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ARTICLE

UNNECESSARY ADVERSARIES AT THE END OF LIFE: MEDIATING END-OF-LIFE TREATMENT DISPUTES TO PREVENT EROSION OF PHYSICIAN-PATIENT RELATIONSHIPS

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INTRODUCTION

Disputes between patients or their family members and the patients' treating physicians routinely arise concerning end-of-life treatment (EOLT). These disputes generally arise in one of two forms.[1] The first involves the refusal of life-sustaining medical treatment. This type of dispute was typical of the "right to die" cases that were at the heart of bioethics from the Karen Ann Quinlan case[2] in 1976 through the Nancy Cruzan case[3] in 1990.[4] The second common form of physician-patient EOLT dispute[5] concerns a demand for life-sustaining treatment that the patient's physician believes is futile or otherwise

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[1] There are other types of EOLT disputes, such as those concerning the validity or meaning of an advance directive or those about choosing a decision-maker for an incompetent patient who does not have any advance directives. While these can include EOLT disputes between physicians and their patients or their patients' decision-makers, they are more likely to be disputes among members of a patient's family.

[2] *See In Re Quinlan*, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976) (holding that life support can be terminated from patients in persistent vegetative states if ethics committees confirm the patients' prognosis).

[3] *See* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278 (1990) (drawing inference that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment").

[4] *See* Paula C. Hollinger, *Hospital Ethics Committees and the Law*, 50 MD. L. REV. 742, 744 (1991) ("Beginning with the *Quinlan* case . . . and continuing through the recent *Cruzan* decision, families, patients, and health professionals have become increasingly concerned with life and death decisions complicated by evolving medical technology and the recent onset of rationing health care.").

[5] The phrase "physician-patient EOLT dispute" as used in this Article refers to disputes about end-of-life treatment in which the disputants are the patient and the patient's treating physician or, if the patient is incompetent, the patient's decision-maker (usually a family member) and the patient's treating physician. Thus, the term "patient" in "physician-patient EOLT disputes" incorporates both a competent patient acting on his or her own behalf and anyone acting as the medical decision-maker on behalf of an incompetent patient. Accordingly, the phrase "physician-patient EOLT dispute" does *not* include EOLT disputes between the patient and the patient's family.

inappropriate.[6] In these cases, the patient or the patient's decision-maker demands life-sustaining treatment, but the patient's physician claims that the patient's prospects for recovery do not warrant the treatment.[7]

While many physician-patient EOLT disputes are likely resolved by the disputants alone, others persist to the point where interested parties ask for consultations by institutional ethics committees to assist in resolving them.[8] Each year in this country, hospital ethics committees attempt to resolve approximately 8600 physician-patient EOLT disputes through consultation.[9] If

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[6] *See* Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 822 (1994) (identifying types of disputes, including cases that "have involved disputes where the health care provider wishes to terminate treatment and the patient's family members desire that everything be done for the patient").

[7] See Robert A. Gatter, Jr. & John C. Moskop, *From Futility to Triage*, 20 J. MED. & PHIL. 191, 191-94 (1995) for an overview of the concept of futility.

[8] *See infra* notes 110-11. *See also* Diane E. Hoffmann, *Regulating Ethics Committees In Health Care Institutions—Is It Time?* 50 MD. L. REV. 746, 747-48 (1991) [hereinafter Hoffmann, *Regulating Ethics*] (explaining the motivations behind the establishment of ethics committees). *See infra* notes 114-20 and accompanying text for an overview of ethics committee proceedings).

[9] This approximation is based upon estimates of the number of active ethics consultation services existing in U.S. hospitals and of the frequency at which those services consult on physician-patient EOLT disputes. There are roughly 5400 accredited hospitals in the country of which approximately 84%, or 4536, have ethics committees. *See* Robin Fretwell Wilson, *Hospital Ethics Committees As the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 N.C. L. REV. 353, 356-57 (1998). *See also* Hoffmann, *Regulating Ethics, supra* note 8, at 747 (noting that a substantial majority of hospitals have ethics committees). Of these, approximately 95%, or 4300, provide ethics consultations. *See* Robyn S. Shapiro et al., *Wisconsin Healthcare Ethics Committees*, 6 CAMBRIDGE Q. HEALTHCARE ETHICS 288, 290 (1997) (finding that 95.5% of responding hospital ethics committees in Wisconsin report providing ethics consultations). These committees on average consult on five cases each year. *See* Diane E. Hoffmann, *Does Legislating Hospital Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia*, 19 LAW MED. & HEALTH CARE 105, 110 (table 10) (Spring, Summer 1991) (concluding that 53% of hospital ethics committees surveyed had performed 0-5 case consultations during the survey year, 20% had performed 6-10 case consultations, 17% had performed 11-15 case consultations, and 10% had performed 16 or more case consultations); Susan E. Kelly et al., *Understanding the Practice of Ethics Consultation: Results of an Ethnographic Multi-Site Study*, 8 J. CLINICAL ETHICS 136, 138 (table 1) (1997). Of these, the vast majority involve EOLT disputes. *See id.* at 139 (table 2) (stating that six of nine consultations clearly involved end-of-life treatment); Mary Beth West & Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 CAMBRIDGE Q. OF HEALTHCARE ETHICS 63, 68 (1992) ("The content of [ethics committees] consultations most often involves interdisciplinary concerns . . . and end-of-life issues such as life-support treatment decisions and 'medically futile' treatment."); Hoffmann, *Study of Hospital Ethics Committees, supra* at 110 (reporting that in a survey of the types of cases most frequently heard, 87% were about withdrawal of a patient from a ventilator). Assuming most of these

similar disputes arising in nursing homes are taken into account, the total number of physician-patient EOLT disputes arising each year for which an ethics consultation is sought could be as high as 13,500.[10] Thus, a unique characteristic of physician-patient EOLT disputes is that, in extraordinary numbers, the disputants rely on institutional ethics consultations as an alternative dispute resolution mechanism.

Despite this sizable caseload, the ethics consultation process by which health care institutions attempt to resolve physician-patient EOLT disputes is almost completely unregulated. National accreditation standards together with federal Medicare regulations encourage health care institutions to implement ethics consultation services, but those standards and regulations do not address the style of dispute resolution employed by those services.[11] Similarly, both Maryland and New Jersey require certain health care institutions to have ethics committees,[12] and Maryland's law even requires that committees provide patients with some minimal due process protections as part of a consultation.[13] But the laws in both states are silent about whether committees must mediate or arbitrate or use any other process when attempting to resolve physician-patient EOLT disputes. New York is the only exception. There, hospitals must mediate disputes concerning do-not-resuscitate orders.[14] But the value of this requirement is limited because it does not apply either to physician-patient EOLT dispute arising outside of hospitals or to disputes concerning EOLTs

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are physician-patient EOLT disputes, a conservative estimate is that active ethics committees, on average, consult on two physician-patient EOLT disputes each year.

[10] In 1995, there were approximately 16,700 nursing homes in the United States. January 23, 1997 press release, United States Department of Health and Human Services, *Americans Less Likely to Use Nursing Home Care Today*, (updated Jan. 27, 1997) <http://www.cdc.gov/nchswww/releases/97news/97news/nurshome.htm>. Assuming nursing homes operate ethics committees with active consultation services at the same rate as hospitals, approximately 13,300 of them have active ethics consultation services. *See supra* note 9. If these nursing homes provide approximately the same number of consultations per year as hospitals (an average of five per hospital per year, *see id.*), we should expect that approximately 4900 physician-patient EOLT disputes arise in nursing homes each year for which third-party dispute resolution assistance is sought. This is because physician-patient EOLT disputes likely account for only about 7.5% of all bioethical disputes addressed by nursing home ethics committees. *See* NAOMI KARP & ERICA J. WOOD, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION, KEEP TALKING, KEEP LISTENING: MEDIATING NURSING HOME CARE CONFLICTS, App. A at 1-2, 7 (1997) (two of twenty-seven disputes were physician-patient EOLT disputes).

[11] *See infra* notes 172-74 and the accompanying text concerning accreditation standards of the Joint Commission for the Accreditation of Healthcare Organizations and the federal government's adoption of those standards through Medicare regulations.

[12] *See* MD. CODE ANN., HEALTH-GEN. II §§ 19-370 through 19-374; N.J. ADMIN. CODE tit. 8, 43G-5.1(h) (1997).

[13] *See* MD. CODE ANN., HEALTH-GEN. II §§ 19-370 through 19-374.

