

Mediation

Story of a Mediation in the Clinical Setting

Haavi Morreim

ABSTRACT

Conflicts in the clinical setting can spiral downward with remarkable speed, as parties become ever more incensed and entrenched in their positions. Productive conversations seem unlikely at best. Nevertheless, such situations can sometimes be turned into collaborative problem solving with equally remarkable speed. For this to happen, those providing conflict-resolution services such as mediation need to bring, not just a set of skills, but also some key norms: the process must be voluntary for all; the mediator must abjure giving advice or taking sides, and must honor the privacy of privately offered thoughts.

This article describes a conflict that had reached the point of a hospital's requesting judicial coercion. However, a conflict-resolution process was then initiated that, in the end, led to amicable resolution and mended relationships, obviating the need for court orders. This article describes that conflict and the resolution process in detail, along the way annotating specific strategies that are often highly effective.

The following story is modified to protect privacy, but all the "moving parts" are preserved intact, just as they occurred.

Henry, now five months old, was born "floppy," with little to no muscle tone or reflexes. Although he did not have spinal muscular atrophy—which has a terrible prognosis—he had significant neurological deficits. Henry was gaining weight but he was thin, and although he could

move, it was not like a normal child. Mom and Dad took him to their pediatrician, concerned about a somewhat persistent dry cough and also wanting Henry to receive physical therapy and speech therapy to improve his feeding. "Let's get a swallowing study," suggested the pediatrician, "to see how well Henry sends food to his stomach rather than his lungs." In a swallowing study, barium (a contrast agent) is mixed with various kinds of food—thin liquid, thickened liquid, pudding, *et cetera*—and radiographic imaging captures where the food goes as the baby eats.

Henry "failed" at every phase. Per the speech therapist, he had severe dysphagia (difficulty swallowing). Per the pediatrician, it was time to implant a gastrostomy tube (g-tube) surgically, so that Henry could be fed directly into his stomach. Mom, shocked, resisted the idea vigorously. "Maybe in the future, but no! He doesn't need it now!" An argument ensued in which the pediatrician intimated that maybe he would need to call DCS, the Department of Children's Services. The doctor was serious. Henry needed this.

The test had been performed in the hospital and now, several days later, Henry's inpatient care was overseen by a hospitalist—a physician specializing in the general care of hospitalized patients. As the situation spiraled downward with increasing intransigence on all sides, Mom and Dad proposed that they could simply leave AMA—against medical advice. "We'll sign whatever documents are necessary, and then the doctors are 'off the hook' and won't be liable if anything goes wrong."

"No way are you taking this baby out of here!" responded the risk manager, posting two hospital security officers outside Henry's hospital room. In response, Mom and Dad "fired" the hospitalist. That evening at 10:30 p.m. the risk manager phoned the chief of social work at home, asking her to initiate proceedings to obtain a court order for the g-tube.

Haavi Morreim, JD, PhD, is a Professor in the Department of Internal Medicine at the University of Tennessee College of Medicine in Memphis. hmorreim@uthsc.edu.

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The next day I received a phone call from the social worker on Henry's floor.

What follows is a story of what I call "clinical-setting mediation." Not really bioethics mediation or even clinical ethics mediation,¹ but simply a mediation for a fairly commonplace clinical disagreement. As the mediator for this case, I tell the story in the first person because a more formal third-person narrative would seem stiff and artificial.

I like this story, not because it shows a mediator's brilliance, but because it does not. Virtually every move, as events unfolded, was Mediation 101. I think it shows well what mediators often teach: "design the process, then trust the process." As colleagues in clinical ethics reach further into the realm of conflict resolution and mediation, I hope it will be helpful to see what a fairly ordinary clinical mediation looks like, in detail. Here, the story as it developed will be offset by smaller type and blank lines, with intermittent discussions about process and method.

As the social worker described the situation to me over the phone, fairly quickly we gravitated toward some sort of conflict-resolution process. Only time would tell whether that would be just an informal conversation or two, or an everyone-at-the-table mediation, or something in between. I proposed that she first reach out to the physicians and then the family. Since the social worker was already familiar to everyone, she would briefly describe to them who I was and what I might offer, and inquire whether they were interested in chatting further with me. I coached the social worker a bit on how I preferred the idea to be presented—particularly, that my role was not to take sides or tell anyone what to do, but just to explore whether they might be interested in some sort of problem-solving conversation.

