MED. ETHICS*, 505, 511 (2005).

- Suspending unwanted or wasteful treatments 41% (40%)
- Reducing the risk of legal liability 40% (49%)²⁸

With this amount of role ambiguity, there is the potential for the roles to overlap and even conflict in a single case.²⁹ Conflicts of interest that ECs potentially face are discussed later in this Article.

In light of this range of possible goals (and therefore the roles that ECs play), “ethics” per se may no longer be the central focus of many case consultations. Many of these goals relate to an array of psychological, emotional, interpersonal, administrative, legal, or other supportive-service goals when patients, families, and health care clinicians and staff disagree over the appropriate course of care for a patient. Commentators have observed that “doing ethics” as traditionally understood has become less a part of the work of ECs than other roles.³⁰ Studies have found that conflicts, disagreements, or communication problems are present in many or even most ethics consultations.³¹

Given the range of views on the appropriate role for ECs and the unique characteristics of any given case consultation, it is probably wise to be flexible in determining the EC’s role in individual case consultations. Depending on the institutional setting, whether and what kind of an ethical issue may be at stake, the nature of the parties’ disagreement, and the individual personalities struggling to address the problem, the most effective and appropriate role(s) for the EC will doubtless depend on the whole context of a case.

²⁸ Fox et al., *supra* note 5, at 16. This list of goals itself has generated controversy. See, e.g., Martin L. Smith & Kathryn Weise, *The Goals of Ethics Consultation: Rejecting the Role of “Ethics Police”*, 7 AM. J. BIOETHICS 42 (2007) (disagreeing that the first three goals are primary and offering four other primary goals).

²⁹ Robert Klitzman, *Additional Implications of a National Survey on Ethics Consultation in United States Hospitals*, 7 AM. J. BIOETHICS 47 (2007); Lisa M. Rasmussen, *Clinical Ethics Consultation’s Dilemma, and a Solution*, 22 J. CLINICAL ETHICS, 380, 384–85 (2011).

³⁰ George J. Agich, *Defense Mechanisms in Ethics Consultation*, 23 HEC FORUM 269, 270 (2011); Gordon DuVal, Leah Sartorius, Brian Clarridge, Gary Gensler & Marion Danis, *What Triggers Requests for Ethics Consultations?*, 27 J. MED. ETHICS i24 (2001); Kelly et al., *supra* note 15, at 141–42; Engelhardt, *supra* note 24.

³¹ Martha Jurchak, *Report of a Study to Examine the Process of Ethics Case Consultation*, 11 J. CLINICAL ETHICS 49, 52 (2000) (two most frequent problems reported in study were communication and value conflict); DuVal et al., *supra* note 30, at i28; Elizabeth G. Nilson, Cathleen A. Acres, Naomi G. Tamerin, & Joseph J. Fins, *Clinical Ethics and the Quality Initiative: A Pilot Study for the Empirical Evaluation of Ethics Case Consultation*, 23 AM. J. MED. QUALITY 356 (2008) (conflict was an issue in majority of cases studied); Elliot B. Tapper, Christian J. Vercler, Deborah Cruze & William Sexson, *Ethics Consultation at a Large Urban Public Teaching Hospital*, 85 MAYO CLIN. PROC. 433, 439 (2010) (communication issues/disagreements were present in many case consultations studied).

IV. PROCESSES FOR ETHICS CONSULTATION

Not surprisingly in light of the multiple goals for case consultation and multiple roles played by ECs, the processes and practices that ECs use to provide ethics consultation services vary considerably. This variation may also be due to size of the institution, resources provided to support the EC, and experience level and length of time an EC has been operating in the institution. For example, some ECs always see the patient, while others often do not; not all ECs require that patients and families be notified of a request for ethics consultation; some ECs employ voting on recommendations, while others do not; and some ECs evaluate their practices retrospectively, while others do not.³² Many EC services have no explicit policies or procedures that govern how they go about their work.³³ Some commentators regard this variation in EC practices as “troubling because almost all guidelines and consensus statements agree that ECSs should have clear standards and follow them consistently.”³⁴

There are a number of procedural models used by ECs when engaging with a clinical case. The primary models that have emerged include the traditional medical model (in which a respected subspecialist’s opinion is sought by a consultation); informal counseling and individual coaching to some or all of the parties to the conflict; third-party facilitation of conversations among the parties, hopefully leading to consensus on a resolution; and neutral mediation of the conflict. Much ethics consultation has moved towards models that use individual consultants or a small team or sub-set of the larger ethics committee, although some have argued for resurrecting the full-committee model.³⁵ While commentators have argued vociferously over which model is the best for ethics consultation, it is likely that the most appropriate process for conflict engagement in a particular case will vary depending on the role that the ECs perceive they should play or are asked to play, the individuals and the stakes involved, as well as the complexity of the situation.

³² Fox, *supra* note 5, at 20.

³³ *Id.*

³⁴ *Id.*

³⁵ Susan B. Rubin & Laurie Zoloth, *Clinical Ethics and the Road Less Taken*, 32 J. LAW, MED. & ETHICS 218, 219–20 (2004). *Contra* Jeffrey Spike & Jane Greenlaw, *Ethics Consultation: High Ideals or Unrealistic Expectations?*, 133 ANN. INTERNAL MED. 55 (2000) (arguing that the full committee is unwieldy in acute care settings and poses “groupthink” danger).

A. *Traditional Medical Consultation Model*

In medicine, physicians with subspecialty expertise may be asked by a medical colleague for a consultation, or “second opinion,” where they have particular expertise relevant to a patient’s illness or injury. For example, an attending physician may ask a psychiatrist to consult about a patient’s mental capacity to make decisions. These consultations can be either formal patient assessments or more informal “curbside consultations” that may be given in the hallway or over the phone without documentation in the patient’s chart.³⁶ Some ECs approach the ethics consultation process similarly, where the ECs are consulted for their ethical expertise and a “second opinion” about how to handle an ethics concern or conflict. Depending on how formal or informal the consultation request is, an EC in this model discusses the case with the requestor, may or may not see the patient and review the chart, formulates an opinion, and provides a specific recommendation about it.³⁷ Reflecting this model, the *Quinlan* court originally suggested a limited reviewing function for an ethics committee, to confirm or not a physician’s determination of a patient’s prognosis.³⁸ Despite their widespread practice, curbside medical consults can raise legal and ethical concerns,³⁹ which could apply to curbside ethics consults.

³⁶ Christopher Grace, W. Kemper Alston, Mary Ramundo, Louis Polish, Beth Kirkpatrick & Christopher Huston, *The Complexity, Relative Value, and Financial Worth of Curbside Consultations in an Academic Infectious Diseases Unit*, 51 CLINICAL INFECTIOUS DISEASES 651 (2010).

³⁷ See Eugene Boisaubin & Michele Carter, *Optimizing Ethics Services and Education in a Teaching Hospital: Rounds Versus Consultation*, 10 J. CLINICAL ETHICS 294, 295–97 (1999) (contrasting ethics consultation model with ethics rounds model); Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U. L. REV. 1091, 1117–18 (1999) (discussing ethics committee acting as medical consultant, often without family or patient involvement); Diane E. Hoffmann, *Case Consultation: Paying Attention to Process*, 6 HEC FORUM 85, 87 (1994) (discussing consultation model); David N. Sontag, *Are Clinical Ethics Consultants in Danger? An Analysis of the Potential Legal Liability of Individual Clinical Ethicists*, 151 U. PA. L. REV. 667, 679–80 (2002) (contrasting “hard” model of consultation in which the EC acts like a traditional clinician with “soft” model in which the EC is largely a facilitator).

³⁸ President’s Commission, *supra* note 6, at 162.

³⁹ Jane M. Grant-Kels & Barry D. Keis, *The Curbside Consultation: Legal, Moral, and Ethical Considerations*, 66 J. AM. ACAD. DERMATOLOGY 827 (2012). See also Sontag, *supra* note 37. The ASBH CORE COMPETENCIES, *supra* note 7 at 13, recommends that when ECs are asked to provide an informal “curbside consultation” on an ethics question, they should give only a general and conditional response, and should not give recommendations for a specific patient without completing a formal consultation process.

B. *Coaching*

Individualized coaching by an ethics consultant or member of an ethics committee has recently gained attention. In this model, which has been adopted at Washington Hospital Center in Washington, DC,⁴⁰ the EC meets with only one party (who is requesting the consult) and provides one-on-one coaching on approaching the problem and coping with the conflict. The EC does not necessarily give an opinion or recommend a solution, as in the medical consult model, but rather focuses on empowering the requestor with the analytical, communication, and interpersonal skills to address the problem herself. While this approach could risk co-opting the EC who has heard only one side of the story and ignoring the perspectives of the other parties, the EC can mitigate these risks by encouraging the requestor to view the problem through the others' perspectives, guiding ethical analysis, and helping to map a strategy going forward.⁴¹ When undertaken at an early stage, individual coaching can be an effective intervention before the requestor's concern has escalated into a full-blown conflict with strong emotions and seemingly hardened opposing positions among all the parties.⁴² Recent research has shown initial promise for conflict coaching in health care settings.⁴³

C. *Facilitation*

It is increasingly common for ECs to play a facilitative role in the resolution of ethics or other values-based conflicts in patient care. This approach is encouraged by the *ASBH Core Competencies*, which identifies two key features of what it calls the "ethics facilitation approach": "(1) identifying and analyzing the nature of the value uncertainty, and (2) facilitating the building of a principled ethical resolution."⁴⁴ The role of the EC in this approach is to clarify what the ethics or values-based concerns actually are in an individual case and to help the parties collectively reach an ethi-

⁴⁰ Lauren M. Edelstein, John J. Lynch, Nneka O. Mokuwonye & Evan G. DeRenzo, *Curbside Consultation Re-imagined: Borrowing from the Conflict Management Toolkit*, 22 HEC FORUM 41 (2010).

⁴¹ *Id.*

⁴² *Id.*

⁴³ Ross Brinkert, *Conflict Coaching Training for Nurse Managers: A Case Study of a Two-Hospital Health System*, 19 J. NURSING MANAGEMENT 80 (2011).

⁴⁴ ASBH CORE COMPETENCIES, *supra* note 7, at 7.

cally acceptable resolution of any disagreements through effective communication and integration of the various perspectives.

A facilitative approach contemplates the involvement of more than one of the parties to the conflict, and may entail either joint meetings among the parties or “shuttle facilitation” back and forth among the parties without joint meetings.⁴⁵ The EC acting in this facilitative role may act as a resource (e.g., on hospital policies), expert (e.g., for analysis of ethical issues), educator (e.g., imparting knowledge of relevant literature), and guide in the discussion of ethically permissible options.⁴⁶ While a facilitative EC may make recommendations (e.g., on next steps) and even share her own views within this approach, the *ASBH Core Competencies* caution against unduly influencing the ultimate decision maker by recommending a single best course of action or imposing her own values on others.⁴⁷

D. Mediation

Mediation has been suggested over the past two decades as a procedural option for ECs to consider in responding to an ethics consult request.⁴⁸ One kind of mediation approach has been called “bioethics mediation” and has been championed by Nancy Dubler and Carol Liebman.⁴⁹ These authors observe that “bioethics disputes are essentially conflicts, and the underlying issues of patient and family rights can best be clarified and addressed by approaching the turbulence and discord with the skills of dispute

⁴⁵ Mary Beth West & Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 63, 63–64 (1992).

⁴⁶ ASBH CORE COMPETENCIES, *supra* note 7, at 8–9.

⁴⁷ *Id.*

⁴⁸ Arthur L. Caplan & Edward J. Bergman, *Beyond Schiavo*, 18 J. CLINICAL ETHICS 340 (2007); I. Glenn Cohen, *Negotiating Death: ADR and End of Life Decision-Making*, 9 HARV. NEGOT. L. REV. 253 (2004); Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821 (1994); Autumn Fiester, *The Failure of the Consult Model: Why “Mediation” Should Replace “Consultation”*, 7 AM. J. BIOETHICS 31 (2007); Autumn M. Fiester, *Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting*, 22 J. CLINICAL ETHICS 363, 370–71 (2011); K. Kovach, *Neonatology Life and Death Decisions: Can Mediation Help?*, 28 CAP. U. L. REV. 251 (2000); Ellen Waldman, *Elegy for Mrs. G: Mediating Losses at the End of Life*, 23 QUINNIPIAC PROB. L.J. 411 (2010); Gatter, *supra* note 37, at 1096–97 (surveying recommendations for the mediation model since 1989); West & Gibson, *supra* note 45.

⁴⁹ Dubler & Liebman, *supra* note 14. See also Edward Bergman, *Surmounting Elusive Barriers: The Case for Bioethics Mediation*, 24 J. CLINICAL ETHICS 11 (2013).

mediators.”⁵⁰ They view the EC’s role as often less about resolving ethical dilemmas and more about resolving conflicts. To this end, “while bioethics consultants certainly need to be experts in ethical, legal, and medical issues, they also should have a good grasp of process and a strong set of dispute resolution skills.”⁵¹ Dubler and Liebman carefully distinguish between bioethics mediation and classic mediation,⁵² tailoring the former to the realities and needs of people and institutional settings delivering health care to sick patients. Central to their approach is the idea that the techniques and tools of conflict-management and dispute-resolution experts can be learned by ECs and used to resolve ethics concerns and conflicts.

One difference between the *ASBH Core Competencies’* “ethics facilitation approach” and Dubler and Liebman’s “bioethics mediation” approach may be in the degree of structure they recommend for engaging the parties. Bioethics mediation adopts a more structured model for bringing the parties together in a joint mediation session that contemplates opening statements, introductions, presentation of facts, problem-solving and resolution processes, and steps for follow-up.⁵³ The ethics facilitation approach “is, by design, a rather general and loose process.”⁵⁴

Another difference may be how neutral or impartial the EC is supposed (or perceived) to be. In mediation, the mediator is supposed to be neutral, not taking a side in a dispute; indeed, another term for a mediator is a “neutral.” Dubler and Liebman state:

A key component of bioethics mediation is the neutral turf created by the presence of a person who is not a member of the health care team and who has not participated in [the prior interventions or discussions in the patient’s case Despite

⁵⁰ DUBLER & LIEBMAN, *supra* note 14, at xv.

⁵¹ *Id.* at xvi.

⁵² *Id.* at 21–30. Compare Nancy Neveloff Dubler, *Commentary on Bergman: Yes . . . But*, 24 J. CLINICAL ETHICS 25, 28–29 (2013) (arguing that to be effective, bioethics mediators need to be well versed in bioethics concepts, best practices, the ethical framework for decisions, and clinical ethics literature) with Bergman, *supra* note 49, at 19 (“The premise that a clinical ethics mediator should be, first and foremost, a professionally trained bioethicist is dubious, in that the primary skills demanded are in the realms of empathy, communication, insight, creativity, trustworthiness, and process management.”).

⁵³ DUBLER & LIEBMAN, *supra* note 14, at 43–72 (discussing the eight stages of bioethics mediation).

⁵⁴ Mark P. Aulisio, “Facilitated Consensus,” “Ethics Facilitation,” and *Unsettled Cases*, 22 J. CLINICAL ETHICS 345, 346 (2011).

often being an employee of the hospital], the bioethics mediator . . . must be impartial to the situation at hand.⁵⁵

By contrast, a member of the Task Force that issued the first edition of the *ASBH Core Competencies* argues that the ethics facilitation approach provides that

[f]ar from an expectation that ethics consultants will be perfectly impartial or neutral . . . ethics consultants need to be clear when they are offering moral judgments based on their own values . . . [subject only to the caveat] that consultants not usurp the decision-making authority of others or impose their values on them.⁵⁶

E. *The Call for Procedural Standardization*

In recent years, there has been a growing movement toward standardizing the processes for ethics consultation, from case intake to documentation in the patient's chart.⁵⁷ Dubler and Liebman⁵⁸ and the *ASBH Core Competencies*⁵⁹ reflect this move toward adoption of specific procedural standards, as does the Veteran's Administration's Integrated Ethics program.⁶⁰ This move to procedural standardization in ethics consultation is not without its critics, however. One highly regarded bioethicist, Nancy P. King,

⁵⁵ DUBLER & LIEBMAN, *supra* note 14, at 13.

⁵⁶ Aulisio, *supra* note 54, at 347–48. *But see* Autumn Fiester, *Mediation and Recommendations*, 13 AM. J. BIOETHICS, 23, 24 (2013) (observing that if “the peculiar species of ‘recommendation’ that the *Core Competencies* have in mind is merely to chart the relevant ethical considerations of a conflict, then the contrast of ‘facilitation’ with ‘mediation’ is a distinction without a difference”).

⁵⁷ Nancy Neveloff Dubler & Jeffrey Blustein, *Credentialing Ethics Consultants: An Invitation to Collaboration*, 7 AM. J. BIOETHICS 35, 35 (2007).