[14] *See* N.Y. PUB. HEALTH § 2972.

other than resuscitation.[15] Consequently, ethics consultation services in all but limited circumstances in one state are free to adopt any style of dispute resolution in attempting resolution of physician-patient EOLT disputes.[16]

Most consultation services provided by ethics committees use non-binding arbitration to attempt to resolve physician-patient EOLT disputes.[17] Under this style of dispute resolution, patients and physicians vie for committees' recommendations.[18] Such a competitive process, however, might do more harm than good. Specifically, the adversarial nature of arbitration risks eroding the trust patients place in their physicians, which is particularly troublesome given the unique characteristics of physician-patient EOLT disputes.

Unlike most disputes, physician-patient EOLT disputes arise in the context of an ongoing treatment relationship. Indeed, in many cases the physician continues to treat the patient throughout an initial ethics consultation.[19] Thus, the patient or patient's family continues to trust that, despite the dispute, the physician will exercise her or his medical skill and judgment for the benefit of the patient. Such trust is an essential ingredient to quality medical care at the end-of-life, and it should not be an unnecessary casualty of the dispute resolution process.[20] Accordingly, the law should assure that the method of ethics consultation employed to resolve physician-patient EOLT disputes is no more adversarial than necessary.

These considerations lead to the hypothesis that mediation is well suited to resolve physician-patient EOLT disputes because it is the least adversarial method of assisted dispute resolution.[21] Mediation relies on facilitation and

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[15] *See id.*

[16] *See infra* notes 175-78 and accompanying text concerning state laws that encourage, but do not require, ethics consultation services to arbitrate treatment disputes.

[17] *See infra* notes 114-21 and accompanying text for an overview of the ethics consultation process.

[18] *See id.*

[19] *See, e.g., In re* Westchester County Medical Ctr., 531 N.E.2d 607, 609 (N.Y. 1988) (facts suggest that attending physician with whom patient's decision-makers disagreed about the use of a nasogastric feeding tube remained the patient's attending physician throughout the resolution of the dispute, including at the initial ethics committee meeting); Conservatorship of Morrison, 253 Cal. Rptr. 530, 532 (Ct. App. 1988) (patient in persistent vegetative state continues to be treated by attending physician and stays at hospital despite disagreement between her decision-maker and the physician and hospital about terminating life-sustaining treatment). In my experience as an ethics committee member and an ethics consultant, physicians routinely seek an ethics consultation to help resolve EOLT disputes between themselves and their patients or patients' family members before transferring care of the patient to another physician.

[20] *See infra* Part I for a discussion of the centrality of trust in the physician-patient relationship.

[21] I use the term "assisted dispute resolution" to mean any form of dispute resolution in which a neutral, third party assists disputing parties to resolve their dispute. I mean for the

conciliation to assist disputants to reach mutually acceptable agreements rather than adversarial argumentation to neutral decision-makers.[22] Thus, mediation is the most appropriate method for resolving many physician-patient EOLT disputes because the disputants have an ongoing trust relationship and seek assistance at a stage in the dispute when reconciliation is possible. In other words, mediation allows the patient and physician to pursue resolution of an EOLT dispute, yet protect their trust relationship.

Surprisingly, current literature ignores the value of preserving patients' trust in their treating physicians at the end of life and therefore overlooks a powerful argument in support of EOLT mediation. Mediation was first identified as a relevant dispute resolution model for EOLT disputes in 1989.[23] The first proposal to use mediation as a dispute resolution process in EOLT disputes was made in 1992.[24] Since then, several commentators have endorsed mediation as an alternative dispute resolution mechanism for EOLT disputes.[25]

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term to encompass mediation, arbitration and adjudication while excluding direct negotiation between disputing parties (or their representatives) without the assistance of any neutral party. It should not be confused with *alternative* dispute resolution, which encompasses any dispute resolution mechanism other than adjudication.

[22] *See infra* Part II.A for an explanation of mediation.

[23] *See* Linda C. Fentiman, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent, Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801, 840-48 (1989) (using mediation theory as one basis for a model of communication in surrogate EOLT decision-making).

[24] *See* West & Gibson, *supra* note 9, at 73 (concluding that facilitation and mediation techniques "can be helpful" to medical ethics committees in case review consultations).

[25] *See, e.g.*, NANCY NEVELOFF DUBLER & LEONARD J. MARCUS, MEDIATING BIOETHICAL DISPUTES: A PRACTICAL GUIDE 5 (United Hospital Fund of New York, Practical Guide Series, 1994) (finding that mediation can yield creative solutions tailored to the needs of the parties, that the parties are more satisfied with the resolution and have a greater commitment to its implementation and that the parties may develop a greater capacity to resolve future disputes without intervention); LEONARD J. MARCUS ET AL., RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION 327, 361 (1995) (stating that mediation is flexible and can be adapted to the needs of bioethical disputes); Karen A. Butler, *Harvesters: Alternatives to Judicial Intervention in Medical Treatment Decisions*, 1996 J. DISP. RESOL. 191, 208 and 212 (1996) (endorsing a mediation-arbitration hybrid and the use of the Bioethics Review Committee proposed by the New York Task Force on Life and the Law as a mediation body); James W. Reeves, *ADR Relieves Pain of Health Care Disputes*, 49 DISP. RESOL J. 14 (Sept. 1994) (reporting on a planned pilot project in St. Louis, which emphasizes mediation over arbitration and litigation); Lynne Sims-Taylor, *Reasoned Compassion in a More Humane Forum: A Proposal to Use ADR to Resolve Medical Treatment Decisions*, 9 OHIO ST. J. ON DISP. RESOL. 333, 336 and 363-370 (1994) (proposing a system of mandatory mediation and non-binding arbitration prior to adjudication); Ellen A. Waldman, *Identifying the Role of Social Norms in Mediation: A Multiple Model Approach*, 48 HASTINGS L. J. 703, 754 (1997) (depicting an EOLT dispute as a paradigm case for the application of a kind of mediation in which the mediator actively advocates for important public values that act as a boundary for any agreement reached by

Supporters argue that mediation is the best form of EOLT dispute resolution because it is: (1) less destructive to the disputants' relationships; (2) more sensitive to the contextual features of disputes; (3) more consistent with the principle of patient self-determination; and (4) less publicly intrusive.[26] There has not been much analysis, however, of these hypothesized benefits. Rather, proponents generally list them as assumptions from which to make an argument about mediation.[27] Accordingly, the claims of mediation proponents lack a solid foundation.

In comparison, the drawbacks of using mediation to resolve EOLT disputes—and *physician-patient* EOLT disputes particularly—have been thoroughly examined. In 1994, Professor Diane E. Hoffmann identified several reasons why proponents of mediation for EOLT disputes should proceed with great caution.[28] Most notable among Professor Hoffmann's concerns are that mediation: (1) will not account for the power imbalance in disputes between health care providers and patients or patients' families;[29] (2) will not sufficiently protect the rights of patients, especially incapacitated patients;[30] (3) will not enforce important public values;[31] and (4) cannot resolve disputes over moral values.[32] Professor Hoffmann concluded that mediation is ill suited to address physician-patient EOLT disputes.[33] Her criticisms quelled early excitement about mediating physician-patient EOLT

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the parties); Erica Wood & Naomi Karp, *"Fitting the Forum to the Fuss" in Acute and Long-Term Care Facilities*, 29 CLEARINGHOUSE REV. 621, 626 (1995) (listing mediation as one method of dispute resolution for long-term care disputes).

[26] *See, e.g.*, Butler, *supra* note 25, at 206 (explaining the advantages that alternate dispute resolution, including mediation, has over judicial intervention).

[27] *See, e.g.*, Brad Burg, *Isn't There Something Better than Suing? There Is!* MED. ECON., July 6, 1992, at 164-71 (providing brief summary of benefits while advocating mediation in a wide range of health-centered disputes).

[28] *See* Hoffmann, *supra* note 6, at 858-73 (examining the appropriateness of mediation for EOLT dispute resolution based on specified criteria and concluding that mediation is not well suited for the resolution of many EOLT disputes).

[29] *See id.* at 865 (stating that the physician is likely to have more resources, technical expertise and control over care than the patient and the patient's family).

[30] *See id.* at 866 ("Perhaps the most problematic aspect of the application of mediation is that there may be no one officially representing the interests of the parties.").

[31] *See id.* at 872 ("In a mediation process, disputants may reject established norms and develop their own . . . Alternatively, they may not develop any norms at all.").