In the clinical setting, inviting people into a conflict-resolution process is the first and often one of the most important steps. It is the mediator's first opportunity to build trust and set the stage for a productive conversation. I find several guideposts helpful. First, the process must be voluntary for everyone throughout, including this first conversation to hear more about what I have to offer.² The goal of conflict resolution in the clinical setting is to explore whether a durable agreement can be forged. "Bullied acquiescence" is rarely durable, as witnessed by the many occasions in which a clinician "got the family to accept a DNR," only to find it repudiated shortly thereafter. Hence, "would you like to talk with this person" is an important beginning.

Second, it was important that the physicians be contacted first. They have a prior and fiduciary re-

lationship with patients and families, however frayed that may be, and it would be impertinent and potentially counterproductive even to appear to "sneak behind the physician's back" via conversations with patients and families before the physicians knew what was afoot.

Third, for logistical reasons, conflict resolution in the clinical setting will almost always be initiated by someone other than the mediator/conflict-resolution person. Mediators don't wander the halls mumbling "anybody wanna mediate?" Rather, someone familiar with this option will think of the idea and reach out. It thus becomes important to help clinical colleagues—whether physicians, social workers, nurses, chaplains, or others—become familiar with what conflict-resolution services do, and do not, offer. A few weeks after the mediation described in this article, I provided an in-service session for that hospital's social workers, to discuss the case and update them on this sort of opportunity.

Later that morning I went to the social worker's office. She managed to reach the pediatrician on the phone, which permitted a helpful, even if brief, conversation. I emphasized that it was not my role to tell anyone what to do, but simply to listen and explore whether there might be room for some problem-solving conversations. I offered no guarantees but indicated that, in my experience, the process is often surprisingly helpful. The pediatrician responded, "oh would you, please?" He felt terrible about how badly things had gone downhill, regretted having mentioned DCS so quickly, and was eager for an opportunity to pull this mess out of the fire. He also seemed glad that there was someone who would have, and take, the time to sit and listen to the family. I was not able to chat with the hospitalist right then, but the social worker had briefly reached her, and she was amenable to the idea. The social worker and I then headed over to Henry's room to chat with his parents, who had expressed eagerness to meet.

I knocked, stuck my head part way into the room, and said hello. A gentleman with them asked, "may we have a moment to pray?" whereupon I nodded "of course" and waited outside in the hall. He was the family's minister and when he emerged I shook his hand, introduced myself and explained my purpose in being there. A warm, gracious person, he liked the idea and suggested that perhaps this family might wish to meet another parishioner up on another floor, since their child had a g-tube inserted about a year earlier. I thanked him for what sounded like a fine idea.

Successful conflict resolution requires building trust at every step. Open minds and a collaborative spirit do not emerge from suspicion and wariness. Here, respect for the pediatrician's important relationship, plus an honest expression of empathy for

the difficult position he'd been in with the family's refusal, helped him to convey how distraught he was, including regrets about his own role in precipitating the situation. Similarly, a chat with the family's pastor was another opportunity to build trust. This was not a sly politician's vote-getting process, but rather a form of transparency that can help to avert potential misimpressions.

The social worker introduced me to the family and departed. I explained that I don't work for the hospital and emphasized that "I'm not here to tell anyone what to do." I did not describe any sort of formulaic process, but rather offered to have a few conversations. I indicated that in situations like these, families often feel as though they have not really been heard, then inquired whether Mom and Dad felt this way. Emphatically yes, they replied. I emphasized that what they say to me in private would remain private, meaning that I would not tell others what they said to me unless they wanted me to.

I asked whether they might at some point be interested in getting together with the two physicians, provided that I would be there as a sort of moderator. Mom and Dad were very amenable to the idea. I also explained that, although technically I am an attorney, I don't practice very actively and that my role would not be to serve as anyone's attorney or advocate. "My job is not to take sides, but just to see if I can help people to have a productive, problem-solving conversation." Most people actually do find common ground in these, I noted.

