Conflict Resolution in the Clinical Setting: A Story Beyond Bioethics Mediation

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Rarely do ethics consults focus on genuine moral puzzlement in which people collectively wonder what is the right thing to do. Far more often, consults are about conflict. Each side knows quite well what is "right." The problem is that the other side is too blind or stubborn to recognize it. And so the ethics consultant is called, perhaps in the hope that s/he will throw the weight of ethics toward one side and end the controversy so everyone can get on with other business.

Perhaps the greater problem in these scenarios is that even if one side "wins" by gaining the power to dictate what happens next, the toxicity permeating the relationships often markedly worsens and other conflicts erupt, major and minor. In thirty-five years of doing clinical ethics consults, not once have I heard a patient, family member or clinician say, "Gosh, the ethics experts think I'm morally mistaken. Surely they're wiser than I, so of course I must change my views!" Not once.[1] Particularly in end-of-life situations a major undercurrent concerns, not just what is the best course of action, but also implied or express threats of mutual coercion.[2]

Accordingly, where an ethics consultant cannot or should not declare an obvious winner on substantive grounds, the challenge often becomes largely procedural: how shall the situation be addressed in a way that acknowledges the legitimacy of diverse voices and strives to preserve, perhaps even to rebuild, the relationships on which good healthcare depends? At that point thoughtful negotiation and creative problem-solving are generally preferable to entrenched combat. This is the point at which "clinical-setting mediation" or other conflict management tools, such as coaching or facilitation, might be invoked.[3] This article will focus on mediation.

This much will be familiar to many readers.[4] Indeed, the American Society for Bioethics and Humanities (ASBH) has now identified facilitation skills as a core competency for bioethics consultation.[5]

This paper broadens the conversation to encompass the conflict that permeates healthcare generally — conflict that commonly arises long before any need for ethics consultation is perceived, and which contributes to problems in quality, patient safety, and satisfaction for everyone. Conflict resolution skills can readily address disputes and tensions throughout healthcare and, in the process, provide a kind of preventive ethics. Indeed, some hospitals and organizational ethics committees are already creating conflict resolution services to be broadly available throughout the institution, even where ethics issues are not directly in play. Accordingly, this paper has several parts.

Part I illustrates these broader conflict resolution opportunities by describing a recent mediation I undertook regarding a difficult discharge negotiation. Although personally identifying information has been changed to protect confidentiality, all the "moving parts" have been preserved in order to provide readers with a window into the kinds of conflict management that can be brought to a wide variety of situations in healthcare — well beyond classic bioethics mediation.

Part II then outlines broader opportunities for conflict resolution across the spectrum of healthcare and describes several initiatives in that direction, particularly from the legal community.

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Finally, Part III discusses several ways in which tclinical-setting mediation, as described in this article, differs significantly from bioethics mediation as it is often described in the literature, and offers a few suggestions for ethics committees interested in providing conflict resolution services. Briefly, mediation and conflict resolution need to be distinguished quite sharply from ethics consultations, whose endpoint is often a consultant's recommendation. In mediation — basically, negotiation assisted by a neutral third-party — the mediator helps disputing parties to explore their own priorities and come to their own resolution. Aside from promoting parties' autonomy, mediation's core values of confidentiality, neutrality and impartiality are designed to foster the trust without which it may be impossible to learn the richer, more complex stories that usually underlie the initial information people present, or to uncover the most important interests motivating each person's expectations. Without a high level of trust throughout the conversation, a genuine, durable resolution is often unattainable. As proposed in Part III, distinctive features of the clinical setting make it virtually impossible to maintain this trust if the mediator simultaneously serves as a consultant handing out advice, i.e., pressuring parties to move one direction rather than another. Accordingly, mediation services should be clearly distinguished from consultation. The following story will help to explain.

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I. A Difficult Discharge Discussion

Louis and Jenny are the parents of 7-year-old Benny. Four years ago they divorced amicably via a mediated settlement and have shared custody equally, living only two miles apart. Jenny's fiancé, Jim, lives with her and has a warm relationship with Benny. Lou lived alone until several months ago when, after the death of his father, his mother Gwen moved in with him.

Six weeks ago when Benny was at Lou's, a terrible accident occurred. Lou lives near a river with a floodplain often used for All-Terrain Vehicles (ATVs). Lou and Benny have often gone out on Lou's ATV, although Lou had admonished Benny never to touch it without him. That Saturday afternoon, Gwen was upstairs working on her craft projects and Lou had fallen asleep watching football on TV. When Lou awakened Benny was gone. So was the ATV. He frantically rounded up neighbors who fanned out across the floodplain on their ATVs. Half an hour later Benny was found next to the overturned ATV, lying face down in a large puddle left by recent heavy rains.

EMT workers intubated Benny and eventually restored a heartbeat, but by day 6 in the Pediatric Intensive Care Unit, doctors told Lou and Jenny that Benny had suffered devastating neurological damage. Hope for significant recovery was dim. During those difficult early days Jim said harsh things to Lou, after which hospital security barred Jim from returning to the hospital.

After three weeks Benny was extubated and moved to a regular floor. Not quite in a vegetative state, he was "minimally conscious" — that is, barely aware and responsive to his environment. Although not on a ventilator, Benny required frequent suctioning of thick mucus, a gastrostomy tube for feeding, and round-the-clock care. Meanwhile, during week 4 Jenny quietly went down to court and filed suit to gain full custody of Benny.

At week 6, discharge planning proceeded in earnest. Each parent insisted that Benny should come home with him/her. Lou had just learned about Jenny's lawsuit and was fearful and angry. Dr. Inhouse, Benny's hospitalist on the floor, suggested mediation as Lou and Jenny faced the question to whose home Benny should be discharged. Because of their favor-

able experience with mediation during the divorce, Lou and Jenny endorsed the idea. Dr. Inhouse had already emphasized that "it will take a village" to care for Benny, especially since their insurance would not likely pay for home nursing care. Meanwhile, Jim had recently been allowed to return to the hospital to visit Benny. The stage was now set, and I was the mediator. The story will proceed in the first person, as a more formal third-person narrative would seem stiff and artificial.

The first conversation included Jenny, Lou, Jim, and Dr. Inhouse. Although I was initially inclined to use a quiet conference room, after conferring with Dr. Inhouse I agreed it would probably be more distracting for the parents to be away from Benny than to be with him. So we all found seats in Benny's room. It was thought likely that Dr. Goode, Benny's community pediatrician, would be available by phone if needed.

I began the mediation by explaining that the process would be very informal, that the goal would be to address whatever issues were important to them, and that I was not there to tell anyone what to do. They would also be welcome to ask for private conversations with the mediator, so they could explore possibilities and "think out loud" with the mediator before bringing an idea to the others. We could meet again in the future as well as this evening; hence there would be no pressure to make decisions immediately.

I indicated that, although I had some idea what our meeting would address, I would like to hear what they would most like to focus on that evening. Jenny did not hesitate. "I need these guys to talk to each other like civilized human beings!" She wanted Jim and Lou to communicate better with each other and for the tension between them to ease. I turned to the two gentlemen and invited any response they might wish to offer. Jim told Lou that he loved Benny very much, and that he was very sorry to have said the things he said…in front of Benny.