[32] *See id.* at 863 ("[A]ny party [who] views the dispute as one in which there is a definite right or wrong answer . . . may view compromise as an admission of 'normative weakness' . . . .").

[33] *See id.* at 826. Despite her conclusion with respect to disputes between health care providers and patients or patient's surrogate decision-makers, Professor Hoffmann agrees that mediation might be an appropriate mechanism for resolving EOLT disputes among family members. *See id.*

disputes.[34]

Beyond the theoretical debates about the application of mediation to EOLT disputes, there has been some practical testing of mediation as a dispute resolution mechanism in EOLT cases. To date, a handful of pilot projects have been completed.[35] These projects have shown that mediation is a viable dispute resolution mechanism.[36] Unfortunately, none of these projects was designed to gather data to substantiate mediation's hypothesized benefits and costs. Consequently, our empirical understanding of mediation in EOLT cases is in its nascent stage at best and lags behind our theoretical understanding.

To summarize, current wisdom about EOLT dispute mediation is that concerns over its fairness outweigh its advantages, especially in the case of physician-patient EOLT disputes. Yet this conclusion has been reached without a thorough understanding of how mediation can prevent the erosion of patient trust, which is integral to the physician-patient relationship.

This Article challenges current thinking and concludes that the value of preserving patients' trust in their physicians at the end-of-life justifies a policy of using mediation to resolve physician-patient EOLT disputes. Part I lays the foundation for this conclusion by showing the importance of patient trust in assuring good medical decision-making and in preserving the physician-patient relationship. Part II argues that mediation has the greatest potential among all forms of assisted dispute resolution to preserve this vital trust relationship at the end-of-life. Part III replies to claims that mediation is ill suited for

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[34] *See, e.g.*, Wood & Karp, *supra* note 25, at 627 (citing the unwillingness of parties to participate and power imbalances as reasons why mediation may not be an ideal means by which to resolve disputes).

[35] *See* DUBLER & MARCUS, *supra* note 25, at ix (reporting on Montefiore Medical Center's project to develop a mediation program for the hospital staff); West & Gibson, *supra* note 9, at 63 (reporting on the National Institute for Dispute Resolution planning grant from its Innovation Fund to the Institute for Public Law at the University of New Mexico School of Law to study what ethics committees can learn from facilitation and mediation techniques); Wood & Karp, *supra* note 25, at 627 (describing how the American Bar Association Commission on Legal Problems of the Elderly, with the support of the American Association of Retired Persons Andrus Foundation and the Commonwealth Fund, launched a pilot program in 1994 for resolving long-term care disputes in 25 nursing homes in the District of Columbia, Maryland and Northern Virginia).

[36] *See* DUBLER & MARCUS, *supra* note 25, at 33 (describing mediation model based on analysis of actual cases from Montefiore Medical Center's program to develop a mediation program for the staff); West & Gibson, *supra* note 9, at 73; Wood & Karp, *supra* note 25, at 626 ("Several landmark projects demonstrate mediation as a means of empowering patients, families, and staff members to resolve difficult decisions."). In contrast, the Colorado Collective for Health Care Decisions reports that its program for mediating disputes about the appropriateness of EOLTs was discontinued for lack of referrals. Telephone interview with Susan Fox Buchanan, Executive Director, Colorado Collective for Health Care Decisions (Oct. 1999). *See also* Colorado Collective for Healthcare Decisions, draft article concerning its end-of-life care mediation project (unpublished manuscript on file with *Boston University Law Review*).

physician-patient EOLT disputes. Finally, Part IV examines laws concerning ethics consultations and argues that they encourage a method of dispute resolution that is unnecessarily destructive of patient trust. Part IV concludes by proposing a law to require hospitals and nursing homes to adopt procedures for mediating physician-patient EOLT disputes and to offer patients or their decision-makers the option of using that service as an alternative to other dispute resolution processes the institution offers.

I. THE CENTRALITY OF TRUST IN THE PHYSICIAN-PATIENT RELATIONSHIP

During initial attempts to resolve a physician-patient EOLT dispute through an ethics consultation, the disputants usually remain in a treatment relationship.[37] This reality is at the heart of claims that mediation is not suited to resolve these types of disagreements. Critics argue that a treatment relationship between a physician and patient is a relationship of unequal power and that this makes mediation an inappropriate form of dispute resolution.[38] But to perceive the physician-patient relationship as one of relative power inequality is to see only part of the relationship, ignoring patients' presumptive trust that their physicians are concerned about and committed to their well-being. This trust is at the ethical core of the physician-patient relationship and is essential to the process of medical decision-making. Accordingly, the suitability of mediation for resolving physician-patient EOLT disputes should be measured by how well it preserves—or at least prevents the erosion of—patients' trust in their physicians.

Because most patients are not able to treat themselves or to direct the medical treatment they receive from another, they turn their care over to the discretion and skill of a physician, laying their bodies and lives open to the physician. Thus, patients place themselves in a position of vulnerability; in other words, patients choose to trust their physicians.[39] Generally, this trust

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[37] *See supra* note 19.

[38] *See* Hoffmann, *supra* note 6, at 865-66 (arguing that the physician is advantaged in education, training, and power within the medical institution, leaving the patient or patient's family at a distinct disadvantage in mediation).

[39] Eric Cassell writes:

> I remember a patient, lying undressed on the examining table, who said quizzically, "Why am I letting you touch me?" It is a very reasonable question. She was a patient new to me, a stranger, and fifteen minutes after our meeting, I was poking at her breasts! Similarly I have access to the homes and darkest secrets of people who are virtual strangers. In other words, the usual boundaries of a person, both physical and emotional, are crossed with impunity by physicians.

1 ERIC J. CASSELL, TALKING WITH PATIENTS 119 (1985). *See also* RICHARD M. ZANER, TROUBLED VOICES: STORIES OF ETHICS AND ILLNESS 8-10 (1993) (considering the passage above and concluding that what makes the physician-patient relationship workable is trust by patients in the physician's skills, knowledge, integrity, and "even in them as persons"). *See generally* ANNETTE C. BAIER, *Trust and Antitrust, in* MORAL PREJUDICES: ESSAYS ON ETHICS 95, 95-129 (1994) (giving a philosophical assessment of trust). Some may argue

consists of two parts: that physicians are professionally competent and that physicians care about their patients' values and well-being.[40] Trust in physicians' professional competence is rooted in a belief that physicians have the requisite medical knowledge and technical skill to effectively treat their patients.[41] Further, patients trust that their physicians will act according to each patient's best interests. More specifically, patients trust that physicians place the well-being of their patients above all other interests—a belief in the fidelity of physicians to the interests of their patients.[42]

There are at least two reasons why, as a matter of public policy, we should prevent the deterioration of patient trust in physicians.[43] First, such trust is essential to the way medical treatment decisions are made, particularly decisions made at the end of life. Second, trust in physicians is essential to the ethical foundation of the physician-patient relationship.

Medical decision-making is a cooperative process based on patient trust. This is true for all types of medical decisions, whether they are made in the context of physician-patient relationships that fulfill the highest ethical aspirations for that relationship or as part of physician-patient relationships in which only the minimal obligations of competent diagnosis and informed

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that patients do not necessarily trust physicians when they choose to be treated by a physician. Because a person in need of medical treatment has few, if any, options other than to be treated by a physician, patients may be forced to "rely" on physicians even if they do not trust physicians. But reliance on another out of need is consistent with trusting another. Trust can include circumstances in which we rely on others because we have no other choice but to do so. Philosopher Annette C. Baier defines trust as "letting other persons . . . take care of something the truster cares about, where such 'caring for' involves some exercise of discretionary powers." *See* BAIER, *supra* at 105. She includes among circumstances of trust, instances in which we trust out of the necessity to do so. "Since the things we typically . . . value include things that we cannot singlehandedly either create or sustain (our own life, health . . .), we *must* allow many other people to get into positions where they can, if they choose, injure what we care about . . . ." *Id.* at 100-01 (emphasis added).

[40] *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL., POL'Y & L. 661, 663-64 (1998) (defining the dimensions of trust in the physician-patient context).

[41] *See id.* at 664 ("[Patients] are reassured by [the] knowledge that medicine is a highly competitive academic endeavor, that entry into medicine is selective and requires talent and perseverance, that training is uniformly careful and rigorous, and that the profession controls entry and licensing through high standards.").

[42] *See id.* at 667 ("The notion of physician agency has an honorable history in medical philosophy and ethics, and the public legitimacy of the medical profession rests substantially on the perception of physicians as dedicated patient advocates.")