⁵⁸ *See* DUBLER & LIEBMAN, *supra* note 14, at 43–72 (discussing eight stages of bioethics mediation) and 95–130 (discussing documentation in patient's medical chart).

⁵⁹ *See* ASBH CORE COMPETENCIES, *supra* note 7, at 34–45 (discussing evaluation of ethics consultation services in terms of quality, structure, process, outcomes, access, and efficiency). *See also* Jeffrey P. Bishop, Joseph B. Fanning & Mark J. Bliton, *Of Goals and Goods and Floundering About: A Dissensus Report on Clinical Ethics Consultation*, 21 HEC FORUM 275, 279 (2009) (“No other document has contributed more to the standardization process than [the first edition of the *ASBH Core Competencies*].”).

⁶⁰ The National Center for Ethics in Health Care of the U.S. Department of Veterans Affairs has designed and implemented a preventive ethics approach for all of the 153 VA medical centers as part of an overall “IntegratedEthics” program, *available at* <http://www.ethics.va.gov/integratedethics/pec.asp>. *See also* Bishop et al., *supra* note 59, at 285 (commenting that the “Integrated Ethics Program at the VHA, which on paper appears to be the most standardized in the country, embodies this emphasis on process.”).

cautions against trying to standardize approaches to addressing cases that are brought to ECs:

In my experience, most [people who request ethics consultation] want one of two things: (1) to be heard, valued, acknowledged, and reassured that somebody knows they are struggling and really trying to do right in hard cases; or (2) to have their own views given the trump card. The first my HEC can always (at least) try to do; the second we cannot and will not do.⁶¹

King believes that there are too many variables in individual cases to advocate for a standardized approach to an EC's process for and role in handling a consult: "When I undertake ethics consultation, I'm always floundering. I guess I think it should always involve floundering, albeit floundering that is 'ethical' in focus."⁶²

Although the appropriate EC roles and processes chosen for ethics consultation in individual cases will often vary, the remainder of this article will focus on common themes and lessons from the conflict-management field that can be applied to conflicts in individual clinical cases. Because so many ethics consultations do involve interpersonal conflicts, the skills and frameworks for addressing conflicts that have been developed in the conflict-management field generally will often be useful and desirable for ECs, and they are reviewed here. At the end of the article, several key challenges and concepts of particular importance for handling conflict in ethics consultations—such as power imbalances, conflicts of interest, personal biases, and the fiduciary responsibilities of health care providers and ECs—will also be discussed.

V. A FRAMEWORK FOR ENGAGING WITH CONFLICT IN HEALTH CARE

Well-known conflict specialist Bernard Mayer coined the term "conflict engagement" to reflect the range of goals for and approaches to conflict, which may include, but are not limited to, conflict resolution:

Rather, [conflict] engagement is about helping people be effective in addressing conflict at whatever point in its progression they may be, whether their need is to prevent it, identify it, escalate it, manage it, deescalate it, resolve it, or heal from its im-

⁶¹ Nancy M. King, *Who Ate the Apple? A Commentary on the Core Competencies Report*, 11 HEC FORUM 170, 174 (1999).

⁶² *Id.* at 175. Accord, Bishop et al., *supra* note 59.

pacts . . . Effective engagement requires finding the right level of depth at which to engage.⁶³

This Article's use of the phrases "conflict engagement" and "engaging with conflict" is intended to reflect the reality that some conflicts in health care ethics consultations may never be resolved, the breadth of alternative ways of dealing with conflict, and the potential that conflict provides to transform a problem into an opportunity to improve patient care and the relationships among all who are concerned with the patient's care and well being. Depending on the stage at which assistance is requested and the kind of assistance requested, an EC can help the parties in an ethics consultation prevent, identify, manage, deescalate, resolve, and recover from a conflict. Like the range of roles that have already been identified for ECs, their roles in engaging with conflict can include non-neutral roles (advocate, strategist, or coach), more neutral roles (fact-finder, facilitator, or mediator), and system roles (process designer, case manager, educator, or policy adviser).⁶⁴ In this sense, an EC is similar to the role of a conflict specialist, who adopts different roles depending on the situation and different processes for engaging with the conflict and the conflicted parties.

The framework that is developed in this article for engaging with conflict through ethics consultations is drawn from many classic resources in the conflict-management field and has been tailored to health care settings. The framework can be used whether the EC is consulting with or coaching only one party or is engaging with all the parties to facilitate or mediate a joint resolution.

⁶³ BERNARD S. MAYER, BEYOND NEUTRALITY: CONFRONTING THE CRISIS IN CONFLICT RESOLUTION 182, 184 (Jossey-Bass 2004). Debra Gerardi has been the principal scholar and conflict specialist who has extended and applied the concept of conflict engagement to health care settings. See, e.g., Debra Gerardi, *The Emerging Culture of Health Care: Improving End-of-Life Care through Collaboration and Conflict Engagement among Health Care Professionals*, 23 OHIO ST. J. ON DISP. RESOL. 105 (2007-2008). See also *EHCCO White Paper for Conflict Healthcare and Dispute Resolution Professionals*, CONFLICT ENGAGEMENT TRAINING FOR HEALTH PROFESSIONALS, RECOMMENDATIONS FOR CREATING CONFLICT COMPETENT ORGANIZATIONS (2010) available at https://docs.google.com/file/d/0B5q_o7uUaYhxN0EtYTxxZG1xSjA/edit?usp=drive_web&pli=1. Debra Gerardi is the Chief Creative Officer of EHCCO (Emerging Healthcare Communities); see <http://ehcco.com/debra-gerardi/>.

⁶⁴ *Id.* at 220-47 (describing these multiple roles of conflict specialists).

A. *Identifying the Issues*

Broadly speaking, conflicts that prompt requests for ethics consultations involve three kinds of issues: substantive issues (e.g., the ethical issues or the other issues that the parties say they are disagreeing over); relational issues (the underlying interpersonal dynamics among the parties); and process issues (selecting the most appropriate approach to resolving the conflict). These issues will often be entangled. The relational dynamics among the parties may be what are keeping them in conflict over the substantive issues, and determining which procedural format (e.g., individual consultation, coaching, group facilitation, or mediation) is the best approach to engaging with the conflict will often depend on both substantive and relational issues.

The first step is to gather enough information to be able to identify the substantive, relational, and process issues that need to be addressed.

1. Substantive Issues and the Parties' Interests

The substantive issues that arise in an ethics consultation could involve issues of ethics, medicine, law, who has the authority to make patient care decisions, or the costs and quality of the health care being provided. Typical substantive ethics issues that can arise in ethics consultations are outlined in Figure 1. Some institutions have developed checklists for ECs to use to identify the nature of the ethics question raised by the request for a consultation.⁶⁵ Other paradigms have been suggested to ensure a complete identification of the relevant issues in an ethics case.⁶⁶

⁶⁵ E.g., Kevin B. O'Reilly, *Success from Surgical Checklists Breeds Idea for Ethical Checks*, AM. MED. NEWS (Apr. 13, 2009), available at <http://www.ama-assn.org/amednews/2009/04/13/prsa0413.htm>; Daniel K. Sokol, *Rethinking Ward Rounds*, BRITISH MED. J., 338:571 (Mar. 7, 2009); DUBLER & LIEBMAN, *supra* note 14, at 95–130. The HHC Ethics Network, which provides ethics consultation services for all public hospitals in New York City affiliated with the Health and Hospitals Corporation, has adopted Dubler & Liebman's approach, listing and collecting "ethics paragraphs" to describe ethical problems that may be present in case consultations, available at <http://www.hcethics.org/paragraphs.shtml>.

⁶⁶ E.g., ALBERT R. JONSEN, MARK SIEGLER & WILLIAM J. WINSLADE, *CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE* (McGraw Hill Medical 7th ed. 2010) (describing a four-quadrant approach to delineating the relevant issues: (1) medical indications for treatment; (2) patient preferences regarding treatment; (3) quality of life for the patient with or without treatment; and (4) contextual features, including family, social, legal, religious and financial considerations).

After discussion with the requestor or other parties, an EC may determine that there is no ethics issue for resolution.⁶⁷ It has been observed that physician-patient disputes “tend to arise from poor communication rather than a clash of moral beliefs.”⁶⁸ The request may be based on factual misunderstandings or lack of information, and the EC can help to promote better communication among the parties to resolve these problems. The request may raise a question that is better addressed by another department, such as legal affairs, social work, or chaplaincy.

If there is an ethics or other value-laden question present, the EC will need to explore some underlying issues that may be prompting the conflict. In particular, the EC will need to distinguish the parties’ differing *positions* over how to resolve the question (what they say they are arguing over) from their underlying *interests* (which may include emotional, psychological, financial, or other needs, fears, or concerns) that are often the motivations and desires behind their positions. Discerning the underlying interests and needs of the parties may allow them to discover common ground for agreement.

This interest-based, problem-solving approach to negotiation and mediation was developed by the authors of *Getting to YES: Negotiating Agreement Without Giving In*,⁶⁹ which was first published in 1981 and whose themes have been elaborated on in later publications.⁷⁰ Through effective communication techniques, conflict resolvers who take this approach try to elicit the interests behind the parties’ stated positions, to help them clarify and prioritize their wants and needs, and to create a problem-solving atmosphere for their collective consideration of various options that meet or at least balance their respective interests.⁷¹ Promoted at Harvard’s Program on Negotiation and elsewhere, this interest-based, prob-

⁶⁷ See *supra* note 30.

⁶⁸ Gatter, *supra* note 37, at 1114–15.

⁶⁹ ROGER FISHER, WILLIAM URY & BRUCE PATTON, *GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN* (Penguin Books 3d ed. 2011) [hereinafter *GETTING TO YES*].

⁷⁰ ROGER FISHER & SCOTT BROWN, *GETTING TOGETHER: BUILDING RELATIONSHIPS AS WE NEGOTIATE* (Penguin Books 1988); ROGER FISHER & DANIEL SHAPIRO, *BEYOND REASON: USING EMOTIONS AS YOU NEGOTIATE* (Penguin Books 2005); DOUGLAS STONE, BRUCE PATTON & SHEILA HEEN, *DIFFICULT CONVERSATIONS: HOW TO DISCUSS WHAT MATTERS MOST* (Penguin Books 2d ed. 2010); WILLIAM URY, *GETTING PAST NO: NEGOTIATING IN DIFFICULT SITUATIONS* (Bantam Dell 1991); WILLIAM URY, *THE THIRD SIDE: WHY WE FIGHT AND HOW WE CAN STOP* (Penguin Books 2000); Bruce Patton, *Negotiation*, in *THE HANDBOOK OF DISPUTE RESOLUTION* 279–303 (Michael L. Moffitt & Robert C. Bordone eds., Jossey-Boss 2005).

⁷¹ *GETTING TO YES*, *supra* note 69. See also CHRISTOPHER W. MOORE, *THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT* (Jossey-Bass 3d ed. 2003).

lem-solving approach is one of the most influential approaches to conflict resolution today. It will provide the initial framework for conflict engagement in this article. Other approaches will also be discussed that stress the importance of relational dynamics between the parties and of understanding the parties' narratives about the patient's illness and what it means to their lives.

The classic example of interest-based conflict resolution is two squabbling sisters who both want the only available orange, and each argues that she should get it.⁷² Their argument just goes around in circles ("I get it!" "No, I get it!") so long as they focus on their *positions* and dig their heels in. The conflict could be resolved by a simple compromise that leaves neither completely satisfied (e.g., divide it in half). A better resolution is found after asking them *why* they each want the orange. When it turns out that one wants the juice to drink and the other wants the peel to grate into a cake, they can fully satisfy both their *interests* by letting one sister have the entire peel and the other sister have all the juice of the orange. This represents the "win-win" outcome that is often referred to in interest-based conflict resolution.

As an illustration in the hospital setting, an ethics consultation may be requested for a situation in which family members of an unconscious dying patient take the position that "everything be done" to keep the patient alive, while the health care team's position is that continued aggressive treatment is "futile" and medically inappropriate and should be discontinued. By probing *why* the parties are taking their respective positions, an EC can begin to understand what underlying interests, needs, or concerns are prompting those positions. In searching for these underlying interests, the EC may discover a way to integrate or balance the interests of the parties.

In this illustration, it may be that the family is awaiting an out-of-town relative who needs to say goodbye to the patient, and the health care team is concerned about the cost and patient's suffering resulting from aggressive treatment. By identifying their interests, the EC might help the parties find common ground in a time-limited course of aggressive treatment until the relative's arrival with a shift to palliative care thereafter. Similarly, another family who demands that "everything be done" may have an underlying need to be reassured that the providers won't abandon the patient. By discovering the family's interest in the psychological security of know-

⁷² John Barkai, *Teaching Negotiation and ADR: The Savvy Samurai Meets the Devil*, 75 NEB. L. REV. 704, 708-11 (1996).

ing that on-going care will be provided to their loved one and that she will not be abandoned, the EC may be able to encourage the providers to explore how to satisfy this interest (rather than the initial demand of “everything”) by offering alternative kinds of care short of maximally aggressive treatment. Other kinds of interests underlying a stated position of wanting to have “everything done” have been suggested, including spiritual and family-related concerns.⁷³ The parties’ underlying interests, needs, and motivations behind their positions should always be explored as part of an ethics consultation.

2. Relational Issues

The influence that relational dynamics have in a conflict can be powerful. In a hospital setting, where life, suffering, and death provide the backdrop to many ethics consultations, emotions and interpersonal tensions can run high. Patients and families, with their history of familial dynamics, may be experiencing fear, guilt, hurt, anger, and resentment among each other in times of crisis, resulting in conflicts over the patient’s care. A family’s internal conflicts may also find outward and antagonistic expression leveled at the health care providers. When their authority or expertise is challenged, whether by the family or by others on the health care team, health care providers can also feel anger and resentment. An ethics consultation may thus be called to sort out intra-family conflicts, conflicts between the patient/family and the health care team, and within the health care team.

Sorting out the multiple relational issues that may be contributing to the conflict is often necessary before any progress can be made on the substantive issues. The history of the relationship between the parties may be important, as well as individual personalities within the relationship. Equally important is the level of trust within the relationship. When people are in conflict, distrust tends also to be present. While trust is usually accompanied by positive emotions and cooperative behaviors, distrust correlates with negative emotions, a tendency to attribute bad motives to others, and uncooperative behaviors – all of which can escalate the conflict.⁷⁴

⁷³ Timothy E. Quill, Robert Arnold & Anthony L. Back, *Discussing Treatment Preferences With Patients Who Want “Everything”*, 151 ANN. INTERNAL MED. 345 (2009).

⁷⁴ Roy J. Lewicki, *Trust and Distrust*, in THE NEGOTIATOR’S FIELDBOOK: THE DESK REFERENCE FOR THE EXPERIENCED NEGOTIATOR 191–202 (Andrea Kupfer Schneider & Christopher Honeyman eds., American Bar Association Section of Dispute Resolution 2006).

Trust is complex and is grounded on an assessment of three factors: one's perceptions of the other party's ability, integrity, and benevolence.⁷⁵ Families in conflict may distrust each other along all these lines. For patients and families, distrust of health care providers may lie not so much in perceptions about the team's technical abilities or personal integrity, but in perceptions about their benevolence—whether they genuinely have the patient's best interests at heart. Here the perceptions of the others' motives and intentions are central: "Being supportive of our interests, communicating honestly and openly, and showing willingness to delegate decisions and share power of control with us, are all indicators of one's benevolence."⁷⁶ The positive or negative attributions that the parties make about each other's motives (either benign or sinister) reflects the level of trust or distrust they have in their relationship, which is fundamental to understanding the nature of their conflict.⁷⁷

In addition to identifying the parties' substantive issues and interests, an EC will often need to dig more deeply into whether the relational dynamics between the parties have triggered any identity-based needs. "These are people's needs to preserve a sense of who they are and what their place in the world is . . . [and include] the needs for meaning, community, intimacy, and autonomy."⁷⁸ For families and patients, the hospital setting is unfamiliar and can seem threatening. In illness, highly competent and capable individuals can feel vulnerable and dependent as patients. Their need to regain a sense of their former selves, or to feel respected by their providers, or even to gain connection with others in order to cope with the solitary experience of illness, may be contributing to a conflict. Similarly, families who are feeling powerless to help their loved one may be attempting to regain a sense of empowerment by controlling the providers' course of care. The hierarchical nature of health care institutions and providers' professional training can contribute to providers' efforts to protect their own sense of professional identity and competence, which can be challenged in conflicts. If identity-based needs are present yet unaddressed,

⁷⁵ *Id.* at 193.

⁷⁶ *Id.*

⁷⁷ Roy J. Lewicki, *Trust, Trust Development, and Trust Repair*, in *THE HANDBOOK OF CONFLICT RESOLUTION: THEORY AND PRACTICE* 96–97 (Morton Deutsch, Peter T. Coleman & Eric C. Marcus eds., Jossey-Bass 2d ed. 2006).