Lou expressed appreciation. Although I surmised that Jim's apology probably was not entirely satisfactory, I opted to leave the matter there for the moment. Mediation is an improvisational dance, so to speak, and one need not always "finish" one topic before moving to another. So I suggested that we try to specify what Benny would need, wherever he might be after discharge. It can be helpful to focus on "what" before turning to "who." Dr. Inhouse indicated that he would need suctioning equipment, a wheelchair and various other equipment, and possibly a special bed. Although Benny had lived alternately between his parents, she envisioned that Benny might need to stay at one parent's home for at least a week or two before he could spend time at the other home. She noted, though, that the latter was perhaps more assumption than established fact.

Still deferring until later the question "to whose home first," I decided to move obliquely, to reduce barriers to that ultimate question. I asked Jenny, "When Benny is at your home, what access will Lou have?" The answer was that Lou could come any time he wished. She and Jim would welcome his participation. To Lou: "When Benny is at your home, what access will Jenny and Jim have?" The answer of course was the same: he would welcome them any time. Both sides thus had said something positive and conciliatory.

At that point I circled back to Lou and Jim's relationship and asked whether everyone was comfortable that communications would be satisfactory, going forward. Lou indicated that, while he welcomed Jim's apology, he wished that Jim had expressed regret for saying those things *to Lou*. Jim responded with a more full apology, which seemed to put the matter to rest.

Each parent was then invited to describe how Benny would live and be cared for in their respective homes. As Dr. Inhouse put it, each could describe a "day in the life." Here too, instead of asking to whose home he should be discharged, the focus was still on facts, specifically what Benny would need day-to-day and hour-by-hour, and what concrete activities either parent would be doing, in what sort of set-up at each home. "Whose home," too early, could easily spiral downward into who is the better parent — not a promising way to reach agreement. Moreover, focusing intently on factual details not only helps de-escalate emotions, it can sometimes yield surprisingly helpful information that demarcates more precisely the contours that any final resolution must meet. As the descriptions went forward, everyone agreed that whatever happened in the short term, and whatever decisions might be made now, they would likely evolve over time simply because Benny's condition would evolve. No doubt, too, there would be setbacks regardless of where Benny was living at the time.

As these day-in-the-life accounts proceeded, I realized we needed more specific information from Dr. Goode. Would Benny actually need a special bed; and would he really need to stay at one home for a prolonged period before he could go to stay with the other parent. If not, then a broader array of options would be available. Dr. Inhouse phoned Dr. Goode, who answered on the first try. He indicated that Benny would not need a special bed, and that there was probably no medical reason why the child couldn't be fairly mobile between the two households. This crucial input opened the door to a care-sharing arrangement in which Benny would move from one home to the other after a designated number of days: 2 days with A, 3 days with B, 3 days with A, 2 days with B, and

so forth. The time would be equal, whereupon Lou concluded, "It's fair — I can't complain about it." The evening concluded with an invitation to get together again if they wished, and that we might likely need to, to work out remaining details.

Indeed we did. Situations this difficult are rarely resolved so readily, and this one was no different. Lou's mother Gwen had not visited Benny at the hospital, and it was doubtful how much she would be involved in Benny's care. Hence an important question, quietly floating, concerned how in the world could Lou care for him, all alone, for days on end. Additionally, Lou remained deeply concerned about the lawsuit. Thus, two days later Dr. Inhouse phoned me that Lou would like to chat further, fearful that Jenny would still pursue full custody. Jenny and Jim also wanted to meet, though that would be a few days later as I was imminently heading out of town.

I stopped by Benny's room at the agreed-on time, and Lou was there alone with him. He doubted that his mother would participate much in Benny's care, and we brainstormed about who might be available to help when Benny was with him. We also talked about the custody suit, and I asked him whether he would like to hear more about how such suits usually go. (One of my "mediator rules": ask for permission, i.e., don't impose that sort of information unless the person wants and is ready for it.) He did, very much so. I explained that I would of course offer the same information to Jenny and Jim.

I told Lou that typically each attorney requires an up-front retainer, commonly $5000 or so, which at $350/hour would cover about 14 hours of attorney time. Additional expenses typically include court costs, deposition fees, expert witnesses, court reporters, guardian ad litem, and the like. When that first retainer is exhausted, the client must pay another if he wishes to keep litigating the matter. The bills tend to add up quickly. Lou needed no prompting from me to conclude that all this money would be better spent on Benny. He expressed fervent hope that Jenny would also hear this information.

In anticipation of meeting next with Jenny and Jim, I contacted an attorney colleague who exclusively practices family law, to confirm and augment my understanding about litigation to modify a judicial custody order. Several days later I met with them in a quiet conference room. As we chatted about the lawsuit, Jenny explained that she envisioned the whole process would be brief and benign, just as it had been with the divorce: the judge had simply reviewed their mediated settlement and stamped approval. Done deal. This time, Jenny expected that the judge would send someone who would look at the situation, conclude that Benny belonged with his mother, and then the judge would stamp approval on such a report. Done deal. I indicated that I have colleagues who practice that sort of law and asked whether they would like to hear details about how such things usually proceed. They did.

As with Lou, I described the litigation process and outlined various costs. I noted that each attorney, as a zealous advocate for his or her client in an adversarial legal system, would deem it a professional obligation to dig up dirt on the other parent — ordinarily essential to prevail in a custody fight. I relayed to them that, per my lawyer colleague, these cases tend to spiral out of control quickly, in ways that neither side envisioned or wanted. Jim and Jenny recognized that litigation takes considerable time and that, because Benny would soon be discharged, it was still important to try to reach a reliable arrangement of their own, at least for the short term.

For both parents my description of custody litigation was presented as a list of facts for their consideration, not as an editorialized account to persuade them. I cannot possibly know all the background information that might truly justify one parent's seeking full custody. Additionally, over years of mediating not just in bioethics, but frequently for local courts (especially, family-suing-family in civil matters concerning property, debt and real estate), it has become ever clearer that one's effectiveness as a mediator is built on trust. The moment a mediator tries to persuade people to accept one option rather than another, s/he erodes some of that trust, potentially becoming just another pair of fists in the fight. And the less the mediator is trusted, the less s/he is likely to learn the most sensitive, private kinds of information that sometimes can completely change one's picture of the case, and with it the direction the conversation can most effectively go next. Admittedly, sometimes it is necessary to introduce "reality checks" if a durable resolution is to be created (discussed below). But that must be done in a way that preserves trust to the greatest extent.

We talked more and I learned more. Jenny described her turmoil over the whole situation. Sometimes she felt like raging against this terrible and senseless tragedy, yet somehow she was not in rage. She couldn't explain it, but somehow she was reconciled to a very different reality for her son. Jim expressed resentment that he was the one cast into such a negative light. How in the world, both wondered, could a responsible parent leave the keys to an ATV within reach of a 7-year-old? And why had Lou been taking allergy medications with a sedating effect? How on earth could he not anticipate that an energetic 7-year-old boy might get into mischief if left unsupervised? They reviewed

other reasons for doubting that Lou would be capable of caring for Benny — especially, his doing so alone, since Gwen had shown no interest whatever in coming to the hospital or participating in Benny's care at any point in the past. They raised other questions about Lou as well. I noted in passing that a legal process of "digging up dirt" would encourage both sides to go far down such paths of scrutinizing each other's behavior. And I offered a small bit of pop-psychology, noting that sometimes the harder we tell someone "you can't," the harder they tend to push back with "yes, I can" — and that on the other hand, sometimes the more one tries to help the other family make things work, the more one's own family ends up the beneficiary.