[43] *See id.* at 661-63 (arguing that maintenance or restoration of patient trust in physicians and health care institutions is a vital public health issue). *See also*, MICHAEL H. ANNISON & DAN S. WILFORD, TRUST MATTERS: NEW DIRECTIONS IN HEALTH CARE LEADERSHIP 19 (1998) (highlighting the pervasive necessity of trust in all relationships in the healthcare community, not just between doctors and patients).

consent are met.[44] Trust is fundamental to the doctrine of informed consent in medical treatment, which enforces a combination of patients' rights and physicians' duties that are basic to the way medical treatment decisions are made.[45] Under that doctrine, physicians must not treat any patient without that patient's consent.[46] Furthermore, physicians are obligated to inform patients about their medical conditions and treatment options so that each patient's consent to or refusal of proposed treatments is informed and intelligent.[47] Depending on the law of the applicable jurisdiction, physicians must either provide patients with information that a reasonably prudent physician in the same or similar circumstances would provide[48] or with information that a reasonable person in the patient's position would consider material to the treatment decision at hand.[49] To fulfill these obligations, the physician must become familiar with the patient's position, assess treatment options together with corresponding risks and benefits to the patient's health and ultimate treatment goals, disclose that information to the patient and allow the patient to decide which, if any, of the proposed treatments to undergo.[50]

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[44] Many scholars of the physician-patient relationship and of the medical decision-making process argue that the ideal process for medical decision-making is one of collaboration between a physician and patient acting in partnership, or even friendship, in which each respects the moral standing of the other. *See e.g.*, Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221, 2222 (1992) (setting forth a deliberative model of physician-patient interaction where the physician "acts as a teacher or friend engaging the patient in dialogue on what course of action would be best"); JAY KATZ, SILENT WORLD OF DOCTOR AND PATIENT 163-64 (1984) (promoting collaboration between doctor and patient to identify the optimal treatment plan for the patient).

[45] *See generally* PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987); RUTH FADEN & TOM BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986); KATZ, *supra* note 44 for detailed explanation, analysis and critical assessment of the informed consent doctrine.

[46] *See* Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972) ("It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment."); FADEN & BEAUCHAMP, *supra* note 45, at 3 (highlighting the legal duty a physician has to both inform the patient and obtain his or her consent).

[47] *See Canterbury*, 464 F.2d at 780 ("True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."); FADEN & BEAUCHAMP, *supra* note 45, at 3 (representing that informed consent includes a duty for physicians to disclose treatment information to patients).

[48] *See e.g.*, Culbertson v. Mernitz, 602 N.E.2d 98, 104 (Ind.1992) (upholding Indiana's physician-based standard).

[49] *See e.g.*, *Canterbury*, 464 F.2d at 787 (enforcing a patient-centered standard in the District of Columbia).

[50] *See id.* at 781-82 (describing the interest patients have in obtaining all relevant information from their doctors so that they can make informed decisions); Susan K. Gauvey,

Each of these minimal steps assumes that patients trust their physicians. For physicians to assess and inform patients about their medical conditions, patients must entrust their physicians with confidential information about their bodies, their lifestyles and their medical and social histories. In addition, it is essential that patients trust physicians to identify and recommend treatments that will achieve each patient's treatment goals. Finally, patients must trust that their physicians will disclose and explain treatment information so that patients can make intelligent treatment choices. Thus, even if most medical decision-making is typically no more cooperative than necessary to meet these basic obligations, the process still assumes that patients have a great deal of trust in their physicians.

In theory, the necessity of patient trust to the process of medical decision-making does not change based on the kind of medical decision being made. As a practical matter, however, the importance of patient trust is heightened at the end of life because the stakes are much higher. A decision that is uninformed or does not reflect the patient's true values risks either prematurely ending the patient's life or subjecting the patient to a prolonged life of often severely diminished quality.[51] In other words, a patient's trust in the assistance of physicians in EOLT decision-making encompasses not only choices among various methods of curing an illness, but also the far more consequential choice about whether to stop fighting an illness and accept the inevitability of death. In facing such choices, patients must trust that physicians' efforts to understand the patients' conditions and treatment goals and to explain that information to patients are based on a sincere concern for patients' welfare and values. Moreover, the stakes are raised in EOLT decision-making because often patients must rely on others (usually family members) to make life and death decisions for them.[52] Family members often are not emotionally

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et al., *Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation*, 15 HARV. J. ON LEGIS. 431, 439 (1978) ("[I]nformed consent requires an exchange of information between the physician and patient which culminates in a decision made by the patient based on this information."); Cathy J. Jones, *Autonomy and Informed Consent in Medical Decision-Making: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 385-86 (1990) (explaining that informed consent "requires that physicians disclose to patients certain information concerning the patients' condition, proposed diagnostic or treatment alternatives, and the risks and benefits associated with those alternatives."); Robert Gatter, *The Forgotten Duty in Informed Consent Law: A Physician's Obligation to Inquire About Patients' Subjective Treatment Goals*, 31 LOY. U. CHI. L.J. _____ (forthcoming 2000) (arguing that informed consent law requires physicians to make a reasonable effort to determine each patient's treatment goals) (manuscript on file with *Boston University Law Review*).

[51] *See e.g.*, Ben A. Rich, *The Values History: A New Standard Of Care*, 40 EMORY L.J. 1109, 1129 (1991) (discussing the case of Dax Cowart, a young man kept alive in a state of severe pain despite his requests to the contrary after suffering third degree burns in an explosion).

[52] *See* David Orentlicher, *Limits of Legislation*, 53 MD. L. REV. 1255, 1263 (1994)

prepared to make such decisions and lack essential information about the patient's medical condition and preferences.[53] Consequently, patients must trust that physicians will work to overcome barriers to informed EOLT decision-making by others rather than permit the quality of decision-making to suffer. The process by which patients make treatment decisions for themselves, or have treatment decisions made for them, is worth protecting because it promotes respect for the autonomy of patients—a central value in medicine.[54] Because patient trust in physicians is essential to the process of autonomous EOLT decision-making, it should be preserved as a matter of public policy.

A second and related reason to preserve patient trust in physicians is that it is an essential part of the ethical foundation of the physician-patient relationship. Theorists have provided a wide array of conceptual models for the physician-patient relationship.[55] Some describe the ideal relationship as a collaborative partnership.[56] Others argue that it is a contract[57] or a covenant.[58]

("Ordinarily, when the patient has not left an advance directive, family members are relied upon to make decisions for the patient. Indeed, physicians have historically turned to family members for medical decisions when patients are mentally incompetent, and courts generally have recognized the authority of families to make life-sustaining treatment decisions for incompetent patients.").

[53] *See id.* at 1278 (outlining empirical studies of family decision-making showing that patients' family members cannot predict the preferences of patients to any degree of statistical significance).

[54] *See, e.g.*, TOM L. BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 142 (4th ed. 1994) (accepting "the premise that the primary function and justification of informed consent is to enable and protect individual autonomous choice"); FADEN & BEAUCHAMP, *supra* note 45, at 235-97 (providing a theoretical model for informed consent based upon the principle of respect for autonomy); KATZ, *supra* note 44, at xiii-xxi (introducing and summarizing the thesis that a history of medical paternalism has hindered patient self-determination in medical decision-making and that a thorough-going respect for informed consent is necessary to reverse that history); H. TRISTRAM ENGLEHARDT, THE FOUNDATION OF BIOETHICS 121-28 (2d ed. 1995) (claiming that the principles of permission and beneficence are the principles of bioethics and that the principle of permission presumptively trumps the principle of beneficence when they conflict).

[55] *See* William F. May, *A Basis for Professional Ethics: Code, Covenant, Contract, or Philanthropy*, 5 HASTINGS CENTER REPORT 29 (Dec. 1975) (describing various moral conceptions of the physician-patient relationship).

[56] *See, e.g.*, Emanuel & Emanuel, *supra* note 44, at 2222 (advancing a physician-patient relationship model based on collaborative discussion).

[57] *See e.g.*, Robert M. Veatch, *Models for Ethical Medicine in a Revolutionary Age: What Physician-Patient Roles Foster the Most Ethical Relationship?*, 2 HASTINGS CENTER REPORT 5 (June 1972) (expounding a general, not legal, conception of contract between patient and physician under which both parties gain a mutual understanding of the other party's rights and responsibilities).