⁷⁸ BERNARD MAYER, *THE DYNAMICS OF CONFLICT RESOLUTION: A PRACTITIONER'S GUIDE* 19–22 (Jossey-Bass 2000). See also *infra* note 113 and accompanying text.

they may be contributing to problems in the relational dynamics between the parties.

Although *Getting to YES* recommends “separating the people from the problem” as an analytical matter for negotiating a conflict, it is frequently hard to do this as a practical matter because the relational and substantive issues are so often intertwined. The goal of attempting this separation is so the parties can determine how best to address both the people problems and the substantive ones, and begin to collaboratively attack the merits without attacking each other.⁷⁹ Relational dynamics are further explored in later sections of this article on values, communication, and emotions.

3. Procedural Issues

A key to successful ethics consultation is adopting fair procedures that can keep the “moral space” open for constructive dialogue among the parties.⁸⁰ Any of the four process models described earlier can serve this goal, depending on the circumstances of individual cases. The advice frequently given in the alternative dispute resolution literature is to “fit the forum to the fuss”⁸¹ — to adapt the process to the kind of conflict presented and the dispositions and goals of the parties. The *ASBH Core Competencies* reflects this advice: “ideally, a consultation service should vary the model used depending on the nature of the particular consultation request.”⁸²

⁷⁹ *Getting to YES*, supra note 69, at 12, 159.

⁸⁰ Margaret Urban Walker, *Keeping Moral Space Open: New Images in Ethics Consulting*, 23 HASTINGS CENTER REPORT 33 (1993); Susan Sherwin & Francoise Baylis, *The Feminist Health Care Ethics Consultant As Architect and Advocate*, 17 PUB. AFF. Q. 141, 145 (2003) (discussing Walker’s metaphor of ethics consultant as architect in “designing collaborative, fair and inclusive sites for moral deliberations and at building good ethical processes”).

⁸¹ Frank E.A. Sander & Stephen B. Goldberg, *Fitting the Forum to the Fuss: A User-Friendly Guide to Selecting an ADR Procedure*, 10 NEGOTIATION J. 49 (1994). More recently, scholars have promoted the importance of “fitting the forum to the folks,” recognizing that not all procedural methods are appropriate for all people in conflict. See, e.g., Timothy Hedeon, *Remodeling the Multi-Door Courthouse to “Fit the Forum to the Folks”: How Screening and Preparation Will Enhance ADR*, 95 MARQ. L. REV. 941, 944 (2012) (observing that “mediation may not fit disputes involving individuals (1) who are emotionally unprepared to discuss the conflict or negotiate consistent with their interests, (2) who are cognitively unprepared to represent their interests, take responsibility for actions, or make behavioral commitments, or (3) who are physically unprepared to participate in a sit-down, business-style meeting for an extended period.”).

⁸² ASBH CORE COMPETENCIES, supra note 7, at 19. See also Jean Abbot, *Difficult Patients, Difficult Doctors: Can Consultants Interrupt the “Blame Game”?*, 12 AM. J. BIOETHICS 18, 19 (2012) (finding that “many of the softer skills [e.g., reframing the problem, modeling curiosity about the patient, refocusing on goals, summarizing] that an ECS offers can be just as important and may make mediation unnecessary”); Arlene M. Davis, Michele Rivkin-Fish & Deborah J.

Some institutions, such as the M. D. Anderson Cancer Center in Texas, have adopted specific criteria to determine the appropriate method—individual EC, small team, or full ethics committee—for an ethics consultation.⁸³ Each method has its advantages and disadvantages.⁸⁴ In the absence of a formal institutional policy, however, the choice of both who (and how many people) will handle an ethics request and what process they will use (individual consult, coaching, facilitation, mediation, or other process) will often be a judgment call and will depend on a variety of considerations. The considerations can include the requestor's, team's or patient's/family's desires; the complexity of the ethical dilemma; how time sensitive the request is; how many parties' perspectives should be represented; whether institutional policies address the concern; whether there are legal or risk-management implications; the potential educational value of the case for others involved in ethics consultations at the institution; the level of emotional or moral distress of the parties; and the history of the relationships among the parties and their patterns of communication.

The specific procedural steps that an EC takes in an ethics consultation will also depend on such considerations. The *ASBH Core Competencies*⁸⁵ and others⁸⁶ have provided detailed roadmaps of the various stages and steps for undertaking an ethics consultation. In general, conflict specialists have encouraged starting with more informal processes before resorting to more formal ones, like mediation, as well as building in opportunities to be flexible and “loop back” to more informal processes as the parties en-

Love, “Difficult Patient” Dilemmas: Possible Alternatives to the Mediation Model, 12 AM. J. BIOETHICS 13, 14 (2012), at 14 (observing that beyond mediation, “facilitation, coaching, education, and advocacy may all be appropriate roles – separately or in combination – to help make transparent both the areas of conflict and the means to resolution.”).

⁸³ Martin L. Smith, Annette K. Bisanz, Ana J. Kempfer, Barbie Adams, Toya G. Candelari, & Roxann K. Blackburn, *Criteria for Determining the Appropriate Method for an Ethics Consultation*, 16 HEC FORUM 95 (2004).

⁸⁴ *Id.* at 96 (Table 1).

⁸⁵ ASBH CORE COMPETENCIES, *supra* note 7, at 10–18.

⁸⁶ Ellen Fox, Kenneth A. Berkowitz, Barbara L. Chanko & Tia Powell, *Ethics Consultation: Responding to Ethics Questions in Health Care*, NATIONAL CENTER FOR ETHICS IN HEALTH CARE OF THE VETERANS HEALTH ADMINISTRATION, available at http://www.ethics.va.gov/docs/integratedethics/Ethics_Consultation_Responding_to_Ethics_Questions_in_Health_Care_2007_0808.pdf (describing the CASES step-by-step approach to ethics consultation used throughout the VA system: Clarify, Assemble, Synthesize, Explain, Support); Robert D. Orr & Wayne Shelton, *A Process and Format for Clinical Ethics Consultation*, 20 J. CLINICAL ETHICS 79 (2009); DUBLER & LIEBMAN, *supra* note 14, at 47–72 (discussing eight stages of bioethics mediation); JONSEN, SIELGER, & WINSLADE, *supra* note 66, at 8 (four-quadrant chart).

gage with their conflict.⁸⁷ The guiding principle should be whether, by the end the process, the parties feel that they were heard and were dealt with fairly.

As part of the process of an ethics consultation, an EC will also have to consider whether to make a specific recommendation to the parties. In practice and philosophically, this has been an impressively controversial question in the ethics literature. The various answers that have been given to it include Yes, No, and Maybe (or, It Depends, or Sometimes). Perhaps reflecting the variety of conceptions of the EC's proper role discussed earlier, there is wide variation among ECs as to when or whether they provide a recommendation. A 2007 study found that some ECs recommend a single best course of action in a given case; others specify a range of acceptable options for resolution of the case among which the parties are left to choose; and others make no recommendation.⁸⁸ Making matters more complex, studies have shown widespread variability in the recommendations offered by ethics consultants in similar cases, suggesting a potential for arbitrariness depending on who the recommender is.⁸⁹

Commentators differ strongly over whether ECs should make recommendations to the parties. While some commentators have argued that ECs should not make a specific recommendation about the course of action the parties should take either because they do not have the moral expertise to determine what is "best" for the parties or because doing so threatens to usurp the decision-making authority of the rightful, ultimate decision makers in the case, others have argued that ECs should at least identify and exclude ethically wrong options for the parties.⁹⁰ Some would go further

⁸⁷ CATHY A. COSTANTINO & CHRISTINA SICKLES MERCHANT, *DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTHY ORGANIZATIONS* 59–60 (Jossey-Bass 1996); WILLIAM L. URY, JEANNE M. BRETT, & STEPHEN B. GOLDBERG, *GETTING DISPUTES RESOLVED: DESIGNING SYSTEMS TO CUT THE COSTS OF CONFLICT* 52–56, 62–63 (Jossey-Bass Publishers 1988). See also Charity Scott & Debra Gerardi, *A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard, Part 2*, 37 JT. COMM. J. QUALITY AND PATIENT SAFETY 70, 73–6 (2011).

⁸⁸ Fox et al., *supra* note 5, at 18.

⁸⁹ Ellen Fox, Frona Daskal & Carol Stocking, *Ethics Consultants' Recommendations for Life-Prolonging Treatment of Patients in Persistent Vegetative State: A Follow-Up Study*, 18 J. CLINICAL ETHICS 64 (2007) (discussing 2003 and 1991 surveys of ethics consultants for responses to a set of hypothetical clinical cases involving a patient in a persistent vegetative state and observing that there was low agreement on recommendations among the ethicists).

⁹⁰ E.g., Fiester (2011), *supra* note 48 (questioning both voting by ECs and their making recommendations as impermissibly "taking sides" in the parties' conflict); Orr & deLeon, *supra* note 22, at 28 (generally describing the range of viewpoints on recommendations, and stating

and suggest that an EC could apply ethical analysis to prioritize for the parties among ethically permissible options,⁹¹ in which case some would caution the EC to be clear with the parties that these are her own views and not usurp the ultimate decision maker's authority.⁹² Others suggest that when it is not clear what the ethically and legally permissible options are—i.e., in “unsettled cases”—ECs should at least share their own ethical analysis and conclusion to guide the parties,⁹³ and some would go further and make this conclusion an affirmative recommendation.⁹⁴ Others think that ECs should express their personal views when they have insights others may lack.⁹⁵ While permitting recommendations on a variety of things other than the central ethical dilemma in the case, the *ASBH Core Competencies* provides that the EC should be careful about recommending a single course of action if there is more than one ethically acceptable one, so as not to usurp the decision-making power of ethically and legally appropriate decision-maker.⁹⁶

that “we agree with Fowler’s assessment that the role of the ethics consultant is to exclude ethically wrong alternatives.”).

⁹¹ Orr & deLeon, *supra* note 22, at 28; Orr & Shelton, *supra* note 86, at 85.

⁹² Aulisio, *supra* note 54, at 351-352; ASBH CORE COMPETENCIES, *supra* note 7, at 9.

⁹³ David M. Adams & William J. Winslade, *Consensus, Clinical Decision-Making, and Unsettled Cases*, 22 J. CLINICAL ETHICS 310, 310 (2011) (“But, in unsettled cases, the role of a consultant should be expanded to include a process of moral inquiry into what the allowable options should be.”); William J. Winslade, *The Roles of the Ethics Consultant*, 22 J. CLINICAL ETHICS 335, 335 (2011) (“I would allow my analysis to speak for itself. But I would stop short of making a personal recommendation about the best option.”).

⁹⁴ David M. Adams, *Ethics Expertise and Moral Authority: Is There a Difference?*, 13 AM. J. BIOETHICS 27, 28 (2013) (in unsettled cases, the ethicist should reason “carefully with others about what the options *should* include, not just supplying information about what they *do* include”); David M. Adams, *The Role of the Clinical Ethics Consultant in “Unsettled” Cases*, 22 J. CLINICAL ETHICS 328, 330 (2011) (“To refuse to offer guidance in this way on an issue so difficult that even the legal, institutional, and practice standards of the community are unsettled would constitute an abandonment of parties faced with an issue of moral uncertainty.”).

⁹⁵ Edmund G. Howe, *When Should Ethics Consultants Risk Giving Their Personal Views?*, 16 J. CLINICAL ETHICS 183, 190 (2005) (“It is essential that ethics consultants express their views when they have insights others may lack. They should do this even when they fear they may be wrong. Doing anything else smacks of indifference.”).

⁹⁶ ASBH CORE COMPETENCIES, *supra* note 7, at 8–9. Accord, Ellen Fox, Sarah Myers & Robert A. Pearlman, *Response to Open Peer Commentaries on “Ethics Consultation in U.S. Hospitals: A National Survey”*, 7 AM. J. OF BIOETHICS W1, W2 (2007) (“consultants may make recommendations about a variety of things other than the central ethical decision in the case. . . . [it is permissible] to recommend against a behavior that falls clearly outside of legal and ethical standards. Thus while we agree that consultants should not usurp the moral authority of the appropriate decision makers, we disagree that consultants should not make recommendations.”); Tarzian, *supra* note 7, at 5 (stating that the “ethics facilitation approach does not preclude offering recommendations or expert opinions”). But see Autumn Fiester, *A Dubious Export: The Moral Perils of American-Style Ethics Consultation*, 27 BIOETHICS ii–iii (2013) (“When ECs

And finally, some argue that the whole point of an ethics consultation is to provide ethical guidance and thus an EC should always make a specific recommendation as to how the ethical matter should ultimately be resolved.⁹⁷

B. *Exploring Options*

Once the various substantive, relational, and procedural issues in the case have been identified, the EC can help the parties explore different options for resolution. This is an important and often difficult step, as the parties' positions may have hardened and their minds may seem closed to considering other options. The EC may start from the parties' perspectives and acknowledge that their respective positions are, indeed, options for resolving the case, and that they should also see if there might be other options which meet their respective interests and needs. The EC's role in generating these additional options can be key for the parties.⁹⁸ The *ASBH Core Competencies* makes identifying the range of allowable options in a case a primary responsibility for an EC.⁹⁹

At the initial stage of generating options, the EC might encourage the parties to refrain from judging each option until all have been put on the table for consideration. The EC should invite the parties to be both creative and open-minded in thinking about potential options and to withhold premature judgment, which can

render a judgment about which side is morally correct, they exceed the limit of their actual expertise.”).

⁹⁷ George J. Agich, *Joining the Team: Ethics Consultation at the Cleveland Clinic*, 15 HEC FORUM 310, 318 (2003) (“The ethics consultant’s primary responsibility is thus to address ethics issues and questions arising in the course of patient care and to make recommendations to the patient/family and the health care team.”); Evan G. DeRenzo, Nneka Mokwunye & John J. Lynch, *Rounding: How Everyday Ethics can Invigorate a Hospital’s Ethics Committee*, 18 HEC FORUM 319, 324–35 (2006) (“[W]e believe that it is our obligation to identify for the clinician the range of ethically permissible options and then assist him or her in identifying the ethically optimal path to pursue at that moment. . . . The practice of neutral provision of advice on a wide range of possible options simply does not meet clinicians’ needs.”); MEYERS, *supra* note 17, at 4 (advocating the approach that “ethicists should provide prescriptive recommendations as to what is the correct moral choice, or at least advice beyond determining which choices fall outside a morally acceptable norm.”); Rubin & Zoloth, *supra* note 35, at 222 (“Advice, not simply a facilitated exchange, is what is being sought and what ought to be promised.”). See *ASBH Liability Report*, *supra* note 9, at 13 (describing the “hard” model (make a recommendation) and the “soft” model (facilitate discussion, clarify the problem, raise issues, and make useful distinctions)). See also *supra* notes 17–19 and accompanying text.

⁹⁸ Fiester, *supra* note 48, at 369.

⁹⁹ ASBH CORE COMPETENCIES, *supra* note 7, at 8–9.

stymie the parties' efforts to work collaboratively in solving their problem. By encouraging such nonjudgmental brainstorming, the EC can frame the issues in a conflict as "problems" that the parties are invited to solve jointly.¹⁰⁰ Using *how* questions can be helpful: how can the patient's best interests be served? How can the team's limited resources be extended? How can family members decide upon procedures to come to consensus? Options can be explored either in a joint session among all the parties, or if the parties are uncomfortable exploring options in front of one another, the conflict-management technique of speaking to the parties in separate meetings, or "caucuses," can be used.¹⁰¹

There are two primary reasons to "separate inventing from deciding"¹⁰²—that is, to generate as many options as possible before settling on one of them. First, it is helpful for the parties to feel that their needs and interests have been heard and will be considered in the options; this allows them to suspend, at least for a time, their ardent commitment to one option.¹⁰³ Second, there will hopefully be options that can effectively integrate the various interests and needs of the parties, so that both sides can "win" in the ultimate resolution. Because of the parties' differences in their respective interests and needs, it may be possible to make them dovetail with each other (like in the story about the orange), so the parties find mutual gain in the resolution.¹⁰⁴

Finally, an EC may want to help the parties explore what the alternatives are if they cannot jointly agree on a course of action. In negotiation parlance, this means identifying each party's BATNA (or "Best Alternative to a Negotiated Agreement").¹⁰⁵ What happens if no agreed-upon resolution among the parties is reached? A patient or family who is threatening to sue if their preferred positions are not pursued may reflect a BATNA to bear the emotional and financial costs of litigation and have a judge resolve the matter one way or the other. The BATNA of a nurse who disagrees strenuously over a physician's decision on treatment may be suspension or firing if she does not carry out the physician's order. The BATNA of a physician who wants to provide treatment despite the objections of a patient or family may be to face discipli-

¹⁰⁰ MOORE, *supra* note 71, at 283–84.