Later that evening I met again with Lou and, for the first time, his mother in a different conference room. Gwen emphasized that she planned to be very involved with Benny's care and was now scheduled to be trained as a caregiver. She had stayed away until now, partly because she was still reeling from her husband's death and partly because the animosity between Lou and Jim was so distressing for her. But now she was fully ready to step up as a member of Benny's Village.

Lou and Gwen listed specific doubts about Jenny's (and Jim's) ability to care adequately for Benny. I asked them how one might determine whether any particular individual was ready to meet Benny's needs. As we reviewed their own training experiences at the hospital, they concluded that the physicians and nurses now training all four of them would be in the best position to detect whether further training would be necessary. Importantly, the criteria for adequacy of training came from them, not from me. We collectively observed that everyone's abilities would evolve over time.

As the conversation turned to Jenny's custody suit, Gwen asked, "So what do we do when the sheriff shows up, serving Lou with a summons for the lawsuit?" I responded that all they needed to do was to sign the document, hand it back to the deputy, and wish him a good day. I said they would likely feel a very bleak moment, but a summons just means they've been told about the suit. I shared with them my impression that Jenny did not seem inclined to gear up for a major legal fight, and that for her and Jim too, the goal was to find an arrangement that really worked. Litigation is a long-term thing and, if both families worked well together, Jenny might well decide not to pursue it. I couldn't be sure, of course, but that was a distinct possibility. Lou and Gwen seemed reassured.

As Gwen described her love for Benny and her commitment to care for him, I offered an idea for her. "You know who needs to hear this? Jenny. I think she will be very reassured. Your voice, your eyes, your love for Benny. That will go a long way, I think." The idea appeared to register with them both, and I offered some coaching on how such a conversation might proceed most effectively.

The final meeting was a few days later in Benny's room, amidst final preparations for discharge. Jenny, Jim, Lou, and Gwen had all satisfied the requisite check-list of skills and a 24-hour stay. Jenny, Lou and I were waiting for Dr. Goode to arrive, so they could ask him questions. I told them both that over the course of our conversations I had noticed that, even when one parent seemed to have pretty good reason to doubt something about the other parent, there usually turned out to be a pretty good explanation. I expressed hope that, in that light, they would give each other the benefit of the doubt. They indicated that they'd had some helpful conversations in the last couple days, and their body language and tones of voice appeared to confirm it. Benny would initially go home with Jenny, transitioning periodically to Lou, and all four family members would actively help in his care.

Although Part III below will discuss broader features of mediation in the clinical setting and contrast this with ethics consultation, here it will be useful to describe a few of the specific techniques used in this mediation, while the story is fresh in the reader's mind.

- Decisions about when to meet with whom are strategic, not automatic. Clinical-setting mediations need not be confined to, or necessarily even include, one major session with all parties present. This one involved five conversations spread over ten days, totaling seven hours, and only one of them included Lou, Jenny and Jim at the same time and place. Mediations often involve private conversations as well as joint ones. In this case, trust grew considerably as each family had the opportunity to say things to the mediator that they would not likely have said in front of the other family.
- The most difficult questions are sometimes best addressed one piece at a time, by laying first the groundwork on less threatening dimensions of the issue. Here: list the child's specific needs; list the particular equipment that will be in each home; identify how the necessary equipment can be transported if the child moves from one home to the other; etc.
- "Turn it back to the parties" emphasizes the importance of letting the people at the table define the issues and possible resolutions as much as possible, rather than having the mediator control the content and direction of the conversation. Here, an open question that began the first meeting allowed Jenny to identify the issue

of foremost importance for her — namely, reducing the animosity between Jim and Lou and improving their manner of communication.

- Overall the conversations focused, not on the parents' respective demands (their "positions" per the language of classic mediation[6]), but rather on their underlying interests and needs. Asking people to articulate their demands too early in the process tends to wed them to those demands, to dig in rather than listening to each other and being flexible.
- "Focus on the problem, not the people."[7] Here, instead of a hopeless dispute about who is the better parent, we explored the particular training, equipment and activities that would be needed and whether/how Benny could be mobile between the two homes — which, in turn, helped the parents to focus on the many specific problems they needed to solve, rather than focusing on each other.
- Appealing to objective information wherever possible is another key principle of mediation,[8] exemplified as we looked to physicians and nurses to discern which family members were sufficiently trained. That helped allay concerns about who would be up to the job and who wouldn't.
- "Priming" involves quietly introducing concepts that can predispose parties to think in some directions and not others.[9] In this case Dr. Inhouse helped both families to understand that it would "take a village" to care for Benny, thereby predisposing everyone to focus more on the need to work together than on the desire to prevail over the other person. The village concept also helped Jenny and Jim to recognize that, because litigation was a very long-term process, an effective working arrangement would still be necessary for the immediate future.
- "Managing expectations"[10] and "normalizing"[11] figured several times. At the outset the mediator described the process, including the permissibility of private meetings that might otherwise have been perceived with suspicion. Expressly noting that the situation would likely evolve over time likewise gave parties permission to change their views as the discussions proceeded. Telling Gwen and Lou that they would likely feel a bleak moment when the sheriff's deputy handed the summons may have helped attenuate an otherwise-difficult experience.
- "Coaching" was an important tool for helping individuals prepare for how they would convey their thoughts and feelings to the other family — what words to use, what tones of voice, and the like. The suggestion that Gwen share with Jenny her love and commitment to care for Benny was accompanied by some coaching on how that might best be done.
- Confidentiality was particularly important for the private conversations, to assure each family that the concerns they expressed would not be shared with the other family unless they specifically wanted to have that information passed along. The parents' final agreement would, of course, be shared with whoever needed to know, but the process for getting there needed considerable privacy.
- Logistics also played a role. Whereas the initial conversation was best set in Benny's room, several subsequent discussions were held in a quiet, non-distracting place. Each had its purpose.
- This particular mediation involved a fair amount of time, with multiple meetings over a 10-day span. Yet reaching a genuine agreement between the parents may have saved considerable time in the longer run for clinical staff and, indeed for other hospital staff who might otherwise have been busy stomping out the flames of an increasingly contentious family conflict. "Start slow to go fast" captures the concept that, if participants have the opportunity to explain what is important to them, take all the time they need in a nonjudgmental setting, and reflect on their most important priorities in a safe and hopeful environment, the outcome can be a very efficient overall use of time.

In many ways, although Benny's case involved important ethical values, the pivotal disputes had more to do with interpersonal tensions and mistrust than with bioethics as such. Indeed, mediation and the broader panoply of conflict resolution skills can be used to address a wide variety of conflicts throughout the complex realm of healthcare, not just bioethics.

These and other mediation tools helped two families in conflict come to a resolution that, it is hoped, will

have genuine staying-power.[12] "Agreements" imposed by people who have power but not necessarily legitimate authority in the eyes of the parties can fall apart quickly. Virtually everyone who has spent time in the clinical setting knows how a nod that ostensibly accepts a DNR recommendation can dissolve as soon as family members have had time to recognize they were bullied into acquiescence, not genuinely asked what they understood and what they valued.