As above, the emphasis is on voluntariness throughout the process. Pushing often sparks push-back. And trust requires transparency. It would not help for Henry's parents to learn, after the fact from someone else, that I am an attorney, or to make assumptions about how I might use that training. It was likewise important to establish, more generally, that I would not help anyone to press their agenda on anyone else. This stance is what mediators usually refer to as neutrality, impartiality.

Although I was able to say, "I don't work for the hospital,"³ I recognize that many colleagues who might provide conflict-resolution services such as this could not make such a statement. Still, one can indicate that one is, for example, part of a conflict-resolution service whose independence has been assured by the way the service has been organized. Exact wording depends, of course, on how the service is actually chartered—an important issue that lies beyond the scope of this article.⁴

In addition to the mediator's independence and impartiality, privacy of conversations is also critically important. Indeed, confidentiality has long been one of the cornerstones of mediation and of mediation ethics.⁵ Participants need to believe they

are safe in telling the truth to the mediator. If Henry's parents were concerned that I would pass along to the doctors whatever they told me, they would likely be very guarded in their communication. Trust would be difficult to build, and I would not likely learn the "back stories"—the underlying events and concerns—that could heavily shape whatever resolution these parents might find acceptable.

Obviously there are some limits on privacy. Patient care decisions must, of course, be written into the medical record. And statements indicating serious intent to harm someone, or acts of child abuse, must be shared. However, generally I don't delve into all these exceptions at the outset unless I see specific reason to. Rattling off such a list would sound too much like a *Miranda* warning—not conducive to building trust. If at some point it seems like someone is about to say something that must be shared, the matter can be discussed at that point. In this case there was no plausible reason for concern.

In addition to fostering trust, the mediator must create a safe and hopeful atmosphere. Here, conveying to everyone the observation that most people, even those deeply enmeshed in conflict, actually find a workable agreement, can promote a note of optimism.

Henry's parents were eager to tell me about their experiences. I asked if it would be okay for me to jot things down as they spoke, so that I wouldn't miss anything important. Fine with them.

Overall, a major problem for the parents was a series of mixed messages. The doctors kept citing aspiration pneumonia as their biggest reason for the g-tube. But Henry had never had pneumonia, not once, so why the rush? Besides that, during the swallowing study, Henry was not in his usual feeding position. And for the last part he was slumped over falling asleep. So why are they so sure the study showed what he really can do? And after the test was done, Mom glimpsed the chest x-rays. She didn't see any river of milk flowing down into his lungs. Not at all. The report said something like "recent viral infection," not "aspiration." Aside from all that, here in the hospital they weren't letting the parents feed Henry at all with the bottle. He was only being fed by an NG (nasogastric) tube. But if it's so dangerous to give him a bottle, then why did the speech therapist give him a bottle right after the study? It made no sense. And then, when the surgery resident came to evaluate Henry, she expressed surprise at placing a g-tube for someone like Henry—she seemed to think it was premature.

The parents also were deeply upset about how they had been treated. The whole thing seemed like one big chain reaction. They were mandated, not asked, what to do. The doctors were looking at the textbooks . . . not at Henry. They had asked the doctors to state, in writing, that Henry would likely die soon without a g-tube. But

the doctors refused to do that. It seemed like they were just trying to avoid responsibility.

Mom and Dad were also worried about surgery. Because Henry still had poor muscle tone, anesthesia carried increased risk. It seemed to them that no one seemed to be taking that risk as seriously as they did. They were quite willing to let Henry have a g-tube when he genuinely needed it. But they were not at all persuaded that this was the time.

Our conversation lasted well over an hour, and the parents expressed gratitude that their concerns were being listened to carefully. I asked whether they were interested in meeting with the doctors to see if something could be worked out. I explained that I would be there, and described a bit more about the process. They were very willing, and I indicated that the social worker would probably help arrange the time and place.