¹⁰¹ *Id.* at 289–90.

¹⁰² GETTING TO YES, *supra* note 69, at 62–72.

¹⁰³ MOORE, *supra* note 71, at 271.

¹⁰⁴ GETTING TO YES, *supra* note 69, at 72–77.

¹⁰⁵ *Id.* at 102–08.

nary action if she does so. Once identified, exploring these BATNAs may help the parties assess their options realistically and gauge how motivated they are (or should be) toward finding a joint solution to the conflict. An EC can be helpful in “reality checking”: asking questions designed to nudge the parties into considering the practical feasibility, benefits, and costs of implementing their preferred positions. Generally, people can be expected to prefer outcomes that are better than their BATNAs.

C. *Respecting Reasons and Values*

Classic advice from the negotiation field is to assess the legitimacy of various proposed options according to a set of “objective criteria,” which are the norms, principles, and values which that may support different options for negotiating a deal or dispute.¹⁰⁶ Consistent with this advice, the *ASBH Core Competencies*¹⁰⁷ and others¹⁰⁸ advocate for the building of a *principled* resolution that falls within a range of allowable options. Four principles have long been considered foundational to bioethics decision-making: respect for patient autonomy; non-maleficence (not harming the patient, reflecting the maxim “Above all, do no harm”); beneficence (benefitting the patient, acting in the patient’s best interest) and justice (the fair and equitable distribution of care).¹⁰⁹ Other bioethics principles that have guided ethics consultations include truth-telling, privacy, confidentiality, and fidelity.¹¹⁰

What is an allowable option will depend on a variety of norms, including applicable law, prevailing medical practice standards, institutional policies, and generally accepted ethics principles or codes. Options that fall outside of widely accepted legal, medical, and ethical norms would not be considered allowable. In some cases, it may be unclear how to proceed when it is not established under applicable law and ethics what are, in fact, allowable options,

¹⁰⁶ *Id.* at 82–93.

¹⁰⁷ ASBH CORE COMPETENCIES, *supra* note 7, at 7.

¹⁰⁸ Nancy Neveloff Dubler, A “*Principled Resolution*”: *The Fulcrum for Bioethics Mediation*, 74 LAW & CONTEMP. PROBS. 177 (2011); DUBLER & LIEBMAN, *supra* note 14, at 14 (“A principled resolution is a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislature, and courts and that facilitates a clear plan for future intervention.”).

¹⁰⁹ TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 99–287 (Oxford University Press 6th ed. 2009).

¹¹⁰ *Id.* at 288–331.

as may occur in cases of first impression. Some have argued that in such a case, ECs should temporarily step out of a facilitative role in addressing a conflict and contribute their own perspectives and guidance on the ethical issues.¹¹¹

The parties may prioritize the allowable options differently in light of their different attitudes toward the norms that support the options. For example, while a physician may think the principles of beneficence (doing what is in the patient's best interest) and non-maleficence (not harming the patient) are the most important principles to consider in determining the patient's care, the patient or her family may believe that the patient's right to exercise autonomy and self-determination over the course of her care is paramount.

The major ethical principles in bioethics are only one kind of norms to be considered in ethics consultations. Wholly apart from these, the parties may have fundamentally different spiritual, cultural, or other values that they use to prioritize the options for the patient's care. In the context of health care decisions, the "reasons" supporting the parties' differing prioritization of the allowable options may not necessarily reflect "objective criteria" as classically contemplated in the dispute resolution literature. Yet the parties' reasons should be respected if they have validity within some legitimate sector of our pluralistic society in terms of providing criteria for fairness, morality, and justice. As the *ASBH Core Competencies* acknowledge, once the ethically and legally permissible options have been identified, if the parties cannot come to agreement, then the option chosen will be the one made by the party with the authority to make the ultimate decision.¹¹² In this circumstance, the EC can provide support to the other parties to help them accept the legitimacy of the decision, even if it is not the one, in light of their own values and norm priorities, they would have made.

¹¹¹ Adams (2011), *supra* note 94, at 328 (arguing that in cases where it is unclear what options are ethically allowable, "the ethics consultant should step outside the facilitation role by recommending to the parties which options he or she concludes ought to be regarded as allowable."); Adams & Winslade, *supra* note 93, at 322 ("In this kind of robust moral inquiry, the ethics consultant cannot put an array of allowed options on the table and let the parties debate and choose among them. Rather, the ethicist must facilitate a different and deeper kind of enquiry.").

¹¹² *ASBH CORE COMPETENCIES*, *supra* note 7, at 9–10. See also Jeffrey P. Burns & Robert D. Truog, *Futility: A Concept in Evolution*, 132 CHEST 1987, 1993 (2007) ("For the small number of intractable disputes that remain, we argue that our efforts should be directed more at finding better ways to support the patient's family and each other in providing care than in seeking to overrule the requests for care that we regard as unreasonable.").

Classic conflict-management cautionary advice is “never negotiate over values.” In the reality of health care settings, however, many conflicts that result in requests for ethics consultations reflect disagreements over fundamental values. Indeed, the *ASBH Core Competencies* describes the role of ECs in addressing “value-laden” conflicts. People have different values concerning the sanctity of life, the relief of suffering, the teachings of different faith traditions, the role of family and community in decision-making, and so on.

Moreover, many health care situations that give rise to ethics requests are ones that threaten the core identities of the parties—for example, the health care provider’s identity as a respected and competent professional; the patient’s identity as a self-sufficient and independent individual; or a family member’s identity as a protective parent or loving and caring son or daughter. Most difficult conversations are undertaken at three levels: (1) arguing over what happened – this is what the parties usually express their conflict about; (2) raising strong emotions, which will be discussed later; and (3) implicating issues of personal identity, self-image, and self-esteem, such as: Am I competent? Am I a good person? And am I worthy of love?¹¹³

Navigating values- and identity-based conflicts is often at the core of ethics consultations, and they pose special challenges. They can be more difficult to manage than largely interest-based conflicts, where generally people are able to weigh the benefits and costs of various options in ways considered more or less “rational.” Values-based disputes have been defined as “disputes in which the parties’ values and identities are so important to the dispute that they interfere with the parties’ ability to settle interest-based issues, or in more severe circumstances, even to proceed with the process of dispute resolution.”¹¹⁴ When a situation threatens one or more of the parties’ self-image or contravenes a long-held set of beliefs or values, which can easily happen given the life-and-death, culturally diverse setting of many ethics consultations, conflicts may appear to become intractable.

Conflict specialists recommend a number of approaches when conflicting values and beliefs are at stake. These include: (1) sepa-

¹¹³ STONE, PATTON & HEEN, *supra* note 70, at 3–20, 112.

¹¹⁴ Lawrence Susskind et al., *Teaching about the Mediation of Values-Based and Identity-Based Disputes: Teaching Notes to Accompany Three Role-Play Simulations*, PROGRAM ON NEGOTIATION AT HARVARD LAW SCHOOL 4 (2010), available at <http://www.pon.harvard.edu/shop/values-based-mediation-simulations/>.

rating consideration of the parties' interests from consideration of their values; (2) engaging the parties in dialogue that deepens their understanding of the others' values and beliefs; (3) appealing to overarching values that the parties have in common; and (4) confronting the value differences openly and truthfully and seeking reconciliation.¹¹⁵

Applying these approaches to an ethics consultation, first it may be possible for the parties to work and make progress on balancing the interests they each have in directing the course of the patient's care, which can form a foundation for tackling their values differences at a later time. Second, undertaking to engage the parties in respectfully discussing their differing values and beliefs may not result in resolution of their dispute, but it may improve the parties' empathy for, and deepen their understandings of, the others' perspectives sufficiently to lessen the tension in their relationship and allow them to move forward constructively.¹¹⁶ The goal of such discussions may not be to satisfy their interests, but rather to respect and honor their differences in such a way that they can understand, even if not necessarily agree with, each other.¹¹⁷

Third, one overarching value that usually all parties to an ethics consultation have in common is a concern for the welfare and best interests of the patient. Keeping that common value in the forefront can help move the parties toward seeing each other as collaborators in problem-solving rather than as adversaries. And finally, while "it does take a kind of therapeutic engagement to help parties confront others with diametrically opposed and deeply-held values and beliefs," it may be possible through a careful, truth-telling dialogue for parties to arrive at an accommodation and reconciliation in their relationship, even if compromise or resolution of the conflict is not reached.¹¹⁸

¹¹⁵ *Id.* at 6–11; Lawrence Susskind, *Mediating Values-Based and Identity-Based Disputes* (Frank Sander Lecture at the Alternative Dispute Resolution Section Meeting of the American Bar Association), *THE CONSENSUS BUILDING APPROACH* (Apr. 8, 2010), available at <http://theconsensusbuildingapproach.blogspot.com/2010/04/mediating-values-based-and-identity.html>.

¹¹⁶ Susskind et al., *supra* note 114, at 8 ("Empathetic understanding, on the other hand, goes deeper [than cognitive understanding of the other's point of view] and aims to promote a level of understanding that builds trust, reduces defensiveness, and potentially changes relationships.").

¹¹⁷ *Id.* at 9.

¹¹⁸ Susskind, *supra* note 115.

D. Communicating Well

As Franz Kafka wrote, "Writing prescriptions is easy, but, otherwise, communicating with people is hard."¹¹⁹ The medical literature has long recognized poor communication among health care providers¹²⁰ and advocated that they get more training in communication skills.¹²¹ Poor communication contributes to medical errors,¹²² stress and burnout,¹²³ and, of course, conflict.¹²⁴

¹¹⁹ Franz Kafka, *The Country Doctor* (1919), in *THE METAMORPHOSIS AND OTHER STORIES* 78 (Dover Publications, Inc. 1996).

¹²⁰ Andrew S. Dunn & Brian Markoff, *Physician-Physician Communication: What's the Hang-up?*, 24 J. GEN. INTERNAL MED. 437, 437 (2009); Wendy Levinson & Philip A. Pizzo, *Patient-Physician Communication: It's About Time*, 305 J. AM. MED. ASSN. 1802, 1802 (2011); David Maxfield, Joseph Grenny, Ramon Lavandero & Linda Groah, *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*, VITALSMARTS, L.C. (2010), available at <http://www.silenttreatmentstudy.com/index.html>; David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson & Al Switzler, *Silence Kills: The Seven Crucial Conversations for Healthcare*, VITALSMARTS, L.C. (2005), available at <http://www.silenttreatmentstudy.com/silencekills/>.

¹²¹ Anna Headly, *Communication Skills: A Call for Teaching to the Test*, 120 AM. J. MED. 912, 912 (2007); Wendy Levinson, Cara S. Lesser & Ronald M. Epstein, *Developing Physician Communication Skills For Patient-Centered Care*, 29 HEALTH AFFAIRS 1310, 1310 (2010); Mayme Marshall, *Placing the Patient at the Center of Care*, 6 PENN. BIOETHICS J. 16 (2010).

¹²² Milisa Manojlovich, *Nurse/Physician Communication Through a Sensemaking Lens: Shifting the Paradigm to Improve Patient Safety*, 48 MED. CARE 941, 941 (2010) ("Physician-nurse communication has been identified as one of the main obstacles to progress in patient safety. Breakdowns in communication between physicians and nurses often result in errors, many of which are preventable."); Kama Nagpal, Amit Vats, Kamran Ahmed, et al., *A Systematic Quantitative Assessment of Risks Associated with Poor Communication in Surgical Care*, 145 ARCH. SURG. 582, 582 (2010); Michelle O'Daniel & Alan H. Rosenstein, *Professional Communication and Team Collaboration*, in *PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES* 270-71 (R.G. Hughes ed., Agency for Healthcare Research and Quality 2008), e-pub 05/06/2011, available at <http://www.ncbi.nlm.nih.gov/books/NBK2637/> ("[C]ommunication failures are the leading root cause of the sentinel events reported to the Joint Commission from 1995 to 2004."); JAMES E. VANCE, *A GUIDE TO PATIENT SAFETY IN THE MEDICAL PRACTICE* 37 (American Medical Association 2008); *Project Detail*, JOINT COMMISSION CENTER FOR TRANSFORMING HEALTHCARE, available at <http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1> (The Joint Commission estimates that "80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off").

¹²³ Diane K. Boyle, Peggy A. Miller & Sarah A. Forbes-Thompson, *Communication and End-of-Life Care in the Intensive Care Unit: Patient, Family, and Clinician Outcomes*, 28 CRIT. CARE NURS. 302, 304 (2005) ("The consequences of unmet communication needs for families of ICU patients include dissatisfaction, lack of understanding, unmet goals of care, lack of trust and conflict with clinicians, increased feelings of burden, as well as guilt, anger, and regret."); Elizabeth G. Epstein & Ann B. Hamric, *Moral Distress, Moral Residue, and the Crescendo Effect*, 20 J. CLINICAL ETHICS 330, 337 (2009) ("[R]epeated experiences of moral distress indicate deeper, systemic problems of poor communication, inadequate collaboration, and perceived powerlessness resulting from hierarchical structures."); J. P. Quenot, et al., *Suffering Among Carers Working in Critical Care Can Be Reduced By an Intensive Communication Strategy on End-of-*

Many of the conflicts referred for ethics consultation result from miscommunication and misunderstandings. Good listening is the foundation for good communication, and it is essential for engaging effectively with conflict. In conflict, parties may seem not to be listening to one another. When one party complains that the other is simply not listening to what she saying, an EC might advise her to speak less and to listen more – and more carefully to what the other is saying. A core insight from the conflict-management field is that people won't listen until they feel heard.¹²⁵ When people feel that they have been heard and understood, they can become less defensive and feel less psychological need to block or deny what the other is saying; they can then become more open to listening.

The key to good listening is not simply good technique, however. It is attitude: actually caring what the other is saying.¹²⁶ Good listening (often called empathetic listening) involves turning off the internal voices in one's own head and focusing on understanding what the other is saying, not preparing one's reply to it. "Listening, even if focused and energetic, that is mostly motivated by a desire to debate, argue, convince, or discount, is likely to lead to further conflict and distance."¹²⁷ Gaining control over those internal voices, which are strategizing about how to respond to what the other is saying, is hard, because the desire to have the other understand one's own point of view before understanding theirs is powerful.¹²⁸ To deescalate conflict, an EC can help the parties to

Life Practices, 38 INTENSIVE CARE MED. 55, 55 (2012) (discussing relation between burnout syndrome and communication); Kevin B. Wright, *A Communication Competence Approach to Healthcare Worker Conflict, Job Stress, Job Burnout, and Job Satisfaction*, 33 J. FOR HEALTHCARE QUALITY 7 (2011) (discussing contribution of communication competence to lower levels of conflict, stress, and burnout).

¹²⁴ David M. Studdert et al., *Conflict in the Care of Patients with Prolonged Stay in the ICU: Types, Sources, and Predictors*, 29 INTENSIVE CARE MED. 1489, 1489 (2003) ("leading sources [of conflict in ICU] were poor communication (44%), the unavailability of family decision makers (15%), and the surrogates' (perceived) inability to make decisions (16%).").

¹²⁵ STONE, PATTON & HEEN, *supra* note 70, at 166–68 ("listening to them helps them to listen to you.").

¹²⁶ *Id.* at 168 ("[T]he heart of good listening is authenticity. . . . Listening is only powerful and effective if it is authentic."); MAYER, *supra* note 78, at 120–21 ("Good communication stems from intention not technique. . . . *Caring about what others are saying is the key to good communication.* . . . When people focus their attention, their energy, and their best listening and articulation skills on an exchange, others generally feel respected, even in the midst of conflict.").

¹²⁷ MAYER, *supra* note 78, at 127.

¹²⁸ STEPHEN R. COVEY, *THE 7 HABITS OF HIGHLY EFFECTIVE PEOPLE: POWERFUL LESSONS IN PERSONAL CHANGE* 239 (Free Press 2004) ("'Seek first to understand' involves a very deep

listen for genuine understanding, rather than for winning an argument.

There are numerous educational and training resources that can help an EC learn (and teach others) empathetic listening and good communication for handling conflicts. Some advice is given in acronyms or mnemonics.¹²⁹ Some advice is given in tables¹³⁰ and lists¹³¹ and as tips.¹³² And other resources survey opportunities for training¹³³ or go in-depth discussing both theory and practical

shift in paradigm. We typically seek first to be understood. Most people do not listen with the intent to understand; they listen with the intent to reply.”).