[58] *See e.g.*, May, *supra* note 55, at 29 (noting that the covenant model includes contractual elements but also involves a heightened social responsibility on the part of

Still others claim that physicians are beneficent caretakers of their patients.[59] Basic to each of these models is that patients must entrust themselves to the skill and integrity of their physicians, making trust a central element of the relationship.[60] Moreover, this is consistent with the law's concept of the physician-patient relationship as a fiduciary one because it "involves every element of trust, confidence and good faith."[61] Without patient trust, the conceptual foundation of a good and just physician-patient relationship would erode.

In light of the crucial role trust plays in the physician-patient relationship, and because that trust is worth preserving as a matter of public policy, the debate about whether to mediate EOLT disputes between physicians and patients must take a different tack. The important question is whether mediation preserves patient trust in physicians better than other methods of dispute resolution, including current methods of ethics consultation. This new tack also places in proper perspective concerns about the power imbalance between physicians and patients. The power imbalance exists in the context of a trust relationship. It is simply a part of that relationship in the same way that vulnerability is part of every trust relationship. Indeed, vulnerability to abuse of power by one in a trusted position is an important characteristic of a trust

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physicians as a result of the societal support they have received throughout their training).

[59] *See e.g.*, EDMUND D. PELLIGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD 54-58 (1988) [hereinafter PELLIGRINO & THOMASMA, PATIENT'S GOOD] (arguing that beneficence is the primary ethical principle in medicine); EDMUND D. PELLIGRINO & DAVID C. THOMASMA, THE VIRTUES IN MEDICAL PRACTICE 37-48 (1993) (emphasizing the role of physicians under a social contract to act according to their patients' best interests and to the exclusion of their own self-interest).

[60] *See* RUTH B. PURTILLO, *Professional-Patient Relationships: Ethical Issues*, *in* 4 ENCYCLOPEDIA OF BIOETHICS 2094, 2099 (Warren T. Reich ed., 2d ed. 1995) ("Only when the professional is truly trustworthy can the patient's security and, importantly, freedom to act flourish within the complex intermingling of dependence and independence that characterizes today's [physician-patient] relationship."). *See also* PELLIGRINO & THOMASMA, PATIENT'S GOOD, *supra* note 59, at 109-10 (concluding that the patient must have confidence in the physician for treatment to be carried out effectively); ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 8 (1977) (suggesting that covenant and contract models are based in trust); Emanuel & Emanuel, *supra* note 44, at 2225-26 (emphasizing the necessity of effective communication between physician and patient so that the patient understands and has faith in the determinations of the physician).

[61] Lockett v. Goodill, 430 P.2d 589, 591 (Wash. 1967). *See also* Canterbury, 464 F.2d at 782 (commenting on the fiduciary nature of the physician-patient relationship that requires the physician to disclose all relevant information to the patient); Moore v. Regents of the University of California, 271 Cal Rptr. 146, 150 (1990) ("[I]n soliciting the patient's consent, a physician has a fiduciary duty to disclose all information material to the patient's decision."). *See generally* Gregory D. Jones, Note, *Primum Non Nocere: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship*, 51 VAND. L. REV. 139, 155-60 (1998) (giving an overview of the physician-patient relationship as a fiduciary relationship).

relationship. It is impossible to say that one person trusts another without also saying that he or she is vulnerable to that other person.[62] Consequently, the power advantage of a physician over a patient and the risk that the physician might abuse that power simply highlights the centrality of trust in physician-patient relationships.

Having proposed that the debate about mediating EOLT disputes between physicians and patients focus on preserving patient trust, I argue next that mediation is more likely than any other assisted dispute resolution process—arbitration or adjudication—to preserve patient trust. Mediation is the only form of assisted dispute resolution that encourages *collaboration* rather than adversarial competition between disputants.

Even before reaching this argument, however, a skeptic might claim that resolving physician-patient EOLT disputes should not focus on preserving patient trust in physicians. First, one might argue that the legally enforceable rights of patients to receive non-negligent, confidential and consensual medical treatment have replaced the centrality of trust in the physician-patient relationship. The purpose of physician-patient EOLT dispute resolution, according to this argument, is to enforce those rights rather than to preserve a non-existent trust. But this criticism fails to appreciate that these legal rights cannot stand alone without an underlying relationship of trust. It is hard to imagine that knowledge of one's right to recover damages in a court of law is sufficient to inspire the kind of confidence needed to place one's physical well-being in the hands of a physician. Rather, it seems more likely that patients need to trust physicians sufficiently to believe that they will not need to resort to enforcing their legal rights. After all, monetary damages are poor compensation for the kinds of human suffering experienced by a breach of a patient's rights.[63] Thus, while legal rights affect the quality of trust relationships, they do not replace trust. Instead, legal rights are interwoven with trust. The protection afforded by legal rights creates "a climate of trust."[64]

A second challenge to the claim that preservation of patient trust should be a central goal of physician-patient EOLT dispute resolution argues that, by the time such a dispute has escalated to the point of needing assisted resolution, there may be little, if any, patient trust left to preserve. Thus, even if preserving patient trust *was* a goal, its importance has diminished and other

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[62] *See* BAIER, *supra* note 39, at 103-05 ("The special vulnerability which trust involves is vulnerability to not yet noticed harm, or to disguised ill will.").

[63] *See* Majorie Maguire Shultz, *From Informed Consent to Patient Choice*, 95 YALE L.J. 219, 251-53 (1985) (identifying dignitary harms to patients deprived of an opportunity to choose their treatments; these harms are not compensated under informed consent law).

[64] *See* BAIER, *supra* note 39, at 111 ("Social artifices such as property, which allocate rights and duties . . . create a climate of trust, a presumption of a sort of trustworthiness."). *See also supra* text accompanying notes 44-50 (regarding the need for trust even assuming that medical treatment decisions are made only on the basis of the limited legal duties established by informed consent).

goals must take priority. While it is true that not all physician-patient relationships can meet the ideal of a trusting relationship, it does not follow that a process to resolve physician-patient EOLT disputes should be based on the assumption that *no* trust remains in *any* relationship that is worth preserving. Instead, it makes more sense to create a presumption that the preservation of patient trust remains a high priority—a presumption that can be overcome on a case-by-case basis.[65] Accordingly, there should be access to non-adversarial dispute resolution mechanisms, such as mediation, for resolving physician-patient EOLT disputes so that the essential trust between the disputants can be preserved.

II. PREVENTING THE UNNECESSARY EROSION OF PATIENT TRUST THROUGH MEDIATION

Preserving patient trust in physicians requires more than providing competent medical services. It also requires a process for resolving foreseeable disputes without destroying the physician-patient relationship.[66] To succeed, such a process must prevent the escalation of a dispute beyond the point at which the disputants can interact with each other. As a practical matter, mediation, as compared to arbitration or adjudication, prevents the escalation of disputes because mediation enables disputants to collaborate with each other. Conversely, arbitration and adjudication pit disputants against each other. There is empirical evidence that supports the effectiveness of mediation in this regard.

A. *General Explanation of Mediation*

Mediation is a form of alternative dispute resolution that is most practically described as assisted negotiation.[67] In mediation, a neutral third party—the mediator—assists disputants in negotiating an agreement that resolves their dispute.[68] The mediator functions as a facilitator, creating an environment in

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[65] *See infra* Part IV.B. for arguments in favor of a law requiring health care institutions to offer mediation to all patients or their decision-makers involved in EOLT disputes with their physicians.

[66] *See* Mechanic, *supra* note 40, at 665 ("The product of medical care is in part the process of doctoring, and how physicians maintain the relationship and manage problems.").

[67] *See* STEPHEN B. GOLDBERG ET AL., DISPUTE RESOLUTION: NEGOTIATION, MEDIATION, AND OTHER PROCESSES 103 (2d ed. 1992) ("Mediation is negotiation carried out with the assistance of a third party."); JAY E. GRENIG, ALTERNATIVE DISPUTE RESOLUTION WITH FORMS 116 (2d ed. 1990) (mediation "is, in effect, an extension of the negotiation process"); CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 15 (2d ed. 1996) (defining mediation as "the intervention in a negotiation or a conflict of an acceptable third party who has limited or no authoritative decision-making power but who assists the involved parties in voluntarily reaching a mutually acceptable settlement of issues in dispute").