I thanked them and returned to the social worker's office. At that point we were able to phone the hospitalist. The hospitalist, like the pediatrician, regretted very much how the whole situation had spiraled so badly downhill, and was glad for the chance to try to mend things. I then suggested to the social worker that we would need a comfortable conference room, ideally with the capacity to project images from the computer so that, if the occasion arose, we could all look at the swallowing study together. And of course we would need a laptop for the same purpose.

As things worked out, the next day I would meet with the two physicians at 10:30 a.m., followed by a meeting for everyone at 11:00.

Such "premediation" conversations are important for many reasons. They can de-escalate emotions significantly, as each person has the opportunity to be heard and taken seriously. Early conversations also enable the mediator to assemble at least a preliminary map of where the key issues lie, where there might be room for movement, and the points at which the people at the table might need some room for private conversation with the mediator. Mediators in litigation often use "caucuses," shuttling back and forth between the parties to carry messages, and sometimes to "lean" on one person or another to encourage compromise. Such a litigation-flavored approach has little or no place in the clinical setting, yet the opportunity for private conversations can be very important. They provide an opportunity for people to think out loud in a safe place where they will not be criticized, and to try ideas on for size and perhaps adjust their thinking, before an idea or observation is brought back to the common table.⁶

Two other things to note. First, I asked the parents' permission before I began taking notes. Successful conflict resolution requires many distinct micro-interventions, and asking for permission is

one of them. It helps to build trust by making clear once again that this process would be entirely voluntary, and that they would be treated with respect.

Second, although this particular situation eventually used a meeting with everyone at the same table, a conflict-resolution process in the clinical setting has no set format. It might be a series of one-to-one conversations, or a series of conversations with variable groupings of people.⁷ In this case the best strategy appeared to involve assembling everyone at the same time and place. Given the outlook and demeanor I had seen from each person, the prospects were good for a high-value exchange of information, leading to a reasonable resolution and perhaps rebuilding a relationship between them. That result is usually more likely if people can speak directly to one another, albeit with some assistance and perhaps coaching from the mediator.⁸

The next morning at 10:30 I returned to the social worker's office. The two physicians were there, along with the speech therapist, a college student who was shadowing the social worker, and the director of the social work department. I thanked them for coming and then turned to the student and the head of the department. While very much appreciating their interest and support, I indicated that the sheer number of people in the room can make a difference in a process like this, and it can be helpful if the family do not feel outnumbered. I encouraged them to remain for the rest of this preliminary conversation. They both accepted the idea graciously.

I asked the physicians—particularly the hospitalist, with whom I had only spoken briefly—what their primary concerns were, and we discussed them. I also let them know that, particularly early on, it might seem like the conversation was proceeding awfully slowly. The "method in the madness" of that, I indicated, was to help de-escalate emotions and set the stage for productive problem solving. I noted that, on the basis of yesterday's conversations, the parents seemed to have more flexibility than had been initially evident. After we chatted, I left to have a few minutes with the parents before we gathered in the conference room.

Determining who belongs in the room, particularly when people in conflict will be speaking directly with each other, is an important process question. I did want to include the social worker, whom the parents trusted, and the speech therapist who, like the physicians, would likely have useful information to share. (Little did I realize at the time, the speech therapist would hold something of a "key" that would open the problem-solving phase nicely.) On the other hand, from a process standpoint, the college student would be just an extra person in the room. And the director of social work could add an

aura of authority that the parents might regard as a power move.

Describing a bit of the process in advance—here, that it would start somewhat slowly—exemplified two important tools of mediation. First, it was “managing expectations” so that the physicians would not begin to think this was a waste of time. Second, “start slow to go fast” captures the reality that, when adequate time is used to de-escalate emotions and build trust for the process and for the mediator, people in conflict are usually better able to engage in a problem solving that, once begun, can proceed with remarkable speed. In sum, mediation requires strategy at every point.

I entered Henry’s room. His parents had been exploring options and they were eager to tell me. Dad’s sister was an emergency medical technician and would be willing to come to their home daily, as part of a program of intensive monitoring. If Henry showed signs of aspirating, they would be willing to consider a g-tube. They recognized that it might one day be necessary. Their main hesitation was whether that day was now.