¹²⁹ E.g., Avonte Campinha-Bacote & Josepha Campinha-Bacote, *Extending a Model of Cultural Competence in Health Care Delivery to the Field of Health Care Law*, 13 J. NURSING LAW 36 (2009) (discussing LIVE & LEARN model of cross-cultural communication: Like, Inquire, Visit, Experience; and Listen, Essential cultural orientations, Acknowledge, Recommend, Negotiate); BILL EDDY, “IT’S ALL YOUR FAULT!”: 12 TIPS FOR MANAGING PEOPLE WHO BLAME OTHERS FOR EVERYTHING 219–37 (Janis 2008) (using EAR to deal with high-conflict people: Empathy, Attention, and Respect); U.S. Department of Defense Patient Safety Program, *Professional Conduct Toolkit, Professional Conduct Additional Resources, Tips and Tools for Connecting: PEARLA*, HEALTH.MIL 1–4 (2010), available at <http://www.health.mil/dodpatientsafety/ProductsandServices/Toolkits/ProfessionalConduct.aspx> (PEARLA: Presence, Empathy, Acknowledge, Reflect and reframe, Listen openly, and Ask); DUBLER & LIEBMAN, *supra* note 14, at 74–75 (STADA – Sit down, Tell me about Mama, Admire, Discuss, Ask).

¹³⁰ E.g., Anthony L. Back & Robert M. Arnold, *Dealing with Conflict in Caring for the Seriously Ill: “It Was Just Out of the Question”*, 293 J. AM. MED. ASSN. 1374, 1376 (2005) (identifying in Table 3 six useful communication tools for addressing conflict, including active listening, self-disclosure, explaining, empathizing, reframing, and brainstorming); Janice L. Dreachslin & Diane Kiddy, *From Conflict to Consensus: Managing Competing Interests in Your Organization*, HEALTHCARE EXECUTIVE 9–14 (Nov/Dec. 2006) (identifying in tables six main causes of conflict, five styles for resolving conflict, and five components of emotional intelligence at work); Mileva Saulo & Robert J. Wagener, *Mediation Training Enhances Conflict Management by Healthcare Personnel*, 6 (Insert Publication) 473, 479 (2000) (Table 5 identifying nine skills taught in mediation training, including active listening, summarizing, reframing, neutrality, balance of power, common positive, BATNA, reality testing, and SMART agreements).

¹³¹ E.g., Kathleen Novak & Christianne Hall, *Conflict Negotiation Guidelines*, HEALTH SYSTEMS 20/20 4-11–4-17 (2001), available at <http://www.healthsystems2020.org/content/resource/detail/1007/> (listing and briefly discussing ten effective communication skills – including active listening, questioning, stating interests, needs and goals, setting a constructive tone, acknowledging and validating the other’s perceptions, improving understanding, providing constructive feedback, deescalating tension, avoiding judging, criticizing and/or blaming, and overcoming negative history—and four steps to building working relationships).

¹³² E.g., Jay Harolds & Beverly P. Wood, *Conflict Management and Resolution*, 3 J. AM. COLL. RADIOLOGY 200 (2006) (discussing tips for solving conflicts); D.C. Saltman, N.A. O’Dea & M.R. Kidd, *Conflict Management: A Primer for Doctors in Training*, 82 POSTGRAD MED. J. 9, 12 (2006) (some tips for conflict management in Box 3).

¹³³ E.g., Rebecca L. Volpe, *Training Currently Practicing Members of the Ethics Consultation Service: One Institution’s Experience*, 22 J. CLINICAL ETHICS 217 (2011) (providing a road map for ethics consultants who would like more training, including in conflict resolution).

skills.¹³⁴ There is some evidence that training in communication techniques does improve skills in health care settings.¹³⁵ At bottom, however, the goal is not perfect technique; it is attitude. Someone can violate all the canonical rules of good communication—such as questioning, paraphrasing, reframing, summarizing, normalizing, acknowledging, and validating—and still be a good listener if she is genuinely motivated to understand the other party.¹³⁶

E. *Recognizing Cognitive Distortions that Impair Communication*

Recent medical literature reflects growing interest in the influence of heuristics (short cuts or rules-of-thumb used in decision

¹³⁴ For health care specific resources, see LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* (Jossey-Bass 1995); Edmund G. Howe, *Beyond the State of the Art in Ethics Consultation*, 20 J. CLINICAL ETHICS 203 (Fall 2009) (discussing communication guidelines for ethics consultations); Kenneth Kressel, Cheryl Ann Kennedy, Elise Lev, Louise Taylor & Jonathan Hyman, *Managing Conflict in An Urban Health Care Setting: What Do the "Experts" Know?*, 5 J. HEALTH CARE L. & POL'Y 364 (2002) (discussing research study of types of conflicts in hospital settings, causes of destructive conflict in hospitals, and strategies for intervention). For general conflict resolution resources, see TRICIA S. JONES & ROSS BRINKERT, *CONFLICT COACHING: CONFLICT MANAGEMENT STRATEGIES AND SKILLS FOR THE INDIVIDUAL* (Sage Publications 2008); CRAIG E. RUNDE & TIM A. FLANAGAN, *DEVELOPING YOUR CONFLICT COMPETENCE: A HANDS-ON GUIDE FOR LEADERS, MANAGERS, FACILITATORS, AND TEAMS* (Jossey-Bass 2010); URY, *THE THIRD SIDE*, *supra* note 70.

¹³⁵ Lauren M. Edelstein, Evan G. DeRenzo, Elizabeth Waetzig, Craig Zelizer & Nneka O. Mokwunye, *Communication and Conflict Management Training for Clinical Bioethics Committees*, 21 HEC FORUM 341 (2009) (discussing a training program being piloted at Washington Hospital Center); Ellen B. Zweibel, Rose Goldstein, John A. Manwaring, & Meridith B. Marks, *What Sticks: How Medical Residents and Academic Health Care Faculty Transfer Conflict Resolution Training from the Workshop to the Workplace*, 25 CONFLICT RESOL. Q. 321 (2008) (discussing study that found conflict resolution training can improve conflict management skills of health care professionals); Saulo & Wagener, *supra* note 130, at 481 (discussing how "study demonstrated that mediation training significantly increased health workers' comfort level with conflict . . . [and the] skills associated with mediation were transferable to the healthcare work setting.").

¹³⁶ MAYER, *supra*, note 78, at 120 ("If one person genuinely wants to understand what the other person is saying, and is willing to work at it, that intention will come through, despite behaviors that might not seem desirable. But all the good techniques in the world will not make up for a lack of genuine interest in what someone else has to say."); STONE, PATTON & HEEN, *supra* note 70, at 168 ("What will be communicated almost invariably is whether you are genuinely curious, whether you genuinely care about the other person. If your intentions are false, no amount of careful wording or good posture will help. If your intentions are good, even clumsy language won't hinder you.").

making) and cognitive biases on both patients¹³⁷ and health care providers.¹³⁸ Because such cognitive distortions can impair communication and impact decision making, an EC should be aware of some of the more common ones. The *framing effect* is well known, in which people make decisions based on how a question is framed. For example, people are more likely to choose treatments when they are framed in terms of a probability of living rather than in terms of a probability of dying.¹³⁹ Physicians and patients are also subject to *overconfidence* in the accuracy of their judgments.¹⁴⁰

In stressful situations, people naturally employ psychological defense mechanisms to protect their egos from being overwhelmed by information and emotions they cannot deal with in the moment. *Denial* is a common defense mechanism in the face of dire news about a loved one. *Intellectualization* is a defense mechanism, which can happen, for example, when family members become fixated on the details of ventilator settings, medication drips, and

¹³⁷ J. S. Swindell, Amy L. McGuire & Scott D. Halpern, *Beneficent Persuasion: Techniques and Ethical Guidelines to Improve Patients' Decisions*, 8 ANNALS OF FAMILY MED. 260 (2010) (identifying common biases and heuristics that may impede optimal patient decisions, including availability heuristic, gambler's fallacy, affective forecasting error, and sunk cost bias).

¹³⁸ Diana Burgess, Michelle van Ryn, John Dovidio & Somnath Saha, *Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology*, 22 J. GEN. INTERN. MED. 882 (2007) (discussing influence of stereotyping and implicit association bias); D. A. Freshwater-Turner, R. J. Boots, R. N. Bowman, H. G. Healy & A. C. Klestov, *Difficult Decisions in the Intensive Care Unit: An Illustrative Case*, 35 ANAESTHESIA AND INTENSIVE CARE 748 (2007) (discussing status quo bias, difficulty making decisions when given multiple alternatives, omission bias, availability heuristic, confirmatory bias, framing heuristic, technological imperative (desire to do something rather than nothing despite lack of evidence of efficacy, and ego bias and overconfidence)); Jill G. Klein, *Five Pitfalls in Decisions About Diagnosis and Prescribing*, 330 BRITISH MED. J. 781 (2005) (discussing the representativeness heuristic, availability heuristic, overconfidence, confirmatory bias, and illusory correlation (perceiving two events as causally related)); Abraham P. Schwab, *Putting Cognitive Psychology to Work: Improving Decision-Making in the Medical Encounter*, 67 SOCIAL SCIENCE & MEDICINE 1861 (2008) (discussing how imagination and explanation tasks bias judgments and behavior; the role of trust in decision making; affective forecasting and impact bias; framing effect; and overconfidence).

¹³⁹ Barbara J. McNeil, Stephen G. Pauker, Harold C. Sox, Jr., & Amos Tversky, *On the Elicitation of Preferences for Alternative Therapies*, 306 NEW ENGLAND J. MED. 1259 (1982). See also John M. Rybash & Paul A. Roodin, *The Framing Heuristic Influences Judgments About Younger and Older Adults' Decision to Refuse Medical Treatment*, 3 APPLIED COGNITIVE PSYCHOLOGY 171 (1989).

¹⁴⁰ D. A. Freshwater-Turner Klestov, *supra* note 138, at 757 ("Doctors generally significantly underestimate their probability of error."); Klein, *supra* note 138, at 782 ("Overconfidence also comes into play when doctors rate their clinical skills."); Schwab et al., *supra* note 138, at 1864 (discussing potential for patients to be overconfident in their own medical judgment and noting that "the bias of overconfidence—the systematic overestimation of the accuracy of judgment—has been demonstrated for over 30 years.").

other treatment markers.¹⁴¹ Such fixation can help the family avoid dealing with painful emotions about a dying patient, but if undetected by the health care team, it can turn to anger and resistance at any suggestion of stopping treatment. As George Agich has observed:

This problem is the result of a pattern of communication that is insensitive to defense mechanisms. It is often encouraged by young clinicians, who dutifully discharge their obligations with respect to informed consent by maintaining communication at a technical level never attaining a true comprehension by the family and thereby avoiding the emotional sphere where the potential loss of a loved one is located.¹⁴²

Other cognitive distortions have been less studied in the medical literature, but their influence is well known in the conflict-management field. *Attribution bias* is the tendency to attribute dispositional (e.g., personality traits) or situational (e.g., external conditions) characteristics to a negative event differently depending on whether we are the actor or another is the actor.¹⁴³ So for example, a doctor may attribute her lateness to a meeting as due to car trouble or administrative demands (situational factors), while attributing a patient's lateness to an appointment to the patient's laziness, disrespect, or incompetence (dispositional factors). *Primacy bias* is the tendency to overweigh the first information received in a fact-gathering process; an EC's initial impression of a problem may be anchored by the clinicians, who requested the consult and unduly influence her interpretation of later information.¹⁴⁴ *Reactive devaluation* is the tendency to devalue or reject a proposal on the basis of who proposed it, rather than on its merits ("if my adversary made the offer, it must be bad for me").¹⁴⁵ *Groupthink*—the tendency of small, cohesive groups "to maintain esprit de corps by unconsciously developing a number of shared

¹⁴¹ Agich, *supra* note 30, at 277.

¹⁴² *Id.*

¹⁴³ Russell Korobkin, *Psychological Impediments to Mediation Success: Theory and Practice*, 21 OHIO ST. J. DISP. RESOL. 281, 301 (2006) ("[P]sychological research shows that people tend to attribute the behavior of other people to disposition, rather than situation, to a greater extent than is warranted.").

¹⁴⁴ Jordan Silberman, Wynne Morrison & Chris Feudtner, *Pride and Prejudice: How Might Ethics Consultation Services Minimize Bias?*, 7 AM. J. BIOETHICS 32, 33 (2007). See also Waldman, *supra* note 48, at 419 (describing cognitive biases that can impair end-of-life decision-making, including catastrophizing (assuming that things are or will be worse than they actually are); all-or-nothing thinking (assuming that only extreme options exist); and overgeneralization (assuming that one negative experience can be broadly generalized to predict all other situations)).

¹⁴⁵ Korobkin, *supra* note 143, at 316–18.

illusions and related norms that interfere with critical thinking and reality testing”¹⁴⁶—could potentially distort how a health care team or ethics committee approaches decision making in a clinical case.¹⁴⁷

Patients who are facing significant future disability from illness or injury may refuse treatment or not cooperate in care because they believe they would “rather die than live like that.” There is a growing field in psychology called *affective forecasting*, which shows that people are poor predictors of their future emotional states. “Specifically, people overestimate the impact and duration of negative emotions in response to loss The overarching conclusion is that people fail to envision their own capacities to adapt to declines in health.”¹⁴⁸ Recognizing this cognitive bias can allow an EC and health care providers to address it through, for example, introducing the patient to a survivor of similar illness or injury who is functioning well in life. Seeing a peer who is coping well can alleviate a patient’s panic over her future disability and lessen her emotional distress so she is able to engage with her caregivers and her care more constructively.¹⁴⁹

The fields of cognitive and social psychology, behavioral economics, and neuroscience are significantly informing our understanding of human nature, human behaviors, patterns of thinking, and emotional lives. Research from these fields can provide ECs with important tools for navigating communication and conflict among providers, patients, and families. Unfortunately, it can be a daunting task for ECs to gain proficiency in these new arenas. While a number of recent popular books are both readable and helpful in learning more about these fields,¹⁵⁰ there is very little

¹⁴⁶ IRVING L. JANIS, *GROUPTHINK: PSYCHOLOGICAL STUDIES OF POLICY DECISIONS AND FIASCOS* 35 (Houghton Mifflin Company, 2d ed. 1982).

¹⁴⁷ Francis Dominic Degrin, *Difficult Patients, Overmedication, and Groupthink*, 20 J. CLINICAL ETHICS 64, 68 (2009) (“Healthcare institutions include all the precursors for groupthink – directive leadership, cohesive in-groups, periodic real or perceived threats.”).

¹⁴⁸ Jodi Halpern & Robert M. Arnold, *Affective Forecasting: An Unrecognized Challenge in Making Health Decisions*, 23 J. GEN. INTERN. MED., 1708, 1710 (2008) (“Research consistently shows that people fail to *predict* adaption, despite findings that, over time, most people are highly adaptive to states of disability.”).

¹⁴⁹ Jodi Halpern, *When Concretized Emotion-Belief Complexes Derail Decision-Making Capacity*, 26 BIOETHICS 108 (2012).

¹⁵⁰ E.g., Daniel Ariely, *Predictably Irrational: The Hidden Forces That Shape Our Decisions* (Harper-Collins Publishers 2009); DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* (Farrar, Straus and Giroux 2011).

research to date about bias and de-biasing techniques in the context of ethics consultation.¹⁵¹

F. *Dealing with Emotions*

Engaging with conflict means accepting the ongoing and inevitable presence of conflict in health care institutions. Emotions are similarly on-going and inevitable—you can't stop them and you can't ignore them—and they can be constructive (making it easier to meet substantive interests and enhance a relationship) or destructive (diverting attention from substantive matters and damaging a relationship) in resolving a conflict.¹⁵² Cases referred for ethics consultations often involve some of the most difficult decisions and heart-wrenching situations in people's lives, implicating questions of personal identity, disability, pain and suffering, grief, and death. Is it any wonder that emotions can run high and erupt into conflict?

An EC may need to address emotional issues before, or along with, engaging with the other substantive or relational issues in an ethics consultation and working on improving communication among the parties. Anger, hurt, fear, guilt, and frustration may be present on all sides, and these emotions can serve as catalysts for negative thoughts and beliefs about the situation and the other people.¹⁵³ At the outset of a consultation, an EC may need to allow the parties the time to "slow down and cool down."¹⁵⁴ Negotiation experts often refer to this as "going to the balcony"—a metaphor for how a negotiator might leave the "stage" of a difficult negotiation and go up to the "balcony" to view it from a more

¹⁵¹ Silberman et al., *supra* note 144, at 33–34.

¹⁵² FISHER & SHAPIRO, *supra* note 70, at 5–12 (discussing how emotions can positively or negatively impact negotiations); Halpern, *supra* note 149, at 111–12 (discussing role of emotions in determining what is salient as well as how beliefs connected to emotions may interfere with perceiving situations realistically).

¹⁵³ Halpern, *supra* note 149, at 111.