[68] *See* GRENIG, *supra* note 67, at 116-17 (defining the role of a mediator); MOORE, *supra*

which the disputants are most likely to find a mutually acceptable resolution of their dispute.[69] To create such an environment, mediators employ various techniques. For example, they often request that the disputants agree to ground rules that include taking turns in speaking and not interrupting each other. Each party is thereby given an opportunity to tell her or his story while the other listens.[70] The ground rules might also require that disputants refrain from slandering or attributing bad motives to each other.[71] Another technique is caucusing, in which the mediator meets privately with each disputant.[72] Mediators might initiate caucuses for any number of reasons, such as refocusing parties on the issues after a contentious joint session, learning information that a party is reluctant to reveal in joint session, privately testing the validity of one party's claims, or controlling the negotiation through shuttle diplomacy.[73] Should an impasse develop, mediators often employ a technique to test the strength of the impasse by challenging the parties to identify their best and worst alternatives to a negotiated agreement ("BATNA" and "WATNA").[74] The mediator, either in joint meetings or in caucuses, reviews

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note 67, at 15; Patrick Mead & Ed Newcomer, Jr., *Alternative Dispute Resolution (ADR) Glossary of Terms*, WASHINGTON STATE BAR NEWS 25, 26 (April 1993) (referring to the non-binding, facilitation role played by the mediator).

[69] *See* MOORE, *supra* note 67, at 18-19 (listing "process facilitator" among the various roles that a mediator might play in addition to "opener of communication channels," "legitimizer," "trainer," "resource expander," "problem explorer," "agent of reality," "scapegoat," and "leader").

[70] *See* KIMBERLEE K. KOVACH, MEDIATION: PRINCIPLES AND PRACTICE 84 (1994) (recommending that mediators obtain "an affirmative commitment from the parties to listen to each other" and otherwise cooperate in the search for settlement options at the start of a mediation); MOORE, *supra* note 67, at 157, 198-99, 201; N. ROGERS & R. SALEM, *A Student's Guide to Mediation and the Law*, *in* DISPUTE RESOLUTION: NEGOTIATION, MEDIATION AND OTHER PROCESSES 107 (Stephen B. Goldberg et al., eds., 1992) (emphasizing the variety of dispute resolution tools available to the mediator).

[71] *See* MOORE, *supra* note 67, at 157.

[72] *See* MOORE, *supra* note 67, at 319-26 (outlining situations that necessitate caucusing and the procedure that should be followed); Lisa G. Lerman, *Mediation of Wife Abuse Cases: The Adverse Impact of Informal Dispute Resolution on Women*, 7 HARV. WOMEN'S L.J. 57, 103-04 (1984) (recommending that mediations between the perpetrator and victim of spousal abuse begin with separate meetings between the mediator and each party); Thomas B. Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107, 120-21 (Winter 1997) (citing evidence that suggests mediators in medical malpractice cases routinely met separately with parties).

[73] *See* MOORE, *supra* note 67, at 319-20 (listing purposes for initiating caucuses).

[74] *See* ROGER FISHER & WILLIAM URY, GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN 97 (1991) (coining the term "BATNA" for the "Best Alternative To a Negotiated Agreement"); Kovach, *supra* note 70, at 128-29 (encouraging the discovery and use of each party's BATNA and WATNA as a means to overcome an impasse); MOORE, *supra* note 67, at 277-78, 330-31 (discussing how mediators may query parties about their best and worst alternatives to a negotiated agreement); Metzloff et al., *supra* note 72, at 121-

with parties the benefits and risks associated with their options if mediation should end without an agreement. Another technique, closely related to BATNA and WATNA, is reality testing, in which the mediator questions a disputant about the basis of the disputant's claims and the risks associated with justifying those claims to other disputants in a joint mediation session or to a court.[75] The reality test is useful to deflate expectations of an uncompromising party and enable further discussion.[76]

Mediation is unique among the classic dispute resolution processes (negotiation, mediation, arbitration, and adjudication) because it is the only one in which a neutral third party intervenes without taking control of the dispute's resolution. In adjudication and arbitration, a third party intervenes to decide the case for the disputants. In contrast, the parties in a mediation resolve the dispute themselves with the assistance of a neutral third party. Mediation is most like negotiation; in both, the parties determine together whether and how to resolve their dispute. Like negotiation, mediation depends on the disputants' ability to work together toward a mutually acceptable agreement. This process requires each party to assist the other party in understanding each party's demands and the reasons for them. Additionally, each party must account for the concerns of the other party in any proposed settlement. Moderation by a neutral third party distinguishes mediation from negotiation. By orchestrating a discussion, the mediator can often facilitate productive and respectful communication between disputants who are otherwise unable to communicate with each other about resolving their dispute.

Mediation attempts to achieve two simultaneous goals: to resolve the dispute and to preserve the disputants' relationship. Thus, mediation should be the preferred method of dispute resolution for cases involving disputants whose relationships are particularly valuable and worth preserving. Typically, these are relationships of trust between persons who, after the dispute is resolved, will have further contact with each other on matters that characteristically involve continued cooperation.[77] For that reason, mediation

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23 (presenting data confirming that mediators play on the doubts of parties about their chances of succeeding in court to facilitate a move toward resolution of the conflict).

[75] *See* GRENIG, *supra* note 67, at 142 (extolling the virtue of testing reality to compel parties to face the risk of not reaching a voluntary settlement).

[76] *See* MOORE, *supra* note 67, at 276-77 (urging the mediator to lower a party's expectations and maintain discussion progress).

[77] Lon Fuller, *Mediation—Its Forms and Functions*, 44 S. CAL. L. REV. 305, 325-26, 331 (1971) (identifying disputes between individuals who have a relationship of mutual trust and confidence as disputes for which mediation is appropriate). The claim that mediation is appropriate for all disputes between those in trust relationships presumes that all trust relationships are worth preserving. This presumption ignores that, even in relationships that *should* be based on trust, trust can be misplaced. This is as true in relationships between patients and health care providers as it is in any purportedly trusting relationship. Thus, the claim that mediation is preferable in disputes involving trust relationships should not be interpreted as a claim that mediation should be mandatory for such disputes. Instead, the

is often used to resolve disputes between spouses, neighbors, and parties with ongoing business relationships.

B. *Mediation Prevents Unnecessary Destruction of Disputants' Relationships*

Mediation works to minimize damage caused to the disputants' relationship during dispute resolution by interrupting the escalation of adversarial conflict. As unresolved conflicts persist, disputants become more adversarial toward each other.[78] Mediation interrupts this escalation by creating an environment in which disputants can pursue mutual understanding about their dispute in a respectful and fair manner. As a result, mediation is more likely than other forms of assisted dispute resolution to prevent the destruction of the disputants' relationship.[79]

Professors Craig A. McEwen and Thomas W. Milburn have examined the phenomenon of dispute escalation and describe how mediation is effective despite the tendency of disputes to escalate.[80] Over time, parties in an unresolved conflict become more adversarial, more polarized in their positions, less likely to identify common goals and less able to communicate or cooperate.[81] As a result, the conflict between them becomes more difficult to resolve. At the root of this phenomenon is the growing inability or unwillingness of disputants to work toward a mutual understanding upon which to base possible resolutions.[82] Professors McEwen and Milburn conclude that mediation interrupts the escalation of hostility and ministers to

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party most likely to discover that she or he has misplaced trust should not be bound to mediate disputes with the one in whom trust was misplaced. *See infra* Part IV.B. for the argument that health care institutions should be required to attempt to mediate physician-patient EOLT disputes at the discretion of the patient or the patient's decision-maker.

[78] *See* Craig A. McEwen & Thomas W. Milburn, *Explaining a Paradox of Mediation*, 9 NEGOTIATION J. 23, 26-31 (1993) (explaining a process of "dispute selection" and "dispute elaboration" through which grievances escalate and transform into conflict).

[79] See *infra* notes 96-102 and the accompanying text for some empirical support for this claim.

[80] *See* McEwen & Milburn, *supra* note 78.

[81] *See id.* at 26-31; SUSAN L. CARPENTER & W. J. D. KENNEDY, MANAGING PUBLIC DISPUTES 11-17 (1988); MORTON DEUTSCH, THE RESOLUTION OF CONFLICT: CONSTRUCTIVE AND DESTRUCTIVE PROCESSES, 351-53 (1973) (explaining that "destructive conflict" escalates through processes of "competition," "misperception," and "commitment [to one's perspective of the dispute]"); DEAN G. PRUITT & JEFFREY Z. RUBIN, SOCIAL CONFLICT 7, 64-65 (1986) (arguing that "moves and countermoves" of parties "trying to do well at the other's expense" escalates and transforms a conflict); Cris M. Currie, *Opinion Wanted: A Theoretical Construct for Mediation Practice*, 53 DISP. RESOL. J. 70, 74 (1998) (explaining that disputes escalate because conflict resolution lacks a solid theoretical foundation and therefore cannot establish boundaries or standards for itself).