I then presented an idea for their consideration. “Sometimes,” I said, “it can be helpful when people hear things through a different voice. When we talked yesterday I heard about a number of mixed messages you’ve had. So here’s my idea. Suppose I were to start out the session by describing those mixed messages to the doctors. I wouldn’t be doing this as your advocate, as you know. But sometimes it can be helpful for people to hear things through someone else’s voice. You’d be right there and can put in any additions or corrections, whenever you want. This is totally your call—what do you think?” I reviewed the list of mixed messages I’d heard. They affirmed the list and liked the idea. We left for the conference room, stopping by the social worker’s office to gather up the rest of the group.

As noted, “a different voice” was offered as an idea for their consideration, not even as a suggestion. I made it clear I would embrace their decision, whatever it might be. Also of note, this was an idea about process, rather than a suggestion toward the substance of an agreement. As often taught in “Mediation 101,” the mediator is the guardian of the process. We are not there to dictate the outcome, but we do bring skills to guide the process as effectively as we can.

As we got to the conference room I realized I’d left my laptop in the patient’s room. The hospitalist offered to come with me, as her badge would allow us expedient passage through otherwise closed areas. We chatted en route, and I asked her whether time-limited trials were ever an option in a situation like this. She indicated that, under certain conditions, that might be a possibility.

The exact wording of such a question is important. I did not say “have you thought about a time-limited trial?” That would have been at best a suggestion, at worst an implied criticism. Rather, it was framed as an inquiry of genuine curiosity—a request to be educated. Overall, mediation in the clinical setting needs to be facilitative rather than evaluative: assist people to come to their own resolution, rather than suggest to them the outcome the mediator considers most reasonable. Otherwise, in these highly contentious situations, the mediator becomes “just another pair of fists in the fight”—not helpful for maximizing the likelihood that people in conflict will reach an agreement they genuinely embrace and will honor. At the same time, this question was a form of “priming.” Priming involves quietly introducing concepts that can predispose parties to think, or at least consider, moving in certain directions.⁹ It can place on the table an idea that otherwise might not be there. Parties are free to do with it as they please.

We fetched the laptop and returned to the conference room. Mom placed her cell phone on the table and asked whether it would be okay for her to record the session. I responded that, on one hand, it was important for people to speak freely, and that some people might feel a bit inhibited if a recording were being made. At the same time, I ventured that it would be important to make sure that whatever agreement they reach is captured clearly. I proposed that, when the parents and physicians arrive at a plan for going forward, I would be happy to write it up in my computer and pass it around for everyone to see and suggest any changes. Then when everyone was in agreement, we could print up a copy for everyone.

Mom’s overriding concern was to ensure that she would not be trapped in a situation of mutual “that’s not what I said—I never agreed to that!” Writing up the agreement honored that important need, even while preserving the overall privacy of the conversation.

As we began, I noted that in these conversations people almost always learn things they had not previously known, and that views usually evolve in the face of new information. I expected that this would happen today, too, and that on the basis of my conversations with everyone, I was quite confident that a good agreement could be reached.

I explained that the parents had received a number of mixed messages. I offered to describe them, not as an advocate, but simply to let them be heard through a different voice. With assent by all I began the description. At some point thereafter Mom and Dad spoke about the swallowing study. The hospitalist offered a reply and I asked if it might make sense to look at the images. The hospital-

ist retrieved them on the laptop. I couldn't manage to bring them up on the projector, but things worked out even better as everyone gathered around the laptop. Literally, the parents and physicians stood side by side, looking together at the problem.

The hospitalist pointed to various features—micro-aspirations leading to bronchial thickening and the like—noting that this explained Henry's persistent dry cough. She discussed the long-term concerns of continuing to expose the lungs to small amounts of inhaled feeds. She also indicated that, among her two dozen patients on g-tubes, some were also able to feed orally, and a couple were about to "graduate" from the g-tube. She added that, the better the nutrition, the better the child can benefit from physical therapy and other services. Conversely, fighting constant micro-aspirations consumes a heavy load of calories that, with a better nutrition route, would be directed instead toward Henry's physical development. The hospitalist also described the potential role of reflux in Henry's condition, indicating that some of Henry's micro-aspirations may well come from reflux (food coming back up) rather than from improper swallowing. Because of this, g-tube surgery often included a "Nissen fundoplication" to stop the reflux.