¹⁵⁴ Evelin G. Lindner, *Emotion and Conflict: Why It Is Important to Understand How Emotions Affect Conflict and How Conflict Affects Emotions*, in *THE HANDBOOK OF CONFLICT RESOLUTION: THEORY AND PRACTICE* 285–88 (Morton Deutsch, Peter T. Coleman, and Eric C. Marcus eds., Jossey-Bass 2d ed. 2006). See also MOORE, *supra* note 71, at 180 (noting that it may take up to twenty minutes for a person recover from a significant emotional event and that "brief breaks or short caucuses alone may not afford adequate time to physiologically or cognitively respond to severe emotional flooding.").

detached perspective, instead of reacting emotionally in the moment.¹⁵⁵

Allowing the parties to talk about their feelings is an option for an EC to consider. Expressing one's feelings can be a helpful first step to engaging with others constructively if it affords physiological release of tension, educates the other parties on the strength of one's feelings, and provides insight into the connection between the emotions and the conflicted issues.¹⁵⁶ Also, if it affords a sense that one has finally been heard, expressing emotions can enable a party to finally focus on the other party.¹⁵⁷ On the other hand, venting can make a bad situation worse.¹⁵⁸ An EC may thus choose to allow one party to express strong emotions separately, out of the hearing of the other, and may save joint sessions for when the parties are more able and willing to listen to each other.

Once someone can begin to listen to the other party, developing empathy for her can be crucial for understanding her. Empathy is emotional attunement, which allows greater understanding of another's emotional state and perspectives: "Empathy has as its goal imagining how it feels to be in another person's situation."¹⁵⁹ Empathy is not simply sympathy.¹⁶⁰ An EC, as a third party to a conflict, may be able to empathize more readily with the parties to a conflict than they with each other, if negative emotions towards each other have flared. If they are going to resolve their conflict, however, an EC should try to aid them in gaining needed perspective on themselves and on each other.

¹⁵⁵ URY, GETTING PAST NO, *supra* note 70, at 37–38.

¹⁵⁶ MOORE, *supra* note 71, at 173–75. See also STONE, PATTON & HEEN, *supra* note 70, at 137–46 (examining possible purposes for when—and when not—to express emotions and initiate difficult conversations).

¹⁵⁷ STONE, PATTON & HEEN, *supra* note 70, at 89 ("Unexpressed feelings can block the ability to listen.").

¹⁵⁸ FISHER & SHAPIRO, *supra* note 70, at 157.

¹⁵⁹ Jodi Halpern, *What Is Clinical Empathy?*, 18 J. GEN. INTERN. MED. 670, 671 (2003). See also FISHER & BROWN, *supra* note 70, at 47 ("Our understanding of another person's perceptions and interests will be inadequate unless it is empathetic – unless we know, to some degree at least, what it *feels* like to be in that situation. If we don't understand how others are feeling, our communication may suffer.").

¹⁶⁰ Jodi Halpern, *Empathy and Patient-Physician Conflicts*, 22 J. GEN. INTERN. MED. 696, 697 (2007) ("For sympathy, it is sufficient to resonate with another's general mood without becoming curious to learn more about another's particular point of view, whereas such curiosity is central to empathy."); Jodi Halpern, *Practicing Medicine in the Real World: Challenges to Empathy and Respect for Patients*, 14 J. CLINICAL ETHICS 298, 302 (2003) ("Physicians need to avoid projecting their own beliefs about how patients feel or ought to feel, to learn to distinguish empathy from sympathy.").

How can one emphasize with another with whom one is in conflict? While obviously people cannot force themselves to be empathetic, “they can cultivate an on-going practice of engaged curiosity.”¹⁶¹ This can include curiosity about one’s own feelings as well as about the perspectives of others about what is going on with the patient.¹⁶² Carefully eliciting all parties’ perspectives is key, because “[w]e can’t solve differences without understanding them.”¹⁶³ Borrowing from the field of anthropology, Arthur Kleinman recommends that physicians do this through a “mini-ethnography” approach, which entails asking a set of specific questions to elicit the patient’s perspective on her illness.¹⁶⁴ Commentators have recommended that ECs adapt Kleinman’s “explanatory model” approach and ask the same set of questions of patients and practitioners alike for a kind of cross-cultural comparison to understand the parties’ perspectives.¹⁶⁵ Health care providers, patients, and families may well use different models to explain what is happening in a given patient case, including scientific, psychological, practical, or spiritual explanations. As Kleinman observed, all of “these models—which can be thought of as cognitive maps—are anchored in strong emotions, feelings that are difficult to express openly and that strongly color one person’s reaction to another’s explanatory

¹⁶¹ Halpern, *Empathy and Patient-Physician Conflicts*, *supra* note 160, at 698; Halpern, *Practicing Medicine*, *supra* note 160, at 300 (“Patients respond well to physicians who are genuinely curious about them, and shut down when they feel they are being viewed in an overly generalized, stereotypical way.”).

¹⁶² Jodi Halpern, *Groupthink and Caregivers’ Projections: Addressing Barriers to Empathy*, 20 J. CLINICAL ETHICS 75, 77 (2009) (“By learning to process [negative] feelings, rather than project them outwards, and by helping each other recognize their blind spots towards patients, team members can engender an attitude of empathic curiosity about who that patient really is.”); Halpern, *Empathy and Patient-Physician Conflicts*, *supra* note 160, at 697 (discussing need for physicians to develop self-reflection and become curious about the meaning of negative feelings in themselves and their patients).

¹⁶³ FISHER & BROWN, *supra* note 70, at 65.

¹⁶⁴ ARTHUR KLEINMAN, *THE ILLNESS NARRATIVES: SUFFERING, HEALING AND THE HUMAN CONDITION* 230–44 (Basic Books 1988); Arthur Kleinman & Peter Benson, *Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It*, 3 PLoS MEDICINE 1673, 1674 (2006) (questions include: What do you call this problem? What do you believe caused it? What course do you expect it will take? How serious is it? What do you think it does inside your body? How does it affect your body and mind? What do you most fear about this condition and the treatment?).

¹⁶⁵ Michele A. Carter & Craig M. Klugman, *Cultural Engagement in Clinical Ethics: A Model for Ethics Consultation*, 10 Cambridge Q. Healthcare Ethics, 16, 23–25 (2001) (“By comparing and contrasting the patient and practitioner responses, the ethicist is able to demonstrate the differences in values, beliefs, and illness constructs, thus isolating the value dispute and paving the way for intercultural understanding.”).

models.”¹⁶⁶ When providers fail to acknowledge or respect the explanations that a patient or family members give for the patient’s illness and needs, it can generate just as much anger and frustration as when patients and families ignore or disregard the providers’ clinical explanations.

While an EC may be uncomfortable with the emotional tension of a conflict and thus be tempted to ignore the emotional undercurrents in an ethics consultation, this can backfire if by devaluing the parties’ emotions they feel demeaned or disrespected. They may react by digging into their positions more deeply. Parties in conflict have natural tendencies to react to each other by arguing, attacking, stonewalling, and resisting—all of which can escalate the conflict. Instead, negotiation expert William Ury recommends doing the opposite of these natural tendencies:

To disarm the other side, you need to do the opposite of what they expect So don’t pressure, don’t resist. Do the opposite: Step to their side If you want them to listen to you, begin by listening to them. If you want them to acknowledge your point, acknowledge theirs first. To get them to agree with you, begin by agreeing with them.¹⁶⁷

Given to one-on-one negotiators, this advice can also be helpful to ECs both in dealing with each party and with helping them to deal with other. No matter what procedural role an EC may have in an ethics consultation—whether coaching one party or acting as a neutral mediator—an EC who understands how to help manage and defuse the emotional dynamics in a conflict will go a long way in helping to resolve it.

Managing emotions can be facilitated by addressing certain core concerns which are at the heart of most emotional challenges, according to negotiation experts Roger Fisher and Daniel Shapiro: appreciation, affiliation, autonomy, status, and role.¹⁶⁸ When these core concerns are not met, a party may react with negative emotions, such as anger, anxiety, or resentment, which can in turn result in rigid thinking, deception, and uncooperative behavior. When they are met, the party may feel positive emotions, which in turn can lead to trust, openness, and a willingness to engage in collaborative problem solving.¹⁶⁹

¹⁶⁶ KLEINMAN, *supra* note 164, at 122.

¹⁶⁷ URY, GETTING PAST NO, *supra* note 70, at 54–55.

¹⁶⁸ FISHER & SHAPIRO, *supra* note 70, at 15–21.

¹⁶⁹ *Id.* at 19.

It is thus important for an EC to understand how these core concerns can be met in order to aid the parties in navigating their conflict. Fisher and Shapiro recommend the following ways to address some of these core concerns and thereby manage emotions and reduce emotional tension between the parties:

- 1) Express *appreciation* – help each party both to find at least some merit in what the other thinks, feels or does and to express appreciation for any legitimacy she can find in the other's thoughts, feelings, or actions, even if she does not agree with them.¹⁷⁰ A clinician may disagree completely with the family's wishes to continue aggressive treatment, but she can still express her appreciation for how much they love and are trying to do the best for the patient.
- 2) Build *affiliation* between the parties – help them find commonalities and build personal connections (e.g., by sharing personal stories and backgrounds).¹⁷¹ For an example in the context of an ethics consultation, Dubler and Liebman recommend sitting down with a family and invite them to begin the discussion by asking, "Tell me about Mama."¹⁷²
- 3) Respect *autonomy* – encourage each party to respect the other's interest in making and affecting decisions, however large or small. This is where it can be helpful to encourage the parties to contribute to brainstorming over options and to consult each other before deciding, no matter who may have the ultimate authority for the final decision.¹⁷³ It is not just patients or family members who can feel powerless or vulnerable in times of health crisis. Feelings of powerlessness can give rise to "moral distress" among caregivers, too, when they feel unable to act according to their core values and sense of professional responsibility.¹⁷⁴
- 4) Acknowledge *status* – everyone needs to feel self-esteem; recognizing high standing whenever it is deserved—for example, by asking advice—means finding the sphere of expertise each party has.¹⁷⁵ The doctor may be an expert in the medi-

¹⁷⁰ *Id.* at 25–51.

¹⁷¹ *Id.* at 52–71.

¹⁷² DUBLER & LIEBMAN, *supra* note 14, at 75.

¹⁷³ FISHER & SHAPIRO, *supra* note 70, at 72–93. *See also* FISHER & BROWN, *supra* note 70, at 92–95 ("ACBD: Always Consult Before Deciding").

¹⁷⁴ Connie M. Ulrich, Ann B. Hamric & Christine Grady, *Moral Distress: A Growing Problem in the Health Professions?*, 40 HASTINGS CENTER REPORT 20, 20 (2010) ("Moral distress . . . is the inability of a moral agent to act according to his or her core values and perceived obligations due to internal and external constraints."); Epstein & Hamric, *supra* note 123, at 331.

¹⁷⁵ FISHER & SHAPIRO, *supra* note 70, at 94–114.

cal sciences, for example, but the nurse may be an expert on what happened last night at the bedside or what the hospital's policy is, and the family may be an expert about the patient as a person.

Conflict specialist Christopher Moore has observed: "Feelings cannot be 'resolved,' as is the case with substantive or procedural problems or issues, but they can be regulated, managed, understood, and worked through to the point that they do not totally control participants."¹⁷⁶ The skills for helping the parties to manage their emotions are similar for helping them to improve their communication, such as active listening and asking open questions.¹⁷⁷ When an EC helps the parties transform their negative emotions toward each other into empathy and understanding of their different and often unspoken goals, fears, and desires, the EC can help to promote real healing, which is at the center of the therapeutic relationship in health care.¹⁷⁸

G. *Making and Implementing a Plan*

What is the conclusion to an ethics consultation? It will depend on the manner in which it was conducted, whether as a medical-model consultation, coaching, or large-group facilitation or mediation. At some point, the parties will have to move forward, whether or not consensus has been reached, and decisions will have to be made over the course of a patient's care. In all conflict-management processes, it is important that there be a clear plan of next steps that can be implemented. Even when agreement is not reached in an ethics consultation, a course of action can be determined by asking who the ethically appropriate decision-maker is.¹⁷⁹ Impasse may also be a sign that perhaps another process is better suited to resolving the conflict.¹⁸⁰ The *ASBH Core Competencies*¹⁸¹ and others¹⁸² have recommended that there be an institu-

¹⁷⁶ MOORE, *supra* note 71, at 172–73.

¹⁷⁷ *Id.* at 175–79.

¹⁷⁸ Halpern, *Empathy and Patient-Physician Conflicts*, *supra* note 160, at 698 (making this point in the context of encouraging empathy in doctor-patient relationship).

¹⁷⁹ ASBH CORE COMPETENCIES, *supra* note 7, at 9.

¹⁸⁰ DUBLER & LIEBMAN, *supra* note 14, at 15.

¹⁸¹ ASBH CORE COMPETENCIES, *supra* note 7, at 16–18.

¹⁸² K. A. Bramstedt, A. R. Jonsen, W. S. Anderreck, J. W. McGaughey & A. B. Neidich, *Optimising the Documentation Practices of an Ethics Consultation Service*, 35 J. MED. ETHICS 47 (2009) (describing method of documentation that promotes sharing of information in a case and

tional policy for when and how ethics consultations and their outcomes will be documented in the patient's medical chart and for follow up after conclusion of the process.

VI. SOME WORDS OF CAUTION: POWER IMBALANCES, CONFLICTS OF INTEREST, AND BIAS IN ETHICS CONSULTATION

It is challenging enough to navigate conflict within the framework just outlined. The task is made significantly more complicated by the power imbalances, conflicts of interests, and other biases that are embedded in ethics consultations. When patients and families are involved in ethics consultation, it is not a level playing field. They are at a significant disadvantage with respect to the health care providers in terms of knowledge, information, and emotional vulnerability in light of the illness that brought them to the hospital.¹⁸³ The *ASBH Core Competencies* acknowledges these power disparities, and cautions: "Failing to recognize the power dynamics in a consultation can make the situation worse by undermining the consultation process and eroding trust."¹⁸⁴

These power imbalances include the ECs themselves. Even if ECs do not perceive themselves as powerful within the institution, patients and families most likely do. Especially if someone on the health care team requested the consult, patients and families may see the EC—who is most likely employed by the hospital—as a member of the health care team and similarly threatening.¹⁸⁵ Perceptions aside, ECs do in fact wield considerable power in terms of their ability to impact patients and families. They have power over

enables quality improvement of and research on consultation practices); Nancy Neveloff Dubler, *The Art of the Chart in Clinical Ethics Consultation and Bioethics Mediation: Conveying Information That Can Be Understood and Evaluated*, 24 J. CLINICAL ETHICS 148 (2013) (discussing the importance of creating the chart note after an ethics consultation and the key elements that should be in it); Nancy Neveloff Dubler, Mayris P. Webber, Deborah M. Swiderski, et al., *Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation*, 39 HASTINGS CENTER RPT. 22, 26–28 (2009) (recommending inclusion of case consultation in patient's medical chart); DUBER & LIEBMAN, *supra* note 14, at 95–130 (providing detailed discussion and examples of how to write a bioethics chart note); Orr & Shelton, *supra* note 86, at 83–88 (describing a method for documenting an ethics consultation and giving examples of chart notes).

¹⁸³ Caplan & Bergman, *supra* note 48, at 342; Dubler & Liebman, *supra* note 14, at 25.

¹⁸⁴ ASBH CORE COMPETENCIES, *supra* note 7, at 15.

¹⁸⁵ Edmund G. Howe, *Ethics Consultants: Could They Do Better?*, 10 J. CLINICAL ETHICS 13, 15, 17–18 (1999).

resources and process (how decisions are made); power by virtue of their expertise; personal and institutional power due to their role and status within the institutional hierarchy; and even moral power because of the word "ethics" in their title.¹⁸⁶ In some cases, they have been granted legal powers by state law to make decisions affecting patients, despite being virtually unregulated by law or professional accreditation.¹⁸⁷ One study found that during observed ethics consultations, these asymmetries in power, status, and culture were sustained.¹⁸⁸ Ethics committees whose decision-making process entails voting among the members have particularly been criticized for creating "situations in which patients and family members are likely to be outnumbered and overpowered by dominant, and perhaps alien, culture of medicine."¹⁸⁹

Beyond the power disparities that can impact the outcomes of ethics consultations, conflicts of interests among providers and ECs alike can consciously and unconsciously influence the consultation process. Most individual ECs and members of ethics committees are either employed by the hospital they work in or have other financial or contractual relationships with it. Giles Scofield has somewhat caustically observed: "One need only ask who hires them, who they are accountable to, and what group they wish least to offend to appreciate how easily ethics consultants can lose the critical distance needed to exercise the independent, objective judgment they claim to possess."¹⁹⁰

ECs' institutional ties and professional ties to the clinicians with whom they interact daily create inevitable conflicts of interest that can affect how ethics consultations are handled.¹⁹¹ A patient's or family's desire for continued aggressive treatment, for example, may be at odds with the hospital's interest in reducing end-of-life care costs, which may influence an EC's perspective on withdrawal

¹⁸⁶ West & Gibson, *supra* note 45, at 66–67.