[82] *See* McEwen & Milburn, *supra* note 78, at 29-30 (stating that disputants' anger and attribution of fault inhibits mutual problem-solving).

its symptoms by assisting the parties' communication in ways that enhance understanding of the dispute.[83] More specifically, the mediator uses techniques to construct a "framework for cooperation" between the disputants, within which the disputants craft a mutually beneficial resolution of their dispute.[84] The mediator shifts the focus of the discussion from attributing fault and identifying bad motives to the substance of the dispute.[85] At the same time, the mediator encourages disputants to explain their perceptions of the dispute, their goals for its resolution and their reasons for those goals.[86] Further, the mediator identifies the parties' common goals and suggests a range of solutions that would satisfy each party's interests.[87]

These techniques effectively preserve trust between the disputants because they promote mutual understanding about their dispute.[88] First, mediation increases each party's knowledge of and appreciation for the dispute and the other party's claims. Each party has an opportunity to describe its perception of the dispute and its goals in obtaining a resolution. This dialogue provides the parties with information that can defuse feelings that erode trust. Telling one's story, in context and without interruption, can lessen feelings of anger.[89] Similarly, hearing one party's story can decrease the other party's frustration caused by not knowing all of the facts about the dispute. A review of the facts also helps eliminate feelings of distrust based on erroneous or exaggerated beliefs about the disagreement or the other party's motives.[90] Finally, each party's statement of her or his goals for resolution of the dispute helps the parties identify common interests that can facilitate cooperation.[91] The less the

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[83] *See id.* at 30-31 (arguing that mediation's "power" is its capacity to help deal with the problems created by dispute selection and elaboration by "challenging [the parties'] narrow perceptions of a dispute and assisting the parties in recognizing the context and consequences of their conflict").

[84] *See id.* at 31 (outlining how mediation can establish a "framework for cooperation").

[85] *See id.*

[86] *See id.* at 30-31.

[87] *See id.* at 31.

[88] *See* Robert A. Baruch Bush, *"What Do We Need a Mediator For?:" Mediation's "Value-Added" for Negotiators*, 12 OHIO ST. J. ON DISP. RESOL. 1, 13 (1996) (identifying research showing that mediation breaks down strategic barriers to settlements by both providing the parties with more information and giving the parties a more accurate perception of each other).

[89] *See, e.g.*, MARCUS ET AL., *supra* note 25, at 352-60 (describing the effect of a female nurse's opportunity to vent her frustrations to a physician who made a sexual advance while she was administering medication to a patient).

[90] *See e.g.*, LaBaron & Carstarphen, *Negotiating Intractable Conflict: The Common Ground Dialogue Process and Abortion*, 13 NEGOTIATION J. 341 (1997) (describing a project to mediate discussions about abortion between pro-choice and pro-life advocates).

[91] *See* Currie, *supra* note 81, at 71 (citing Deutsch's theory of "constructive de-escalation" of conflict through cooperative processes that "encourage division of labor in a joint search for truth").

parties perceive each other as competitors, the less they need to distrust each other.

Second, mediation involves the disputants in a collaborative process. Mediation employs what modern social theorist Jürgen Habermas calls a "communicative ethic."[92] Under a communicative ethic, ideal communication results from a process in which: (1) everyone "with the competence to speak and act is allowed to take part in a discourse"; (2) everyone "is allowed to question any assertion[,] ... to introduce any assertion ... [and] to express his attitudes, desires and needs"; and (3) "[n]o speaker [is] prevented, by internal or external coercion, from exercising his rights as laid down in [the first two rules]."[93] It claims that participants in discourse should collaboratively pursue mutual understanding on the basis of well-reasoned argument rather than coercion.[94] Similarly, mediation strives for mutually respectful, fair and reasoned communication among disputants. Mediation's primary goal is to engage the parties in a collaborative, mutually beneficial project in order to better understand and perhaps satisfactorily resolve the dispute. Parties in a mediation practice cooperation as they attempt to resolve their differences. They do so by making claims, offering reasons substantiating those claims, hearing competing claims and reasons and attempting to persuade each other of various points of view. This process breeds mutual respect because it demands that each party observe the other's right to possess an independent understanding of the dispute, and it conditions resolution on the parties' negotiating a *mutually* beneficial agreement.

Empirical data shows that mediation better preserves relationships between disputants than does adversarial dispute resolution.[95] Several studies have

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[92] *See* Jürgen Habermas, *Discourse Ethics: Notes on a Program of Philosophical Justification*, *in* MORAL CONSCIOUSNESS AND COMMUNICATIVE ACTION 43 (Christian Lenhardt & Shierry Weber Nicholsen trans., MIT Press, 1990). Habermas derives communicative ethics from his larger theory of communicative action, which argues, among other things, that members of social groups maintain their unity by communicating with each other for the purpose of arriving at a mutual understanding about their shared worlds. *See id. See also*, SIMONE CHAMBERS, REASONABLE DEMOCRACY: JÜRGEN HABERMAS AND THE POLITICS OF DISCOURSE 96-97 (1996). For background reading concerning communicative ethics, *see generally*, THE COMMUNICATIVE ETHICS CONTROVERSY (Seyla Benhabib & Fred Dallmayr eds., 1990); WILLIAM REHG, INSIGHT & SOLIDARITY: THE DISCOURSE ETHICS OF JÜRGEN HABERMAS (1994); and SEYLA BENHABIB, SITUATING THE SELF 1-55 (1992).

[93] *See* Habermas, *supra* note 92, at 89 (quoting R. Alexy, *Eine Theorie des praktischen Diskurses*, *in* NORMENBEGRÜNDUNG, NORMENDURCHSETZUG (W. Oelmüller ed., 1978)).

[94] *Id.*

[95] *But see* Kenneth Kressel, *Research on Divorce Mediation: A Summary and Critique of the Literature*, *in* THE ROLE OF MEDIATION IN DIVORCE PROCEEDINGS: A COMPARATIVE PERSPECTIVE 219, 221 (Vermont Law School Dispute Resolution Project, 1987) (criticizing the methodology of divorce mediation research for comparing mediation and adjudication without controlling for cost differences between the two processes, bias in the

attempted to measure and compare how mediation and adjudication affect the relationships of the disputants.[96] Researchers asked disputants to report changes in various aspects of their relationships with their co-disputants, including the intensity of anger felt toward their co-disputant,[97] their perception of their co-disputant's negative behavior (e.g., stubbornness, unreasonableness, unpleasantness)[98] and their perception of improvement in the overall quality of their relationships.[99] Each study concluded that

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administration of mediations, and self-selection among disputants).

[96] *See* Jessica Pearson & Nancy Thoennes, *Mediating and Litigating Custody Disputes: A Longitudinal Evaluation*, 17 FAM. L. Q. 497, 505-51 (1984) (presenting information collected as part of the Denver Custody Mediation Project and considering the effects of mediation and "adversarial intervention" on (1) the agreement, (2) compliance with or relitigation of the agreement, (3) the relationship between ex-spouses, (4) parent-child interaction, (5) time and money savings); Joan B. Kelly et al., *Mediated and Adversarial Divorce: Initial Findings From a Longitudinal Study, in* DIVORCE MEDIATION: THEORY AND PRACTICE 453, 454 (Jay Folberg & Ann Milne eds.,1988) (analyzing data from study of divorcing couples at five time points from entry into the process until two years after divorce on the basis of eight variables: "(1) demograph[y,] (2) individual psychology . . .[,] (3) interpersonal (spousal and ex-spousal) relationship[s] . . . [,] (4) coparental relationships and parental functioning . . . [,] and (5) parent-child relationships . . . [,] (6) satisfaction with process and result[,] (7) post-divorce compliance with all agreements[,] (8) situational, legal, cost and divorce settlement variables"); Jessica Pearson & Nancy Thoennes, *Divorce Mediation Research Results, in* DIVORCE MEDIATION: THEORY AND PRACTICE 429 (Jay Folberg & Ann Milne eds., 1988) (analyzing research from the Denver Custody Mediation Project and the Divorce Mediation Research Project to determine "divorce mediation's patterns, outcomes and impact"); Craig A. McEwen & Richard J. Maiman, *Small Claims Mediation in Maine: An Empirical Assessment*, 33 ME. L. REV. 237, 238, 241, 245 (1981) (studying the "nature and consequences" of mediation and adjudication by comparing outcomes in Maine small claim courts offering mediation to those that only offer adjudication); Roselle L. Wissler, *Mediation and Adjudication in Small Claims Court: The Effects of Process and Case Characteristics*, 29 L. & SOC'Y REV. 323, 326 (1995) (analyzing interviews with disputants in Boston small claims courts to "examine the characteristics that differentiate . . . mediation and adjudication . . . and the disputants who use each in order to explore the relative effect of resolution process and case characteristics on (1) disputant's evaluation of the third party, (2) description of outcome, (3) evaluation of process and outcome, (4) description of [the disputants'] relationship, and (5) reports of compliance [with the agreement]").