Everyone at the table, in essence, had a "do-over" on the conversation about the swallowing study and what it meant.

This phase of the mediation used several traditional mediation techniques. Observing, at the very outset, that new information was likely and that views usually evolve, was another example of priming. It gives people permission to change their minds while preserving their dignity. And a genuine expression of optimism helped to create a safe and hopeful space for productive conversation. Finally, standing side by side, looking together at the radiographs, is an example of a classic mediation strategy: focus on the problem, not the people.¹⁰ Instead of dwelling on mutual distrust and disrespect for each other, parents and physicians alike now turned toward concrete facts, problem particulars, and the specific interventions that might address them.

Henry's parents had not previously linked the importance of nutrition with the opportunity to maximize the benefits of physical therapy, nor had they been aware that Henry might be able to eat orally even while on the g-tube, and perhaps one day to return to fully oral nutrition. At that point the speech therapist said, "sometimes before we decide whether a g-tube is needed, we do an in-house trial, typically for a week or so, in which a nurse or physician listens to the baby's chest before, during, and after feeds." The parents liked the idea, but expressed concerns that their insurance might not support such a lengthy inpatient stay.

Further discussion constructed three options: (1) there could be a three-day trial in the hospital with oral feeds,

no nasogastric tube, and intensive monitoring, listing specific criteria that could end the trial and insert a g-tube; (2) the swallow study would be repeated, with Henry placed in a more favorable feeding position; (3) Henry would have an upper gastrointestinal study and a pH probe (measures acid reflux in the esophagus), tests that would need to be done anyway, for a g-tube.

I wrote them in my laptop and passed it around for everyone to review, to ensure that it captured their agreement correctly. Since everyone owned a computer, printouts would be unnecessary. I emailed the agreed-upon list of options to everyone at the same time, using Bcc: (blind carbon copy) to protect the privacy of each person's e-dress. The parents would review the options and convey their choice later that day.

That afternoon they chose the g-tube.

Epilogue: The next morning Mom asked the social worker whether perhaps she might be allowed to serve as a "parent mentor" to help other parents whose children were receiving a g-tube.

As I noted at the outset, this mediation did not exemplify any particular brilliance on my part. It relied on conflict-resolution tools familiar to mediators. The process is highly intentional at every point and, particularly in the clinical setting, seeks at every turn to build trust, empower the people at the table, and create a setting in which problems can be solved not by some outside "expert," but by those who are most deeply affected.

As discussed elsewhere,¹¹ ethics committees could be well-situated to provide healthcare institutions with a conflict-resolution service. Importantly, mediations such as that described here need not and should not be such a service's sole offering. Conflict resolution spans a panoply of services. Sometimes, for instance, the most important thing to provide is coaching. A resident or colleague about to undertake a difficult disclosure may benefit from the opportunity to discuss and strategize the conversation in advance, with someone who is trained in the skills of difficult conversations. In another instance one might simply offer a "sounding board" to help someone think through what s/he values most, what options make most sense.¹²

Also as discussed elsewhere,¹³ conflict-resolution services would need to be carefully distinguished from traditional ethics consults that produce an advisory regarding what the requestor "ought" to do. To be sure, a good consult often begins by uncovering communication misfires, a need for further information and the like. Often when such matters are unearthed and addressed, the apparent problem disappears. This is why the American Society for Bioethics and Humanities strongly (and soundly) recommends that ethics consultants have training in skills of facilitation.¹⁴

However, mediation such as that described here differs fundamentally from a traditional ethics consult. At some point, if an issue still lingers after the traditional ethics consultant addresses communication issues and the like, s/he is ordinarily expected to say “I recommend X” or “I suggest that X, Y, or Z are ethically appropriate options.”