In many ways, although Benny's case involved important ethical values, the pivotal disputes had more to do with interpersonal tensions and mistrust than with bioethics as such. Indeed, mediation and the broader panoply of conflict resolution skills can be used to address a wide variety of conflicts throughout the complex realm of healthcare, not just bioethics — as we will now see.

II. Conflict Resolution throughout Healthcare

End-of-life cases present the most familiar scenarios in which ethics consultants find conflict. The clash may be a "bedrock" collision of fundamental beliefs about the value of life,[13] or more commonly may involve cultural disparities, systematic miscommunication, mutual disrespect.[14] The need for high-level expertise in conflict resolution in this difficult realm has recently gained major recognition in a Policy Statement issued by five major critical care organizations:

> The committee recommends increased efforts to teach clinicians end-of-life communication skills, including strategies to achieve shared decision making, conflict-resolution skills... Clinicians should generally seek the assistance of consultants skilled in mediation and conflict resolution....[15]

Still, conflict in healthcare is hardly limited to end-of-life crises. Some of it is the conflict familiar in any workplace, as bosses try to manage workers toward institutional goals, as coworkers struggle with each other and with management, and as unclear job expectations sometimes lead to misdirected performance, adverse job evaluations, resentment and burnout.

And yet healthcare is different. The stakes are often higher. If the barista at the local coffee shop mis-tallies the bill, it can be corrected and, even if not, the consequences are usually minimal. In healthcare the very same kind of error, perhaps by entering a wrong digit in a medication order or programming an IV pump, can kill someone. Similarly, although limiting residents' duty hours was hoped to reduce morbidity and mortality by reducing sleep-deprived decision making, the results indicate little or no improvement in patient outcomes and, in some cases, the contrary result.[16] One proposed reason is that, the less time residents have with patients, the more frequently patients' care must change hands, requiring a level of communication that does not always happen.[17]

Overall, the Joint Commission (TJC)[18] has found that communication failures are "a root cause in nearly 70% of reported sentinel events, surpassing other commonly identified issues such as staff orientation and training, patient assessment, and staffing."[19] Many of those communication lapses are the result, or the cause, of conflict. Accordingly, in 2009 TJC issued standards requiring that hospitals' governing bodies "provide[] a system for resolving conflicts among individuals working in the hospital" (LD.01.03.01 EP-7) and that, particularly for senior management, "[t]he hospital manages conflict between leadership groups to protect the quality and safety of care" (LD.02.04.01).[20] Hospitals should identify an individual, inside or outside the hospital, "with conflict-management skills who can help the hospital implement its conflict-management process....This individual can also help the hospital to more easily manage, or even avoid, future conflicts."[21]

In the clinical setting, opportunities for conflict resolution abound. Tensions among staff — e.g. as a nurse believes a colleague routinely fails to do a fair share of work or fails to honor requisites of safe care[22] — can often be better addressed by carefully facilitated conversations, than by allowing tensions to build. A variety of situations otherwise sent to HR (human resources) might also be better addressed by conversation in a safe space than by invoking mechanisms that may feel, or actually be, more punitive than problem-solving. Indeed, as healthcare systems become increasingly integrated, and as workforces from diverse institutions are expected to blend with one another, tensions are sure to arise as people from one work culture are expected to abide by unfamiliar sets of practices and norms. Such differences can have significant implications for clinical care, and they are often better resolved by communication than by ongoing friction or by supervisors' adjudication.[23]

Physicians, whether employees or independent contractors, likewise often face problems such as productivity expectations, office arrangements, electronic medical record dysfunction. When allowed to drag on, they can produce burnout, counterproductive responses, poor relationships with staff and patients and in some cases a dissolution of practice arrangements. Conversely, if addressed through well-constructed conflict resolution processes, these tensions

can lead to stronger relationships, and improved quality and satisfaction.[24]

Patients and families likewise have concerns that are not directly "bioethics" in character. Disputes about who should be allowed to stay with the patient, resistance to hospital rules and regulations, or feelings that one's culture is disrespected, exemplify. Informally, hospital security personnel indicate that perhaps half the calls they receive not only are unnecessary, but are not optimally managed by summoning burly uniformed people bearing handcuffs. Rather, many of those occasions could be far better managed by respectful conversations. The challenge, of course, is that those in the midst of the conflict may not, by themselves, be equipped to navigate a reflective, productive resolution process — which is why people trained in the skills of conflict resolution become important, not just to help resolve individual conflicts but also, through the process, perhaps to promote better communication going forward.

The legal community, like the bioethics community, is moving toward meeting these challenges. In response to TJC initiatives, for instance, the American Health Lawyers (AHLA) created a "Conflict Management Toolkit" outlining structures and processes for addressing conflict in healthcare.[25] Thoughtful scholars have also responded.[26] Additionally in 2013 the American Bar Association (ABA) created a Task Force on ADR[27] and Conflict Management in Healthcare, while that same year AHLA initiated an ADR Affinity Group within that organization. Both emphasize educating attorneys and the broader public on the importance of conflict resolution in healthcare, and on creating new avenues for engaging conflict productively. It seems noteworthy that lawyers, whose traditional role is to help their clients fight after conflict has erupted, have taken such a keen interest to resolve problems at far earlier stages.

Specific examples abound. Many hospitals, and indeed some state legislatures, actively promote early resolution of adverse medical events: disclose providers' errors openly to improve quality and safety, and offer fair compensation to those who were harmed.[28] Substantial data now attest that these institutions are "doing well by doing good," markedly reducing litigation costs by treating injured patients and families with honesty, respect, and appropriate compensation.[29]

On a very different front, business disputes — e.g., payor/provider — are increasingly being mediated to avoid costly legal battles over contracts and, perhaps more importantly, to maintain relationships that both sides may find worth continuing. Peer review and medical credentialing issues are likewise being brought into mediation at earlier stages, sometimes averting the need for antagonistic disciplinary procedures. Indeed, even criminal matters, such as alleged violations of the False Claims Act (fraud against the government), are now being addressed with mediation.[30]

Overall, well-conceived processes for conflict resolution in the clinical setting can reasonably be deemed a genre of preventive ethics, because unresolved lower-level conflicts can easily spiral into major disputes. An important question, then, is whether ethics committees or ethics consultants can perhaps provide the conflict resolution/mediation services expected by TJC, increasingly encouraged by health law attorneys, and clearly needed in the clinics, the hospital, and the board room.[31]

III. The How-To of Conflict Resolution and Clinical-Setting Mediation

The answer must begin by describing key features of successful mediation in the clinical setting, highlighting major differences between this kind of mediation, versus "Bioethics Mediation" as it is often[32] (though not universally[33]) described in the bioethics literature. Following that is a discussion of how ethics committees might optimally construct a conflict consultation service.

A. Key Features of Clinical-Setting Mediation

The goal of mediation in the clinical setting is to assist people in conflict, not just to come to some sort of agreement, but to forge a durable resolution. Durability requires two things.

First, the parties must actually embrace — personally endorse, agree with — the resolution that completes the mediation. Sometimes in clinical care, providers "get the consent" or "get the DNR" by rattling off a litany of facts followed by the other person's nod of the head or signature on a document. In some instances the same providers are subsequently shocked (shocked!) to hear that the person changed her mind. Acquiescence does not constitute genuine agreement, and any such "agreement" can and often does fall apart quickly. Hence, clinical mediations must seek an agreement that is genuinely endorsed by those who are in conflict.[34]

This contrasts with the mediations that often resolve lawsuits.[35] There, a successful mediation ends in a contract signed by all parties. Days later someone may wish he had not signed, but so long as the contract is legally enforceable, he is stuck. In contrast, a clinical agreement generally is not similarly enforceable, and will stand only so long as no one has changed his mind (and ensuing events have not made retraction impossible, e.g. the surgery is already completed).