¹⁸⁷ Bethany Spielman, *Has Faith in Health Care Ethics Consultants Gone Too Far? Risks of an Unregulated Practice and a Model Act to Contain Them*, 85 MARQ. L. REV. 161 (2001-2002); Hoffman & Tarzian, *supra* note 15, at 51–63 (discussing lack of regulation of ethics committees and continued operation with minimum oversight and without legal standards).

¹⁸⁸ Kelly et al., *supra* note 15, at 145.

¹⁸⁹ Nancy Neveloff Dubler, Commentary on Fiester's "Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting", 22 J. CLINICAL ETHICS 373, 374 (2011).

¹⁹⁰ Giles R. Scofield, *Ethics Consultation: The Least Dangerous Profession?*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 420 (1993).

¹⁹¹ Christopher Meyers, *Clinical Ethics Consulting and Conflict of Interest: Structurally Inter-twined*, 37 HASTINGS CENTER REPORT 32 (2007); Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 276–92 (2009).

of life support for this patient.¹⁹² ECs may feel obligated to “settle” an ethics consultation and downplay patient rights in order to avoid the adverse publicity and costs to the hospital from a family’s going to court.¹⁹³ ECs may keep quiet despite strong ethical concerns in a case “for reasons of job security, collegial collaboration, or hope for advancement.”¹⁹⁴

Even beyond these institutional and professional power dynamics and conflicts of interest, ECs are (like everyone else) subject to a variety of personal biases based on social and economic status, educational background, and other influences. Such biases can be reflected in an EC’s philosophical outlook (most ethicists adhere to a post-enlightenment Western tradition of ethics);¹⁹⁵ in political leanings (a left-wing bias among academic bioethicists has been noted);¹⁹⁶ and in social class and cultural orientations (“white normativity” in the cultures of bioethics and medicine has been criticized for failing to account for widely pluralistic lay cultures and perspectives in our society).¹⁹⁷ Similarly, the assumption of unbiased neutrality among conflict resolvers in general has been questioned in the conflict literature.¹⁹⁸

¹⁹² Rasmussen, *supra* note 29, at 381. See also BERNARD LO, *RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS* 200–08 (Lippincott Williams & Wilkins 3d ed. 2005) (discussing incentives for physicians to decrease services).

¹⁹³ Spielman, *supra* note 187, at 189–93.

¹⁹⁴ Andrea Frolic & Paula Chidwick, *A Pilot Qualitative Study of “Conflicts of Interests and/or Conflicting Interests” among Canadian Bioethicists. Part 2: Defining and Managing Conflicts*, 22 HEC FORUM 19 (2010) (identifying “in-role” sources of conflicts (due to different roles with organization - e.g., consultant, policy resource, advocate, ethical leader - and different “clients” - e.g., patient, physician, organization, board, staff) and “out-of-role” sources of conflicts (involving personal interests such as job security, reputation, relationships with leadership, and personal values)); H. Tristram Engelhardt, *Healthcare Ethics Committees: Re-Examining Their Social and Moral Functions*, 11 HEC FORUM 87, 94 (1999); Meyers, *supra* note 191, at 38 (“Of the various kinds of intangible benefits (fame, prestige, promotion) [which can impact an EC’s judgment], among the more subtle and insidiously influential is *being accepted in the club*.”).

¹⁹⁵ Nancy S. Jecker, *New Challenges for Ethics Consultation: Combining Feminism, Multiculturalism, and Caring*, 17 PUBLIC AFFAIRS Q 83, 84 (2003).

¹⁹⁶ Griffin Trotter, *Left Bias in Academic Bioethics: Three Dogmas*, in THE ETHICS OF BIOETHICS: MAPPING THE MORAL LANDSCAPE 108–17 (Lisa A. Eckenweiler & Felicia G. Cohn eds., The Johns Hopkins University Press 2007).

¹⁹⁷ Catherine Myser, *White Normativity in U.S. Bioethics: A Call and Method for More Pluralist and Democratic Standards and Policies*, in THE ETHICS OF BIOETHICS: MAPPING THE MORAL LANDSCAPE 241–59 (Lisa A. Eckenweiler & Felicia G. Cohn eds., The Johns Hopkins University Press 2007); Laura S. Johnson, Jason Lesandrini & Grace S. Rozycki, *Use of the Medical Ethics Consultation Service in a Busy Level I Trauma Center: Impact on Decision-Making and Patient Care*, 78 AM. SURGEON 735, 739 (2012) (citing studies of cultural bias in approaches to end-of-life care and decision-making).

¹⁹⁸ JOHN WINSLADE & GERALD MONK, *NARRATIVE MEDIATION: A NEW APPROACH TO CONFLICT RESOLUTION* 36–37 (Jossey-Bass 2000).

Of course, ECs cannot simply and unilaterally eliminate these power imbalances, conflicts of interests, and personal biases.¹⁹⁹ They can strive, however, to be attuned to them as they go about their work. An EC's best defense against allowing these influences to impact a case consultation is in assiduously cultivating the skills of self-awareness and self-reflection, which indeed may be the hallmark of any professional practice.²⁰⁰ While interpersonal skills have been the focus of this article thus far, perhaps the most important skills in conflict engagement are intrapersonal: the ability to be self-reflective and self-aware of one's own behavior and its potential to contribute to or ameliorate a situation.

Such practices of self-reflection and self-awareness can contribute to ECs' ability to discharge their fiduciary duties, whether in law or as a matter of ethical obligation. The *ASBH Core Competencies*²⁰¹ assume and others²⁰² suggest that ECs stand in a fiduciary relationship to the parties in an ethics consultation. A fiduciary is someone who, through superior knowledge, skills or expertise, holds potential power and influence over another such that she is in a position to take unfair advantage of the other.²⁰³ Legally and ethically, the physician-patient relationship is a fiduciary relationship of trust and confidence, as is the lawyer-client relationship. Unlike sellers and buyers in arm's-length commercial transactions where caveat emptor is the rule, fiduciaries are subject to higher duties of care, loyalty, trust, and confidence to their vulnerable beneficiaries. They are also subject to legal and ethical restrictions

¹⁹⁹ DUBLER & LIEBMAN, *supra* note 14, at 82; ASBH CORE COMPETENCIES, *supra* note 7, at 48.

²⁰⁰ DONALD A. SCHON, *THE REFLECTIVE PRACTITIONER: HOW PROFESSIONALS THINK IN ACTION* 50, 61 (Basic Books, Inc. 1983) ("It is this entire process of reflection-in-action which is central to the 'art' by which practitioners sometimes deal well with situations of uncertainty, instability, uniqueness, and value conflict Through reflection, [a practitioner] can surface and criticize the tacit understandings that have grown up around the repetitive experiences of specialized practice, and can make new sense of the situations of uncertainty or uniqueness which he may allow himself to experience.").

²⁰¹ ASBH CORE COMPETENCIES, *supra* note 7, at 48 (referring to "consultant's fiduciary relationship to the parties in the consultation").

²⁰² Gordon DuVal, *Liability of Ethics Consultants: A Case Analysis*, 6 CAMBRIDGE Q. HEALTHCARE ETHICS 269, 272 (1997); Laurence B. McCullough, *The History of Medical Ethics Is Crucial for a Critical Perspective in the Continuing Development of Ethics Consultation*, 1 AM. J. BIOETHICS 55, 56 (2001); Jeffrey P. Spike, *Do Clinical Ethics Consultants Have a Fiduciary Responsibility to the Patient?*, 12 AM. J. BIOETHICS 13, 14 (2012) ("I would hold that we do have a fiduciary responsibility to the patient, and that is part of what is meant by our being *clinical* ethics consultants, not just ethics consultants.").

²⁰³ Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL'Y 331, 334 (2008).

that prevent them from putting their self-interests ahead of their beneficiaries' interests.²⁰⁴

The extent to which a health care institution, non-physician professionals and, by extension, ECs can be considered fiduciaries under law is unclear.²⁰⁵ Ethically, however, the assumption that ECs are fiduciaries, through their employment by the institution and their work with other professionals providing care, is supported by the principles of beneficence, non-maleficence, and fidelity (or loyalty) in health care. A fiduciary duty would oblige ECs to put patients' interests ahead of, not only their own self-interests, but also the interests of their health care institutions and others who work in them.

Doing so can be a challenging responsibility in light of the inherent power imbalances, conflicts of interests, and personal biases which were just discussed. As Dubler and Liebman have observed: "[I]f clinical ethics consultants are not sensitive, skilled, and experienced, consultations offer them opportunities to impose their own prejudices, ideologies, and values on patients and families under the guise of accepted bioethical solutions."²⁰⁶ Yet putting a beneficiary's interest ahead of one's own is the foundational duty of a fiduciary. Using fiduciary principles as a guide, ECs should practice self-reflection and self-awareness both to develop sensitivity to these power imbalances, conflicts of interest, and personal biases as well as to help guard against their adverse impact on both the process and the outcome of an ethics consultation.

VII. AN OUNCE OF PREVENTION

The best way to handle a conflict is to prevent it from arising in the first place. The next best way is to intervene in it early,

²⁰⁴ *Id.* at 334–51.

²⁰⁵ Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439, 484 (2009) (arguing for a legally-imposed fiduciary role for hospitals in the promotion of patient safety); Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF. L. REV. 715 (2011) (arguing that fiduciary obligations should be extended to all major participants in the health care industry). See also Paul M. Schyve, *Leadership in Healthcare Organizations, A Guide to Joint Commission Leadership Standards*, THE GOVERNANCE INSTITUTE (2009), available at http://www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf (discussing new hospital leadership accreditation standards and fiduciary obligations of leadership groups).

²⁰⁶ DUBLER & LIEBMAN, *supra* note 14, at xviii. See also ASBH CORE COMPETENCIES, *supra* note 7, at 9.

before it escalates. Studies show, however, that many health care professionals are reluctant to request a formal ethics consultation and may delay seeking help until the situation has become seriously conflicted.²⁰⁷ The solution is to have both well-trained individual ECs and a well-designed system for ethics consultation that is accessible, well run, and accountable.

Unfortunately, the knowledge, skills, and attributes needed to be an effective EC would make saints hesitate to apply for the job. The *ASBH Core Competencies* includes among its "core" competencies: (1) knowledge of moral reasoning and ethical theory, common bioethical concepts; health care systems; basic aspects of clinical medicine and care; hospital mission, structure, and policy; beliefs and perspectives of local patient and staff populations; relevant ethics codes and professional guidelines; and health law; (2) the skills to engage in ethical assessment and analysis; process skills (from facilitating meetings to teamwork to documentation); evaluation and quality-improvement; administrative skills to run a service; and interpersonal skills; and (3) such attributes as tolerance, patience, compassion, honesty, forthrightness, self-knowledge, courage, prudence, humility, leadership, and integrity.²⁰⁸

The nineteen primary abilities (only four of which related to ethics) that Washington Hospital Center identified in a recent recruitment effort for a full-time clinical ethicist are equally impressive and daunting. They included the abilities to:

[G]arner the respect of clinical leadership . . . tolerate gore and emotional and logistical chaos . . . identify and manage chaotic and dysfunctional organizational systems . . . tolerate having a daily/monthly/yearly list of unaccomplishable activities without

²⁰⁷ Louise Davies & Leonard D. Hudson, *Why Don't Physicians Use Ethics Consultation?*, 10 J. CLIN. ETHICS, 116, 118 (1999) (study reporting that physicians did not find ethics consultations useful); Gordon DuVal, Brian Clarridge, Gary Gensler & Marion Danis, *A National Survey of U.S. Internists' Experiences with Ethical Dilemmas and Ethics Consultation*, 19 J. GEN. INTERNAL MED. 251, 251 (2004) (study finding that some physicians "hesitated to seek ethics consultation because they believed it was too time consuming (29%), might make the situation worse (15%), or that consultants were unqualified (11%)."); S. A. Hurst, S. C. Hull, G. DuVal & M. Danis, *How Physicians Face Ethical Difficulties: A Qualitative Analysis*, 31 J. MED. ETHICS 7, 13 (2005) (finding physicians to be conflict avoidant and observing that "[e]thics consultation appears to be perceived as a last resort rather than as the primary source of help in cases of ethical difficulty."); J. P. Orlowski, S. Hein, J. A. Christensen, R. Meinke & T. Sincich, *Why Doctors Use or Do Not Use Ethics Consultation*, 32 J. MED. ETHICS 499, 501 (2006) (reasons doctors did not use ethics consultation included doctors' beliefs that it was their responsibility to resolve issues with patients and families; that ECs could not grasp the full picture from the outside; and that doctors were already proficient in ethics).

²⁰⁸ ASBH CORE COMPETENCIES, *supra* note 7, at 22–33.

becoming psychologically overwhelmed . . . face angry patients, family and friends, clinicians and administrators fearlessly while, simultaneously, being able to “bring the volume down” . . . have unimpeachable personal integrity . . . [and] be a “straight shooter” and not a “waffler.”²⁰⁹

Alongside these aspirational expectations for competency across a range of knowledge, skills, and personal attributes, however, are studies that show that many members of ethics committees have had little formal training or educational background in ethics.²¹⁰ With no accreditation system for clinical ethics education, no set of professional standards or conduct codes that ECs must adhere to, and wide variation in the backgrounds and training for ECs, concerns have been voiced about the level of competence among ECs. In response, some have called for more standardization in the training, education, and even professional credentialing of ECs.²¹¹ Historically the focus in ethics education and training

²⁰⁹ Nneka O. Mokwunye, Virginia A. Brown, John J. Lynch & Evan G. DeRenzo, *Hiring a Hospital Staff Clinical Ethicist: Creating a Formalized Behavioral Interview Model*, 22 HEC FORUM 51, 56–57 (2010).

²¹⁰ Fox et al., *supra* note 5, at 17; Diane Hoffmann, Anita Tarzian & J. Anne O’Neil, *Are Ethics Committee Members Competent to Consult?*, 28 J. LAW, MED. & ETHICS 30, 36 (2000). See also George J. Agich, *Clinical Ethics as Practice*, 20 J. INTERNATIONAL DE BIOETHIQUE 15, 20 (2009) (citing numerous commentators questioning the legitimacy of clinical ethics, who should be allowed to do ethics consultations, and the qualifications or credentials for being a clinical ethicist).

²¹¹ Cathleen A. Acres, Kenneth Prager, George E. Hardart & Joseph J. Fins, *Credentialing the Clinical Ethics Consultant: An Academic Medical Center Affirms Professionalism and Practice*, 23 J. CLINICAL ETHICS 156 (2012); Andrew Courtwright, *From Unregulated Practice to Credentialed Professions: Implementing Ethics Consultation Competencies*, 13 AM. J. BIOETHICS 16 (2013); Denise Dudzinski, *Education to Dispel the Myth*, 7 AM. J. BIOETHICS 39 (2007); James Andrew Hynds, *The Core Competencies: Addressing Yesterday’s Challenges?*, 13 AM. J. BIOETHICS 22 (2013); Kenneth Kipnis, *The Certified Clinical Ethics Consultant*, 21 HEC FORUM 249 (2009) (outlining considerations for how to go about certification and accreditation); Gerard Magill, *Quality in Ethics Consultations*, MED. HEALTH CARE & PHILOS. 1, 1 (May 25, 2013) (“the most serious concern that threatens quality in ethics consultations is the lack of a credentialing process.”); Henry J. Silverman, Emily Bellavance & Brian H. Childs, *Ensuring Quality in Clinical Ethics Consultation: Perspectives of Ethicists Regarding Process and Prior Training of Consultants*, 13 AM. J. BIOETHICS 29 (2013); Martin L. Smith, Richard R. Sharp, Kathryn Weise & Eric Kodish, *Toward Competency-Based Certification of Clinical Ethics Consultations: A Four Step Process*, 21 J. CLINICAL ETHICS 14 (2010); Jeffrey P. Spike, *Training in Clinical Ethics Consultation: The Washington Hospital Center Course*, 23 J. CLINICAL ETHICS 147 (2012) (advocating for a rigorous training program for ECs); Jeffrey P. Spike, *Who’s Guarding the Henhouse? Ramifications of the Fox Study*, 7 AM. J. BIOETHICS 48, 50 (2007); Dubler et al., *supra* note 182, at 29–32; Dubler & Blustein, *supra* note 57, at 36–37; Volpe, *supra* note 133. But see Lisa Rasmussen, *The Chiaroscuro of Accountability in the Second Edition of the Core Competencies for Healthcare Ethics Consultation*, 24 J. CLINICAL ETHICS 32, 35 (2013) (examining the problems with trying to hold consultants accountable to the standards set forth in the ASBH Core Competencies); Giles R. Scofield, *Ethics Been Very Good To Us*, 23 J. CLINICAL ETHICS 165, 166 (2012)

was on improving ECs' ethics background and their analytical skills. Increasingly, there has been a shift in focus to improving their clinical skills, many of which are the skills of a conflict manager. While there has been historic reluctance within the health care industry to adopt conflict resolution processes more generally,²¹² training in negotiation and conflict-management skills has been particularly encouraged for ECs.²¹³

As important as it is for ECs to be well qualified to handle individual cases, however, it is at least as important for hospitals to take a strategic approach to their EC service with an eye toward early intervention in, as well as overall reduction and prevention of, ethics and other value-laden conflicts across their units. Conflict specialists recommend that an opportunity for post-conflict feedback and evaluation of the program's effectiveness be built into the design of every conflict-management program.²¹⁴ A 2007 study showed, however, that most ethics consultation services lacked any mechanisms for evaluation and quality control of their services.²¹⁵ The *ASBH Core Competencies*²¹⁶ and others²¹⁷ have

("one cannot rule out the possibility that the move to accredit programs, and to certify and/or credential hospital ethics consultants, has more to do with protecting market share than it does with protecting patients and the public from the harm that supposedly could and pre-supposedly would befall them otherwise."); Fox, et al., *supra* note 96, at W2 ("[W]e have no real evidence the education leads to better ethics consultations outcomes, much less evidence about the types of education that are most effective."). ASBH has published an education guide for ECs: AMERICAN SOCIETY OF BIOETHICS AND HUMANITIES (ASBH) CLINICAL ETHICS TASK FORCE, *IMPROVING COMPETENCIES IN CLINICAL ETHICS CONSULTATION: AN EDUCATION GUIDE* (American Society for Bioethics and Humanities 2009). ASBH also has a standing committee, the Clinical Ethics Consultation Affairs (CECA) Committee, to explore such issues as certifying health care ethics consultants and/or accrediting programs that educate/train them; available at <http://www.asbh.org/about/content/committees.html>.