That last step formally forswears the impartiality that is essential to mediation, and which sits as a bedrock for trust. One cannot say, at the outset, “I’m not here to tell anyone what they should do,” and then later opine that “well, since you couldn’t decide for yourselves, I’ll now tell you that really I think you ought to do X.” At that point the mediator has renounced a commitment and betrayed trust.

This is not to say that there is no room for traditional ethics consults. Mediation is not necessarily appropriate for every issue—not even for every conflict—and is not necessarily suited for every person. But once begun, the process must be respected. If somehow a mediation does not yield an agreement among those in conflict (uncommon, but not unheard of), and if some sort of advisory is needed, then the mediator should offer parties the option of a traditional consult. The mediator should not, him- or herself, become that consultant, but rather must refer the case to a consultant colleague.

At the same time, it can be entirely appropriate for an ethics committee to offer both kinds of service, so long as they are understood to be distinct. After all, resolving conflict is a form of preventive ethics. As emphasized in a recent discussion about disputes over end-of-life treatment, “most disagreements in ICUs arise not from intractable value conflicts but from breakdowns in communication that are amenable to communication interventions. . . . conflicts typically develop and worsen over time as communication breaks down and parties become entrenched in their positions.”¹⁵ On the whole surely it is better, whenever possible, to resolve such matters thoughtfully and by agreement than by a kind of vote taking that often leaves some people triumphant at the expense of others’ distress.

NOTES

1. Nancy Dubler and Carol Liebman introduced the concept of “bioethics mediation” in the 1990s, greatly enhancing the options for ethics consults. See N. Dubler and C. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (Nashville: Vanderbilt University Press, 2011). “Clinical ethics mediation,” covering roughly the same scope, likewise refers to techniques of conflict resolution and mediation to address ethical challenges in healthcare. Both arise from a recognition that many in-

stances of what initially appears to be an ethics issue turns out, in fact, to be a product of miscommunication, inadequate listening, and conflict. Beyond this, mediation can help people in an ethical conflict come to a reasonable working resolution even if they do not agree on all the underlying values.

In contrast, “clinical-setting mediation” encompasses ethics disputes but additionally recognizes that the broad clinical setting of healthcare is fairly rife with conflict, much of it having little or no obvious connection with ethics. The disputes may be relatively ordinary workplace disagreements, e.g. whether one nurse is leaving too much work for a co-worker. Or researchers might argue about who deserves first authorship in their shared project. Or patients and families may oppose hospital visitation limits or other routine rules. Clinical-setting mediation is a way of addressing the broad panoply of conflict in healthcare and, in the process, recognizing that, because the stakes in healthcare are so high—life and death, literally—successfully addressing all sorts of conflict is part of safe care, not just patient and workplace satisfaction.

2. Voluntariness is just one of many ways in which clinical-setting mediation can differ from the mediations associated with litigation. Although many of the latter mediations are voluntary, they can be court ordered, and parties refusing to participate can potentially be cited for contempt. Moreover, even though the outcome of a mediation is generally voluntary (parties can simply fail to agree and go back to court for the judge to resolve their dispute), a contract sealing parties’ agreement becomes legally binding.

In contrast, agreements in the clinical setting are rarely “enforceable,” other than the simple irreversibility of a *fait accompli*. People can change their minds about a plan at any point until, e.g., a surgery has been completed. In these and other ways, clinical mediation differs markedly from litigation-mediation. For further discussion about the differences between mediations in the clinical versus litigation settings, see E.H. Morreim, “Conflict Resolution in Health Care,” *Connections* 18, no. 1 (2014): 28-32; E.H. Morreim, “Conflict Resolution in the Clinical Setting: A Story Beyond Bioethics Mediation,” *Journal of Law, Medicine & Ethics* 43, no. 4 (2015): 843-56; E.H. Morreim, “In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers,” *Health Lawyer* 25, no. 3 (2014): 10-4.

3. Specifically, I am a professor in a medical school. Given that my institution does not own its own hospital, it has contractual relationships with several hospitals in town. When I am in one of those hospitals it is typically for the purpose of providing education for medical students and residents.