Second, durability requires that there be no external constraints likely to render even a genuine agreement void. Some constraints concern practical realities. In the case above, it was clear that Lou could not possibly care for Benny alone, staying awake for days on end. Other constraints concern policies. A family may want their vent-dependent father moved from the ICU to a regular floor, for instance, but hospital policy and physical set-up may render that impossible. Additionally, laws may intervene. Medical marijuana is not legal in some states, regardless how beneficial it might be for a particular patient.

Perhaps the most important overriding principle is that in mediation, the "currency of the realm" is trust. This is particularly true in clinical-setting mediation.

To the list of practical, policy, and legal constraints, a traditional conception of Bioethics Mediation[36] would add another: ethical constraints. This approach sees bioethics mediation as a subset of ethics consultation by promoting, as Dubler describes it, a "principled resolution":

> A principled resolution is a 'consensus that identifies a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts, and that facilitates a clear plan for future intervention.'[37]

More precisely, "[t]he bioethics mediator provides information, enforces norms, and ensures that resolutions fall within medical 'best practice' guidelines."[38] Those principles, for instance, include the idea that "[d]eath may be preferable to extending the process of dying in children and incompetent patients."[39] Indeed, the mediator might even go so far as to order a psych consult to assess capacity if s/he deems it advisable, e.g., to distinguish loss of capacity from psychotic denial.[40] The rules of decision-making authority and responsibility in clinical medicine are said to be "crisp and clear," even if implementation is not.[41]

This last suggestion — that clinical mediators should "enforce norms" of "crisp and clear" ethical values by ensuring that parties do not endorse an ethically "unacceptable" conclusion, brings us to broader questions about how mediators should go about their task of seeking durable resolutions, including how best to manage constraints.

Perhaps the most important overriding principle is that in mediation, the "currency of the realm" is trust. This is particularly true in clinical-setting mediation. One of the greatest services a mediator can provide is to earn enough trust that people who are deeply entrenched in conflict will be willing to confide their worst fears, tell what really happened prior to the current events, and describe what courses of action or compromise they might find acceptable. Only then is it likely that the people in dispute will become sufficiently comfortable to engage in collaborative problem-solving and forge a durable resolution.

Conversely, where each side in the dispute, heretofore, has repeatedly insisted "you must" and "you can't," a mediator who then adds to that litany of "must" and "can't" (and who "enforces norms" and "ensures" that resolutions meet certain guidelines[42]) will quickly become just another pair of fists in the fight. A mediator qua next-pair-of-fists will not likely learn crucial hidden information. Worse, s/he will probably never know what s/he is missing.

The picture that emerges when parties genuinely trust the mediator is usually very, very different from the case's initial description. In Part I's discharge mediation, it was only after a relationship had been built that Jenny and Jim became sufficiently comfortable to describe Lou's use of sedating allergy medications and to detail more precisely his sometimes-careless approach to child safety. Later conversations with Lou likewise unearthed a number of reasons for his regarding Jenny and Jim as less-than-responsible adults. I did not deem either set of information to be final or necessarily entirely factual. But they were important additions to the picture and a sobering reminder that I, as mediator, had little basis for assuming either that Benny's custody should still be shared between them, or that it should not. Perhaps even more importantly, only when trust for the mediator and the mediation process is strong are parties then likely to engage in the collaborative brainstorming and creative problem-solving that can forge a resolution no one had initially envisioned.

Trust, then, clearly is crucial to reach the first element of a durable resolution — genuine agreement. At that point the mediator's challenge turns to the second element, namely constraints: how can the mediator effectively introduce a negative without disrupting trust. We will consider each type of constraint in turn: practicalities, policy, law, and ethics. "Reality-testing," as it is sometimes called, must of course be part of

mediating a durable resolution. But it must be done with utmost care.

Although this is not the forum for extended discussion of mediation strategies, a few comments will be illustrative. Lou initially did not expect his mother Gwen to help care for Benny, raising the important practical reality that no one could provide care alone, 24/7, for days on end. Instead of directly offering a negative — "you can't possibly do that" — I opted to ask questions in a private session, inviting Lou to envision day-to-day realities of care. He recognized the problem on his own, and the conversation shifted to problem-solving. If Gwen would not available, what other resources might there be.

Constraints from policy and law can often be introduced via someone else's voice — that is, by seeking out the appropriate authority to articulate that constraint, explain its purpose, and perhaps help identify alternate options. Thus, if a family wants their vent-dependent father moved from the ICU to a regular floor, and if such a move is clearly impermissible per hospital policy, the mediator need not be the one to say "you can't." Rather, s/he can identify someone who could speak with authority (e.g., someone from administration) and ask that person to discuss whether such a move would be possible and why/not. At that point the family may be better able to accept that a move to the floor cannot happen. The mediator could then ask the family what goals they would like to achieve by moving the patient to the floor, and ask everyone to get creative and think of ways those goals might be achieved, shy of moving the patient. Trust is thereby built rather than eroded.

In this sense, clinical mediations carry a helpful difference vis-à-vis litigation-mediation. Typically mediation to resolve a lawsuit occurs via a single session (often, a very long day), or occasionally also a follow-up, and features only the parties in dispute and their attorneys. In clinical mediation such marathons are often impossible and, fortunately, often neither necessary nor even helpful. Benny's mediation consisted of five separate conversations, in varying combinations of people, spread out over several days. Although life in the clinical realm is fast-paced, at the same time the situations most likely to need mediation concern complex patients with fairly lengthy admissions. A mediator can often utilize remarkable flexibility to meet whenever, wherever, with whomever.

We come, then, to alleged ethical constraints. Here, the classic bioethics mediation model described above becomes deeply problematic. It is a picture in which the mediator is as much a consultant as a mediator, an advisor who circumscribes ethical parameters even as s/he uses traditional mediation techniques to facilitate a discussion within those parameters. Indeed, "[b]ioethics mediators are often involved in following up on implementation of the agreement"[43] – an "enforcer" after as well as during the mediation.

Unfortunately, the mediator who instructs a party that "the option you want is not ethical" precipitates two problems. First, where the clash truly concerns fundamental ethical values (that is, it does not, upon further inquiry, turn out to be a very different issue such as miscommunication), the statement is intellectually untenable. By definition, "bedrock" values and beliefs are so fundamental, they comprise the foundations of all that follow. They are the "buck stops here" tenets that remain when we can no longer say "A is true because of B, and B is true because of C...." They are the values and beliefs that are beyond rational defense, and for which any attempt to defend will be inherently question-begging.[44] If a mortally ill patient's spouse believes that every moment of life is infinitely precious, regardless of quality, it is to little avail for a mediator to declare s/he is wrong, and that "[d]eath may be preferable to extending the process of dying in children and incompetent patients."[45] The fight is reduced to a "'tis so! - 'tis not!" dispute.[46]

Hence, second, by declaring him/herself to be the arbiter of moral rectitude, the mediator has become just another pair of fists in the fight. Any such assertions of "authority" will almost certainly come at the expense of damaging trust, diminishing dramatically the odds of reaching genuine agreement. By definition, clashes of bedrock values cannot be resolved by rational discourse. But this does not preclude process-oriented agreements regarding how and by whom decisions will be made, going forward.