²¹² Edward A. Dauer, *Postscript on Healthcare Dispute Resolution: Conflict Management and the Role of Culture*, 21 GA. ST. U. L. REV. 1029, 1038–42 (2005).

²¹³ Robert Arnold, Mark Aulisio, Ann Begler & Deborah Seltzer, *A Commentary on Caplan and Bergman: Ethics Mediation – Questions for the Future*, 18 J. CLINICAL ETHICS 350, 352 (2007); Courtenay R. Bruce, Martin L. Smith, Sabahat Hizlan & Richard R. Sharp, *A Systematic Review of Activities at a High-Volume Ethics Consultation Service*, 22 J. CLINICAL ETHICS 151, 160 (2011); Hurst et al., *supra* note 207, at 12–13; Tapper et al., *supra* note 31, at 437 ("[O]ur data support a refocus on the skills that best address the most difficult conflicts, which in our series are conflicts that demand excellent communication and mediation skills.").

²¹⁴ COSTANTINO & MERCHANT, *supra* note 87, at 168–86; URY, BRETT, AND GOLDBERG, *supra* note 87, at 61–62, 80–81.

²¹⁵ Fox et al., *supra* note 5, at 19–20.

²¹⁶ ASBH CORE COMPETENCIES, *supra* note 7, at 34–46.

²¹⁷ Ellen Fox, *Evaluating Ethics Quality in Health Care Organizations: Looking Back, Looking Forward*, 4 AM. J. BIOETHICS, 71 (2013); Elisa J. Gordon, *A Better Way to Evaluate Clinical Ethics Consultations? An Ecological Approach*, 7 AM. J. BIOETHICS 26, 28 (2007); Elizabeth G. Nilson & Joseph J. Fins, *Reinvigorating Ethics Consultations: An Impetus from the "Quality"*

advocated that health care institutions begin to undertake more systematic and ongoing assessment, evaluation, and research of the quality, access, and efficiency of their ethics consultation services.

On a related note, there has been gathering momentum over the years toward taking a “preventive ethics”²¹⁸ approach to ethics consultation services, which mirrors similar trends in “preventive law”²¹⁹ and parallels the concept of “preventive medicine.” Having an EC regularly go on walking patient/teaching rounds in various hospital units²²⁰ or participating in ethics rounds held regularly after patient rounds²²¹ have been suggested as systematic processes for the prevention of, or early intervention in, ethics problems or conflicts. While dispute system design is a whole field unto itself,²²² there are an increasing number of resources available to help ethics consultation services consider different models for organizational design and quality improvement.²²³

Debate, 18 HEC FORUM 298 (2006); Deborah M. Swiderski, Katharine M. Ettinger, Mayris Webber & Nancy N. Dubler, *The Clinical Ethics Credentialing Project: Preliminary Notes from a Pilot Project to Establish Quality Measures for Ethics Consultation*, 22 HEC FORUM 65 (2010); Dubler et al., *supra* note 182, at 32 (recommending robust quality improvement process for ethics consultations services); Nilson et al., *supra* note 31, at 361. See also Agich, *supra* note 97, at 315 (describing quality improvement process for ethics consultation at one institution).

²¹⁸ Mary Beth Foglia, Ellen Fox, Barbara Chanko & Melissa M. Bottress, *Preventive Ethics: Addressing Ethics Quality Gaps on a Systems Level*, 38 JOINT COMM. J. QUAL. & PATIENT SAFETY 103 (2012); Lachlan Fottow, Robert M. Arnold & Lisa S. Parker, *Preventive Ethics: Expanding the Horizons of Clinical Ethics*, 4 J. CLIN. ETHICS 287 (1993); William A. Nelson, Paul B. Gardent, Eliza Shulman & Mark E. Splaine, *Preventing Ethics Conflicts and Improving Healthcare Quality Through System Redesign*, 19 QUAL. SAF. HEALTH CARE 526 (2010); Mark E. Splaine, William A. Nelson & Paul B. Gardent, *Editorial: Broadening Implementation of a Preventive Ethics Approach*, 38 JOINT COMMISSION J. QUAL. & PATIENT SAFETY 99 (2012).

²¹⁹ THOMAS D. BARTON, *PREVENTIVE LAW AND PROBLEM SOLVING: LAWYERING FOR THE FUTURE* (Vandeplas Publishing 2009); Edward A. Dauer, *Preventive Law Before and After Therapeutic Jurisprudence A Forward to the Special Theme Issue*, 5 PSYCHOL. PUB. POL’Y & L. 800 (1999). The National Center for Preventive Law is hosted at Cal Western School of Law, available at <http://www.preventivelawyer.org>.

²²⁰ Evan G. DeRenzo, Janicemarie Vinicky, Barbara Redman, John J. Lynch, Philip Panzarella & Salim Rizk, *Rounding: A Model for Consultation and Training Whose Time Has Come*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 207 (2006); Agich, *supra* note 97, at 313–31 (discussing weekly bedside ethics rounds and opportunities for earlier involvement before crisis occurs); DeRenzo et al., *supra* note 97.

²²¹ Boisaubin & Carter, *supra* note 37.

²²² See, e.g., COSTANTINO & MERCHANT, *supra* note 87; URY, BRETT, & GOLDBERG, *supra* note 87.

²²³ Foglia et al., *supra* note 218; Nelson et al., *supra* note 218. The National Center for Ethics in Health Care of the U.S. Department of Veterans Affairs has designed and implemented a preventive ethics approach for all of the 153 VA medical centers as part of an overall “IntegratedEthics” program, and it offers numerous free resources about the VA’s model of system design for health care ethics, available at <http://www.ethics.va.gov/integratedethics/pec.asp>.

VIII. ENGAGING WITH CONFLICT AS AN OPPORTUNITY FOR HEALING AND RELATIONAL TRANSFORMATION

The conflict-engagement approach to ethics consultation described in this article offers a framework for ECs to help health care providers, patients, and families address their differences, at least well enough for them to be able to move forward. Even when a problem or conflict has been addressed, however, some emotional and relational issues may remain unresolved, and may have even been the triggers for creating the conflict in the first place.

Not all ethics consultations will result in a repair of the parties' relationship. By the time an ethics consultation is requested, the relationship may have already suffered so much that it is all an EC can do to get the parties to tolerate each other long enough to implement a plan of action. Despite some research suggesting high levels of satisfaction with the ethics consultation process,²²⁴ one ethnographic study found that families were extremely angry about the proceedings and "[o]ne family member referred to the consultation as a 'big sham' in which the family had been 'railroaded.'"²²⁵ Similarly, some research suggests that after a mediation has been held, genuine relationship repair is the exception, not the rule.²²⁶

Nonetheless, every conflict in health care represents an opportunity to enhance the therapeutic relationship. It has often been said that the overarching purpose of ethics consultation is the improvement of the quality of patient care.²²⁷ Conflict will never be eliminated from health care settings, and it can be a healthy symp-

²²⁴ Lawrence J. Schneiderman et al., *Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial*, 290 J. AM. MED. ASSN. 1166 (2003) (study reporting 80% of patients/surrogates and 90% of physicians and nurses were satisfied with ethics consultation). See also Lawrence J. Schneiderman et al., *Dissatisfaction with Ethics Consultations: The Anna Karenina Principle*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 101, 105 (2006) (in a related study, reporting two factors associated with surrogate dissatisfaction: (1) "the difficulty family members have in accepting the limits of medicine and the inevitable mortality of a loved one," and (2) lack of follow-up contact).

²²⁵ Kelly et al., *supra* note 15, at 143.

²²⁶ Dwight Golann, *Beyond Brainstorming: The Special Barriers to Interest-Based Mediation, and Techniques to Overcome Them*, 18 DISPUTE RESOL. MAG. 22, 23 (Fall 2011) (in survey of leading mediators, finding that 17% of sixty cases resulted in relationship repair, while 83% did not and observing that "[e]ven when a repair effort was successful it usually did not achieve reconciliation, in the sense that the parties voluntarily wished to reconnect.").

²²⁷ John C. Fletcher & Mark Siegler, *What Are the Goals of Ethics Consultation? A Consensus Statement*, 7 J. CLINICAL ETHICS 122, 125 (1996); Peter A. Singer, Edmund D. Pellegrino & Mark Siegler, *Clinical Ethics Revisited*, 2 BMC MEDICAL ETHICS 1 (2001); ASBH CORE COMPETENCIES, *supra* note 7, at 3.

tom of an underlying problem that needs to be addressed. As The Joint Commission has acknowledged, when effectively managed, conflict can result in new and positive institutional changes that improve the quality of patient care.²²⁸ And as the *Getting to YES* authors have observed: "The challenge is not to eliminate conflict but to transform it. It is to change the way we *deal* with our differences."²²⁹

A therapeutic orientation should be central to the work of ethics consultation, regardless of the procedural format adopted in individual cases or whether agreement can be reached.²³⁰ Beyond offering the opportunity for the resolution of a question or conflict over the course of a patient's care, an ethics consultation offers a potential for the healing and relief of suffering of both the patient and all those who care for him or her, including caregivers and loved ones. The therapeutic potential of an ethics consultation thus extends beyond helping the patient to transforming the relationships among the parties who are struggling to do the right thing for the patient.

There is growing interest in whether the model of "transformative mediation" might be adapted in ethics consultation to create more positive and beneficial relationships among the parties.²³¹ Some in the conflict field see the potential through mediation not only for resolution of conflict, but also for "transformation" of conflict from a negative and destructive interaction to a more positive and constructive one.²³² Transformative mediation involves two dynamics: empowering parties by enhancing their sense of their own value and strength and their capacity to handle problems, and developing their capacities for understanding or empathy for the views of others.²³³

To promote the therapeutic potential for ethics consultation, the clinical ethics field may be enhanced by another trend in the mediation field that encourages eliciting the "stories" of the parties

²²⁸ The Joint Commission, *supra* note 3, at LD-12-LD-13, Introduction to Standard LD.02.04.01 ("Conflict commonly occurs even in well-functioning hospitals and can be a productive means for positive change.").

²²⁹ *GETTING TO YES*, *supra* note 69, at xiii.

²³⁰ Agich, *supra* note 26, at 15-16 (discussing therapeutic orientation of clinical ethics).

²³¹ Arnold et al., *supra* note 213, at 352 (discussing transformative and narrative models of mediation).

²³² ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, *THE PROMISE OF MEDIATION: THE TRANSFORMATIVE APPROACH TO CONFLICT* 21 (Jossey-Bass rev. ed. 2005).

²³³ *Id.* at 22, 53 ("In the transformative mediation process, parties can recapture their sense of competence and connections, reverse the negative conflict cycle, reestablish a constructive (or at least neutral) interaction, and move forward on a positive footing, with the mediator's help.").

to help them to see each other new ways before trying to address the immediately presenting conflict they find themselves in. John Forester borrows the format of a tribal “talking circle” to illustrate this re-orientation from a debate to a discussion during a conflict:

That is what we were trying for in this fellowship circle: thoughtful discourse, where I had the opportunity to tell you something about me, the way I see the world, the way I think about things, and you not being in “rebut mode” – where you’re sitting there poised to say, “Yes, but . . .” or poised to use what I am saying as a way of making your own point better — but instead to really see my world, see things from the vantage point that is mine and mine alone.²³⁴

In health care settings, where time seems constantly in short supply and professional training typically stresses efficiency over relationships, health care providers may feel more pressure, and may be more comfortable trying, to “fix” a problem rather than undertaking a time-consuming effort to explore the deeper values, identities, and worldviews of their patients and families. And yet particularly in ethics consultations involving conflicts with patients and family members, it can be more constructive for an EC to take a break from trying to solve the parties’ immediate problem and to offer “careful attention to their roots and their stories before ever turning to their demands.”²³⁵

The orientation toward “story-telling”²³⁶ or “narrative mediation”²³⁷ in the conflict field suggests that taking the time to allow the parties fully to tell their stories, including discussing what they deeply believe and who they are as individuals and helping them to understand each other’s perspectives, is time well spent and creates

²³⁴ JOHN FORESTER, *DEALING WITH DIFFERENCES: DRAMAS OF MEDIATING PUBLIC DISPUTES* 63 (Oxford University Press 2009).

²³⁵ *Id.* at 72.

²³⁶ Jennifer Gerarda Brown, *Peacemaking in the Culture War Between Gay Rights and Religious Liberty*, 95 IOWA L. REV. 747, 802 (2010) (discussing storytelling as being at the heart of mediation).

²³⁷ WINSLADE & MONK, *supra* note 198, at xi, 71 (“Narrative mediation is different from problem-solving approaches in its character and in its basic assumptions. It does not ascribe to the assumption that what people want (which gets them into conflict) stems from the expression of their inner needs or interests. Rather, it starts from the idea that people construct conflict from narrative descriptions of events. . . . [T]his means endeavoring right from the start to develop ways of speaking that invite relationship repairing and rebuilding, or at least promote a respectful encounter.”).

the potential for genuine reconciliation and transformation.²³⁸ This trend parallels the approach of “narrative ethics”²³⁹ for addressing ethical dilemmas in health care and of “narrative medicine”²⁴⁰ for listening to patients’ stories of their illnesses and the meanings they ascribe to them in order to provide better care for them.

IX. CONCLUSION

Ethics consultation is not simply about “doing the right thing” in medicine, ethics, and law. It is fundamentally about people, who reflect individual personalities, needs, and desires as well as enduring themes in human nature. It is about the values and motivations that brought them together in a health care system, whether to receive care or to provide it. When a conflict arises between them, an EC should fully engage with it, and help the parties to be constructively engaged with each other, in order to address questions, concerns, misunderstandings, and distress as well as to help them to envision the next steps in their future. While many people’s first impulse is to avoid conflict, a conflict resulting in an ethics consultation should be embraced as an opportunity to begin a conversation that deepens understanding and enhances the therapeutic relationship.

²³⁸ FORESTER, *supra* note 234, at 71 (“[W]hen we face value- and identity-based disputes, we need to mine stories, not sharpen debates. . . . [We should] take the ambiguity of value positions as an *invitation* rather than an obstacle to conversation.”).

²³⁹ Ansley Barton, *A Narrative Approach to Bioethical Decision Making: The Missing Link Between Bioethics and Conflict Management?*, 25 CONFLICT. RESOL. QUARTERLY, 497 (2008); Howard Brody, *Narrative Ethics and Institutional Impact*, 11 HEC FORUM 46 (1999); Rita Charon & Martha Montello, *Framing the Case: Narrative Approaches For Healthcare Ethics Committees*, 11 HEC FORUM 6 (1999); Anne Hudson Jones, *The Color of Wallpaper: Training for Narrative Ethics*, 11 HEC FORUM 58 (1999); J. McCarthy, *Principlism or Narrative Ethics: Must We Choose Between Them?*, 29 J. MED. ETHICS 65 (2003).

²⁴⁰ RITA CHARON, *NARRATIVE MEDICINE: HONORING THE STORIES OF ILLNESS* (Oxford University Press 2006); Kleinman, *Illness Narratives*, *supra* note 164.