4. One option for creating a conflict-resolution service with a high degree of independence is the organizational ombuds. These are gaining traction in healthcare. Some healthcare institutions, e.g., have ombuds who focus strictly on employee disputes. See, e.g. M.D. Anderson Cancer Hospital, <https://www.mdanderson.org/about-us/for-employees/employee-resources/ombuds-office/what-we-do/index.html>; or see the National Institutes of Health Ombuds Office, <https://ombudsman.nih.gov>. Else-

where one might find ombuds-mediators to address patient-provider issues, as with the Kaiser system. See, e.g., M. Montijo et al., "Bridging Physician-Patient Perspectives following an Adverse Medical Outcome," *Permanente Journal* 15, no. 4 (2011): 85-8.

Whatever their focus, a well-constructed organizational ombuds office is designed to be independent, typically reporting only to top management and even then in only via general information about the ways in which conflict occurs and affects the organization. Similarly, a well-designed ombuds office has express protection for the confidentiality of all visitors' concerns. See, e.g., University of California Davis Office of the Ombuds, "Annual Report June 2014-July 2015," http://ombuds.ucdavis.edu/local_resources/docs/2014-15%20Annual%20Report.pdf. An ethics committee could design its own conflict-resolution service on a similar footing.

5. B.G. Picker, *Mediation Practice Guide*, 2nd ed. (Washington, D.C.: American Bar Association, 2003), 87-8. See also C. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict*, 3rd ed. (San Francisco: Josey-Bass, 2003), 218-9, 376-7. In the litigation context, confidentiality means that parties can feel free to make statements and offers that cannot be used against them in a subsequent (e.g., court) proceeding, if the mediation fails to reach agreement. In the clinical context, privacy is critical to trust. In healthcare, people often decline to tell things to their physicians, wishing not to be judged stupid or lazy or noncompliant, or wanting to avoid being the "squeaky wheel" that causes annoyance or disdain from providers. The nonjudgmental acceptance a mediator offers, and the assurance that one's private thoughts, "dumb ideas" or embarrassing secrets will not go any further, is often essential to any willingness to share those things.

6. At the same time, often in the clinical setting it is important to bring people together for conversations around the table. After all, when people must continue in a relationship with each other following a mediation or conflict-resolution process, they must learn how to talk with each other in constructive ways. As discussed below, this particular case did indeed lead, the next day, to a conversation with everyone present. Strategically, however, the build-up to that meeting was carefully laid out, and, in this case, everyone needed private conversations in which to build trust and hope in the process and the mediator.

7. For detailed description of another clinical-setting mediation, see Morreim, "Conflict Resolution in the Clinical Setting," see note 2 above.

8. For additional discussion of coaching in the mediation context, see Morreim, *ibid.*

9. More specifically, "priming" refers to a phenomenon in which introducing one stimulus—perhaps a word or concept—can influence subsequent responses in the hope that the people at the table will be more receptive, later, to options involving those concepts. See M. Gladwell, *Blink* (New York: Back Bay Books, 2007), 53-8, 76.

10. As framed by Fisher and Ury, "separate the people from the problem." R. Fisher and W. Ury, *Getting to Yes: Negotiating Agreement Without Giving In*, 2nd ed. (New

York: Penguin, 1991), 17.

11. Morreim, "Conflict Resolution in the Clinical Setting," see note 2 above.

12. In many ways, these functions are very much like an organizational ombuds, if well-designed for the health-care setting. See note 4 above. See also C.L. Howard, *The Organizational Ombudsman: Origins, Roles and Operations: A Legal Guide* (Chicago: ABA Publishing, 2010); University of California, Davis, Office of the Ombuds, "Annual Report for 2013-2014" and "Annual Report for 2014-2015," http://ombuds.ucdavis.edu/local_resources/docs/AnnualReport2013-14.pdf and http://ombuds.ucdavis.edu/local_resources/docs/2014-15%20Annual%20Report.pdf.

13. Morreim, "Conflict Resolution in the Clinical Setting," see note 2 above.

14. *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, Ill.: American Society for Bioethics and Humanities, 2011).

15. G. Bosslet et al., "An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units," *American Journal of Respiratory and Critical Care Medicine* 191, no. 11 (1 June 2015): 1318-30, 1320.