The idea that a mediator will enforce the agreement's implementation[47] is likewise deeply troubling. A cornerstone of the trust on which good mediation relies, is that the mediator is impartial, favoring neither side over the other. In litigation-mediations the mediator is virtually never involved in enforcing the contract. The parties can choose to enforce it or not. More importantly, a mediator who polices the agreement is effectively taking one party's side against the other — quite likely without knowing whether changed circumstances may have rendered the agreement less desirable for both, or whether it was somehow not based on full and fair information in the first place.

In the clinical setting it is particularly difficult to envision mediators as enforcers. Even a well-conceived, thoughtfully negotiated agreement can be rendered less useful by the patient's changing medical condition, or by evolution in parties' thinking. If for some reason the agreement begins to fall apart, a

mediator can provide far greater service by helping people renegotiate, than to declare, "You agreed to X and you aren't allowed to change your mind."[48]

B. Key Features of a Conflict Consultation Service

From these observations we turn to the question how an ethics committee might structure a conflict consultation service. As discussed in Part II, healthcare institutions need to provide conflict management services, and ethics committees might provide a suitable platform.

Per the foregoing, the roles of mediator and bioethics consultant must be quite sharply distinguished. Both kinds of service need to use high-quality communication skills, of course. The consultant needs first to discern whether a given ethics problem is in fact a communication misfire or a need for further information — a common phenomenon. Still, once those cases have been addressed, usually the consultant's job for the remaining cases is to make a recommendation — to weigh in, in one direction or another.

It is the mediator's job to avoid doing so. For all the reasons discussed above, in situations where the goal is to resolve conflict, ordinarily the resolution must emerge from the people in the conflict, not as an imposition or even heavy leaning from the outside. Admittedly, the "mediator's proposal" is a recognized part of a litigation-mediator's toolkit. But mediators generally agree it should be used rarely if ever, and its use is usually a signal that the mediator has simply run out of skills.[49]

Ideally these two very different kinds of service — consultation and mediation — should be provided by different people even though both need good facilitation skills. In principle, the same person could of course provide both services — just as, in the legal world, the same person can serve as arbitrator in one case and mediator in another. The downside of such an overlap in healthcare is social rather than theoretical. If the same person frequently serves as a consultant for a group of people, e.g., the ICU team, it can be difficult for that team to understand that mediation is a completely different role. Reciprocally it can be difficult for the mediator to resist the temptation or indeed the habit of opining at critical junctures when much of the audience expects consultation. In the end, a mixing of the roles becomes difficult to avoid, likely to the detriment of mediation.

If for economic or logistical reasons consultants and mediators cannot be different people, then a person providing both services in the institution must make it very clear which "hat" s/he is wearing on a given occasion, and clearly guide those s/he is serving about what (not) to expect. The mediator must emphasize, "I'm not here to tell anyone what to do," even as the consultant says, "I will investigate and then suggest what I think you should do." We need not propose that mediation should outright replace the ethics consult[50] but, at the least, mediation needs to preserve the most fundamental elements of conflict resolution: neutrality, impartiality, confidentiality, and trust.

More broadly, conflict resolution services are needed throughout healthcare — not just for bioethics disputes but, per Part II, across the spectrum to help people address the endless variety of conflicts in this high-stress environment, from workplace disputes to "disruptive doctor" situations to the flareups for which security staff might be called. Some institutions are fortunate enough to provide an independent ombuds office or similar conflict management service.[51] Absent such an independent office, ethics committees could potentially serve well. Indeed, conflict resolution can reasonably be deemed a genre of preventive ethics. Ongoing disputes among clinical staff, for instance, can precipitate the communication lapses and thereby errors that diminish patient safety even when they do not specifically cause an adverse outcome. As TJC understands, usually it is far better to address such tensions long before they erupt into entrenched battle-lines that can then become clear-cut bioethics issues.

At the same time, this raises an important question going forward. Mediation is incredibly challenging to do well. It requires training, experience and ongoing opportunities to augment one's skills,[52] including debriefing with like-minded colleagues after each case. Although bioethicists and others in clinical healthcare are now able to take intensive trainings in conflict resolution and bioethics mediation,[53] opportunities to practice those skills may currently be limited. Therefore, if ethics committees are to serve as a primary resource for conflict resolution throughout a hospital or healthcare system, they should attend carefully to the need for those who provide this service to develop just such experience, mentoring, and networking. It is a challenge well worth undertaking and can be addressed better as ethics committees establish broader conflict services that thereby provide just such experience. It is hoped that this article will prompt further discussion in that direction.

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References

1. In many scenarios requesting a consult, although some options may be clearly ruled out, the contest appears to be between options that cannot be decisively defended or defeated on rational or empirical grounds. One side, e.g., says the tiniest chance for survival must be pursued at all costs, while the other insists that some qualities of life are worse than death. See E. H. Morreim, "Moral Distress and Prospects for Closure," *American Journal of Bioethics* 15, no. 1 (2015): 38-40. Engelhardt described such situations long ago: no single viewpoint can definitively command the moral high ground, and so our challenge is to resolve the conflict procedurally or, as he put it, without resort to force. T. Engelhardt, *The Foundations of Bioethics*, 2nd ed. (New York: Oxford University Press, 1996). See also E. Bergman, "Surmounting Elusive Barriers: The Case for Bioethics Mediation," *Journal of Clinical Ethics* 24, no. 1 (2013): 11-24; A. Fiester, "Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting," *Journal of Clinical Ethics* 22, no. 4 (2011): 363-72.
2. E. H. Morreim, "Profoundly Diminished Life: The Casualties of Coercion," *Hastings Center Report* 42, no. 1 (1994): 33-42.
3. N. Dubler and C. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (Nashville: Vanderbilt University Press, 2011).
4. *Id.*; N. Dubler, "A 'Principled Resolution': The Fulcrum for Bioethics Mediation," *Law and Contemporary Problems* 74, no. 3 (2011): 177-200; see Bergman, *supra* note 1; A. Fiester, "Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting," *Journal of Clinical Ethics* 22, no. 4 (2011): 363-372; A. Fiester, "The Failure of the Consult Model: Why 'Mediation' Should Replace 'Consultation,'" *American Journal of Bioethics* 7, no. 2 (2007): 31-32; E. Howe, "How Mediation (and Other) Approaches May Improve Ethics Consultants' Outcomes," *Journal of Clinical Ethics* 22, no. 4 (2011): 299-309.
5. A. J. Tarzian and ASBH Core Competencies Update Task Force, "Health Care Ethics Consultation: An Update on Core Competencies and Emerging Standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force," *AJOB* 13, no. 2 (2013): 3-13, at 5.
6. R. Fisher and W. Ury, *Getting to Yes: Negotiating Agreement Without Giving In, 2nd Ed.* (New York: Penguin Books, 1991).
7. *Id.*
8. *Id.*
9. Priming refers to a phenomenon in which introducing one stimulus – perhaps a word of suggestion – can influence later responses. In mediation, the mediator might use certain words or concepts early, in hopes that the people at the table will be more receptive, later, to options involving those concepts. Here, the idea that it would "take a village" to care for Benny helped the families to adopt the idea that they should collaborate with each other in the discharge planning process and in caring for Benny long term. See M. Gladwell, *Blink* (New York: Back Bay Books, 2007): at 53-58, 76.
10. Managing expectations involves preparing people for what to expect, so that the described event(s) will be familiar when they come to pass. Unpleasant or unexpected developments can quickly derail progress, often by disrupting parties' trust.
11. When people are assured that their concerns, feelings, activities are shared by many other people – that they are normal – the associated level of emotionality can be diffused.
12. Several months later, a brief follow up with Dr. Goode indicated that the parents' arrangement continued to work reasonably well, and that Benny was able to exhibit social smiling – encouraging and gratifying for both his parents.
13. See Morreim, *supra* note 1.
14. See Morreim, *supra* note 2.
15. G. Bosslet and T. Pope 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 (2015): 1318-1330, at 1320, 1322.
16. N. Ahmed, K. S. Devitt, and I. Keshet et al., "A Systematic Review of the Effects of Resident Duty Hour Restrictions in Surgery: Impact on Resident Wellness, Training, and Patient Outcomes," *Annals of Surgery* 259, no. 6 (2014): 1041-1053.
17. S. V. Desai, L. Feldman, and L. Brown, "Effect of the 2011 vs 2003 Duty Hour Regulation–Compliant Models on Sleep Duration, Trainee Education, and Continuity of Patient Care among Internal Medicine House Staff: A Randomized Trial," *JAMA Internal Medicine* 173, no. 8 (2013): 649-655; see also "Reducing Work Hours for Medical Interns Increases Patient 'Handoff' Risks," *Hopkins Medicine*, March 25, 2013, *available at* <http://www.hopkinsmedicine.org/news/media/releases/reducing_work_hours_for_medical_interns_increases_patient_handoff_risks> (last visited November 18, 2015).
18. The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations, is the leading organization for accreditation of health care organizations such as hospitals. Many states, for instance require Joint Commission accreditation as a condition for Medicaid reimbursement.
19. ECRI, *Healthcare Risk Control: Supplement A*, September 2009, at 1, *available at* <http://www.ecri.org/PatientSafety/RiskQual16.pdf>. The ERCI recommendations include: "Assess the quality of communications in the organization to identify factors contributing to patient safety problems," "[p]rovide education and training in effective communication," and "[i]mplement strategies to improve communication and teamwork…." *Id.*
20. For an excellent discussion of Joint Commission standards and their respective elements of performance, see C. Scott and D. Gerardi, "A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part 1," *Joint Commission Journal on Quality & Patient Safety* 37, no. 2 (2011): 59-69; *A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part II*, *Joint Commission Journal on Quality & Patient Safety* 37, no. 2 (2011): 71- 80. See also J. Reister Conard and J. F. Franklin, "Addressing the Art of Conflict Management in Healthcare Systems," *Dispute Resolution Magazine* 16, no. 3 (2010): 15-18.

    The Joint Commission described in-house conflict resolution in the Elements of Performance for Standard LD.02.04.01

    "4. The conflict management process includes the following:
    - Meeting with the involved parties as early as possible to identify the conflict
    - Gathering information regarding the conflict
    - Working with the parties to manage and, when possible, resolve the conflict."

    Elements of Performance for LD.02.04.01, Element #4. Element #3, initially in the 5-item set but later removed said: "Individuals who help the hospital implement the process are skilled in conflict management. This accreditation standard became effective on January 1, 2009. Note: These individuals may be from either inside or outside the hospital."

    M. G. O'Hare, "A Case Study for Effective Conflict Management in the Health Care Workplace: Lessons from Babb v. Centre Community Hospital," *AHLA Labor & Employment Newsletter* (December 2013): 5-7.
21. Governance Institute, *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership* (Governance Institute White Paper, Winter 2009): at 17; *available at* <http://www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf> (last visited November 18, 2015). The Governance Institute's White Paper provided the standards and underlying rationale that were adopted as Joint Commission standards on January 1, 2009.
22. L. Krautscheid, "Microethical Decision Making among Baccalaureate Nursing Students: A Qualitative Investigation," *Journal of Nursing Education* 53, no. 3, Suppl. (2014): S19-S25. See also P. Korn, "Nursing Professor's Studies Suggest Ethics Problem," KOIN TV, July 31, 2014, *available at* <http://koin.com/2014/07/31/nursing-professors-studies-suggests-ethics-problem/> (last visited November 18, 2015).

23. One noteworthy example of informal conflict resolution for employees comes from M.D. Anderson Cancer Center's Ombuds Office. This particular ombuds service focuses on conflicts among employees, providing a nonthreatening avenue for addressing issues that might otherwise become toxic and destructive. See, e.g., MD Anderson Cancer Center, "About Us: Resolution Pathways," *available at* <http://www.mdanderson.org/about-us/for-employees/employee-resources/ombuds-office/resolution-pathways/ombuds-office-resolution-pathways.html> and MD Anderson Cancer Center, "About Us: Ombuds," *available at* <http://www.mdanderson.org/about-us/for-employees/employee-resources/ombuds-office/index.html> (both last visited November 18, 2015).
24. For a detailed story of such conflicts and the processes by which they might be addressed, see E. H. "Morreim In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers," *The Health Lawyer* 25, no. 3 (2014): 10-14; E. H. Morreim, "Conflict Resolution in Health Care," *Connections* 18, no. 1 (2014): 28-32.
25. American Health Lawyers Association, *Conflict Management Toolkit* (2010), *available at* < https://www.healthlawyers.org/dr/SiteAssets/Lists/drsaccordion/EditForm/Conf%20mgmt%20toolkit.pdf > (last visited December 8, 2015).
26. See Scott and Gerardi, *supra* note 20; see also Reister Conard and Franklin, *supra* note 20.
27. "ADR" stands for "alternative dispute resolution."
28. Particularly in California, many Kaiser Permanente medical centers provide an ombudsman/mediator service whose focus is to work with patients, families, providers and staff to resolve patient/provider disputes quickly and, in the process, improve patient safety and reduce the costs of adverse events. See, e.g., <https://www.linkedin.com/jobs2/view/9192503> (last visited November 19, 2015).

    See also, e.g., Oregon Laws 2013 Chapter 5, amending ORS 30.278, 31.250 and 743.056, and Administrative Rules *325-035-0001 to 325-035-0050;* N. Budnick, "New Oregon Program Allows Mediation for Medical Errors Instead of Suing," OregonLive, July 1, 2014; *available at* <http://www.oregonlive.com/health/index.ssf/2014/07/new_oregon_medical_program_all.html> (last visited November 19, 2015).

    And see Mass. Gen. Laws ch. 231 § 60L (2012), creating a 6-month "cooling-off" period for potential litigants of a medical malpractice case. The potential claimant must tell providers specifically what they believe happened, why it appears to violate the standard of care, what should have happened instead, and how the deviation from care caused the injury. The provider must promptly respond with comparably rich information. Such detailed disclosures permit both sides to undertake at an early point the kind of realistic analysis that, in more traditional settings, can drag discovery out for years. The legislation also strengthened protections for apologies and led to the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) (<http://www.macrmi.info/#sthash.bLRr481Q.dpbs> (last visited November 19, 2015)).
29. S. S. Kraman and G. Hamm, "Risk Management: Extreme Honesty May Be the Best Policy," *Annals of Internal Medicine* 131, no. 2 (1999): 963-967; D. C. Hetzler, "Superordinate Claims Management: Resolution Focus from Day One," *Georgia State University Law Review* 21, no. 4 (2005): 891-909; A. Kachalia, S. R. Kaufman, and R. Boothman et al., "Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program," *Annals of Internal Medicine* 153, no. 4 (2010): 213-222, at 219; R. C. Boothman, A. C. Blackwell, and D. A. Campbel, et al., "A Better Approach to Medical Malpractice Claims? The University of Michigan Experience," *Journal of Health & Life Sciences Law* 2, no. 2 (2009): 125-159; R. C. Jenkins, A. E. Smillov, and M. A. Goodwin, "Mandatory Presuit Mediation: 5-Year Results of a Medical Malpractice Resolution Program," *Journal of Healthcare Risk Management* 33, no. 4 (2014): 15-22; R. C. Boothman, S. J. Imhoff, and D. A. Campbell, "Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk through Disclosure: Lessons Learned and Future Directions," *Frontiers of Health Services Management* 28, no. 3 (2012): 13-28; S. Langel, "Averting Medical Malpractice Lawsuits: Effective Medicine – or Inadequate Cure?" *Health Affairs* 29, no. 9 (2010): 1565-1568; T. H. Gallagher, D. Studdert, and W. Levinson, "Disclosing Harmful Medical Errors to Patients," *New England Journal of Medicine* 356, no. 26 (2007): 2713-2719; S. K. Bell, P. B. Smulowitz, and A. C. Woodward et al., "Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation," *The Milbank Quarterly* 90, no. 4 (2012): 682-705; UPMC, Intermediation Program, *available at* <http://www.upmc.com/patients-visitors/Documents/intermediation-program-upmc.pdf> (last visited November 19, 2015); Drexel University College of Medicine's Dispute Mediation Program, *available at* <http://www.drexelmedicine.org/mediation/#sthash.dsw4GufT.dpuf> (last visited November 19, 2015).
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31. By analogy, it has been proposed that ethics committees could be the home-base for other kinds of "communication consult services," such as coaching physicians and others before they disclose errors and adverse outcomes to patients and families. See R. Truog, D. Browning, J. Johnson, and T. Gallagher, *Talking with Patients and Families about Error* (Baltimore: Johns Hopkins University Press, 2011): at 61. See also Bosslet and Pope et al., *supra* note 15.
32. See, e.g., Dubler and Liebman, *supra* note 3; Dubler, *supra* note 4.
33. See Bergman, *supra* note 1; A. Fiester, "Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting," *Journal of Clinical Ethics* 22, no. 4 (2011): 363-372; A. Fiester, "The Failure of the Consult Model: Why 'Mediation' Should Replace 'Consultation,'" *American Journal of Bioethics* 7, no. 2 (2007): 31-32; E. Howe, "How Mediation (and Other) Approaches May Improve Ethics Consultants' Outcomes," *Journal of Clinical Ethics* 22, no. 4 (2011): 299-309.
34. Even with bona fide agreement, changing circumstances or new information can still render an agreement nonfunctional.
35. See Morreim, *supra* note 24.
36. Bioethics mediation, as traditionally framed, generally concerns patient care decisions and focuses especially on life-and death situations: "[a]ll participants in a bioethics mediation have a common interest in the well-being of the patient." See Dubler, *supra* note 4, at 187. "A presumptive common concern for the patient's best interests distinguishes bioethics mediation from conflicts in which opposing parties have disparate and irreconcilable interests," says Bergman, in *supra* note 1.
37. See Dubler, *supra* note 4, at 178.
38. *Id.*, at 187.
39. See Dubler, *supra* note 4, at 181, #5.
40. N. Dubler, "Commentary on Bergman: 'Yes... But'," *Journal of Clinical Ethics* 24, no. 1 (2013): 25-31, at 28.
41. See Dubler, *supra* note 4, at 178.
42. *Id.*, at 187.
43. *Id.*
44. See Morreim, *supra* note 1.
45. See Dubler, *supra* note 4, at 181, #5.
46. If someone's values call for a solution that is ethically so dubious as to be illegal, the mediator can invite the appropriate voice to introduce that legal reality, as discussed above.
47. See Dubler, *supra* note 4, at 187.
48. Admittedly, in some instances patients or surrogates will withdraw from an agreement not so much to express honest evolution of thought, as to manipulate providers. This is not the forum for discussing such cases; suffice it to say the mediator needs to inquire carefully and avoid being coopted where sub-

terfuge is afoot. If the mediator has built a reasonable level of trust, s/he should usually be able to discern reasonably well which is which.

49. As Lee Jay Berman observes, "I define the mediator's proposal as the exact point in time where the mediator ran out of skills." See S. G. Mehta, "The Mediator's Proposal Roundtable: The Good, the Bad, The Ugly." Mediation Matters (blog), January 19, 2010, *available at* <http://stevemehta.wordpress.com/2010/01/19/the-mediators-proposal-roundtable-the-good-the-bad-the-ugly/> (last visited November 19, 2015).
50. "Adoption of bioethics mediation as a primary clinical dispute resolution process, available at the request of patients' families, surrogates, and caregivers, would dramatically enhance the manner in which hospitals address conflict. Reliance on bioethics consultation by those who are expert in bioethics principles, for imposition of juridically based decisions on individuals in crisis, premised on questionably superior access to moral judgments, has been nothing short of 'scandalous' and an embarrassment to the healthcare system.78 Patients and their families, in particular, are entitled to a nonthreatening, inclusive forum in which they can be heard and respected for their relevant competencies." E. Bergman, "Surmounting Elusive Barriers: The Case for Bioethics Mediation," *Journal of Clinical Ethics* 24, no. 1 (2013): 11-24, at 21.
51. See, e.g., M.D. Anderson Cancer Center Ombuds Office, *supra* note 23; National Institutes of Health Office of the Ombudsman, *available at* <http://ombudsman.nih.gov> (last visited November 19, 2015); Akron General Hospital ombuds service, <http://ombuds-blog.blogspot.com/2010/05/five-long-days-with-hospital-ombuds.html> (last visited November 19, 2015); University of California Davis, <http://ombuds.ucdavis.edu> (last visited November 19, 2015); University of Pittsburgh Medical Center, Intermediation Program, *available at* <http://www.upmc.com/patients-visitors/Documents/intermediation-program-upmc.pdf> (last visited November 19, 2015); Drexel University College of Medicine's Dispute Mediation Program, *available at* <http://www.drexelmedicine.org/mediation/#sthash.dsw4GufT.dpuf> (last visited November 19, 2015).
52. As a "Rule-31 listed mediator" in the state of Tennessee I have the opportunity to provide mediations on a regular basis for local courts, and have particularly focused on civil cases in which family have sued family over real estate, unpaid debt, return of property and the like. The emotional intensity of these cases is often comparable to that found in healthcare, and thus provides the kinds of opportunities described.
53. Advanced training in healthcare mediation is offered, e.g., by the Center for Conflict Resolution in Healthcare LLC (www.healthcare-mediation.net; last visited December 8, 2015), American Health Lawyers Association (healthlawyers.org), and the Penn Department of Medical Ethics (http://medicalethics.med.upenn.edu; last visited December 8, 2015).