[97] *See* McEwen & Maiman, *supra* note 96, at 256 (finding that 39.7% of litigants and 24% of mediating disputants remember feeling more angry after resolving the conflict and that 26.1% of litigants and 40.3% of mediating disputants feel less angry).

[98] *See e.g.*, Wissler, *supra* note 96, at 347-48 (reporting "greater pre- to post-court reduction" in negative perceptions of the other party among those disputants who mediate their dispute).

[99] *See* Pearson & Thoennes, *Divorce Mediation, supra* note 96, at 443 (arguing that mediation is a "less damaging intervention" into the parties' relationship in divorce and custody proceedings based on the finding that 30% of those who settled a disagreement through mediation thought the process had improved their relationship and that 60% of them

disputants who mediated their disputes were significantly more likely to report reduced feelings of anger toward their co-disputants, less negative behavior by their co-disputants, and improved quality of their relationships than were disputants who litigated their disputes.[100]

Research uncovered only one study comparing mediation with arbitration, and it supports the claim that mediation does a better job of preserving relationships among disputants than does either binding or non-binding arbitration.[101] A survey of construction attorneys, construction contractors and design professionals suggests that each of these groups believes that mediation preserves construction relationships, opens channels of communication and minimizes future disputes more effectively than do either binding or non-binding arbitration.[102]

Not only is mediation the *best* chance to resolve a persistent dispute without substantially damaging the disputants' trust in each other, it is also the *last* chance. Parties who cannot resolve their dispute through mediation are left only with the options of arbitration or adjudication, both of which are adversarial. In both, the disputants compete for the opinion of a decision-maker. Because arbitration and adjudication do not require the agreement of both parties to the resolution, neither process provides any incentive for the

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reported that some cooperation occurred between parties after the dispute, as compared to 30% of those who litigated their disputes).

[100] *See supra* notes 96-99. Some studies found that disputants who mediated their disputes but did not reach settlements were significantly more likely than both those who reached agreements in mediation and those who only litigated their disputes to report increased negative behavior by their co-disputants and significantly less likely than any other group to report an improved relationship. *See* Jessica Pearson & Nancy Thoennes, *Mediation Versus the Courts in Child Custody Cases*, 1 NEG. J. 235, 240 (1985); Wissler, *supra* note 96, at 347-48. Wissler implies that, when mediation does not result in an agreement, it worsens a relationship more often than litigation. *Id.* But Wissler's conclusion is flawed because it assumes that the sampled groups (successful mediation, unsuccessful mediation, adjudication) were equally adversarial pre-process. It is likely that the disputants who failed to reach settlement through mediation had more persistent disputes or more adversarial relationships prior to attempts at dispute resolution than the other sampled groups. In other words, by separating mediating disputants who reached a mediated settlement from mediating disputants who did not, the researcher may actually be sorting those with relatively easy-to-resolve disputes and relatively cooperative relationships from those with relatively hard-to-resolve disputes and relatively combative relationships. Thus, her finding that mediating disputants who did not reach mediated settlements were more likely to report negative behavior by their co-disputants may be explained by the fact that the disputants in those cases were significantly more combative with each other as compared to the entire sample of all mediated and adjudicated cases.

[101] *See* Thomas J. Stipanowich, *Beyond Arbitration: Innovations and Evolution in the United States Construction Industry*, 31 WAKE FOREST L. REV. 65, 146-47 (1996) (comparing mediation and arbitration as means of resolving construction disputes and presenting tables of comparative results).

[102] *See id.* at 146-47.

parties to cooperate except in ways imposed upon them by procedural rules. Thus, parties in arbitration, like parties in a lawsuit, are likely to treat each other as adversaries as they compete for the decision of the arbitrator.[103]

C. *Mediation Can Resolve Physician-Patient* EOLT *Disputes More Effectively Than Other Forms of Assisted Dispute Resolution*

Mediation likely can resolve physician-patient EOLT disputes effectively and prevent unnecessary harm to a patient's trust in her or his physician. First, mediation facilitates communication by restructuring the dialogue between patient and physician and identifying how misunderstanding fuels the conflict. Second, mediation can provide early intervention to resolve a dispute while reconciliation is still possible.

Poor communication plagues physician-patient communication. Studies reveal that physicians generally do not communicate well with patients. During clinical encounters, physicians often interrupt patients with questions and ignore patients' comments.[104] Similarly, physicians tend to use medical jargon when explaining medical conditions and treatments to patients.[105] As a

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[103] *See* Sheila M. Johnson, *A Medical Malpractice Litigator Proposes Mediation*, 52 DISP. RESOL J. 42, 46 (Spring 1997) (arguing that the mandatory medical malpractice "mediation" procedures in Michigan and Wisconsin are a form of non-binding arbitration that promotes adversarial competition among the parties).

[104] *See* NANCY AINSWORTH-VAUGHN, CLAIMING POWER IN DOCTOR-PATIENT TALK 68-71, 89 (1998) (describing how physicians control conversations with patients by acknowledging a patient's comment and immediately changing the subject); ALEXANDRA DUNDAS TODD, INTIMATE ADVERSARIES 82-90 (1989); CANDACE WEST, ROUTINE COMPLICATIONS: TROUBLES WITH TALK BETWEEN DOCTORS AND PATIENTS 51-96 (1984) (analyzing patterns of interruptions and question in patient-physician conversations and concluding that conversations function as a mechanism of physician control).

[105] *See* Vera M. Henzl, *Linguistic Means of Social Distancing in Physician-Patient Communication*, *in* DOCTOR-PATIENT INTERACTION 78, 86-87 (Walburga von Raffler-Engel ed., 1989) (stating that physicians' use of "technical information . . . is one of the most obvious areas of potential miscommunication . . ."). Further evidence that physicians use medical terminology to communicate medical information to patients are studies concluding that informed consent forms are often written using a vocabulary that is beyond what the average patient can understand and that includes technical medical terminology. *See, e.g.*, Goldstein et al., *Consent Form Readability in University-Sponsored Research*, 42 J. FAM. PRACT. 606, 608 (1996) (analyzing research that indicates consent forms for university research read at a twelfth grade level whereas the general population reads at a sixth grade level); Hopper et al., *Informed Consent for Clinical and Research Imaging Procedures: How Much Do Patients Understand?*, 164 AM. J. ROENTGENOL. 493, 494 (1995) (finding that clinical radiologist's consent forms are more difficult to understand than research radiologist's consent forms, despite the use of more complex words in clinical consent forms); Grossman et al., *Are Informed Consent Forms that Describe Clinical Oncology Research Protocols Readable by Most Patients and Their Families?*, 12 J. CLIN. ONCOL. 2211, 2212, 2215 (1994) (suggesting that medical information should be written so that it can be read by a patient with an eighth grade education); Hopper et al., *Readability of*

result, patients often lack or misunderstand crucial information about their medical conditions and treatment options.

Interviews with family members of deceased patients indicate that physicians struggle to effectively communicate information about EOLT at least as much as they struggle to convey other medical information. Physicians often fail to communicate with dying patients at all, or, when physicians do talk with those patients, they often do not give complete and accurate information about the patients' conditions.[106] Additionally, physicians use medical terminology when speaking to patients and family members.[107]

In fact, the quality of communication from physicians to patients or their decision-makers may be even poorer at the end of life than in any other medical context. Physicians commonly perceive a patient's dying as a professional failure; thus talking to a patient or patient's family about the imminence of death is, to many physicians, conceding such failure.[108] As a result, physicians may be more likely to avoid or inadequately address EOLT decisions than any other kind of treatment decision. Accordingly, there is a substantial risk that poor communication lies at the root of physician-patient EOLT disputes.

Mediation can resolve physician-patient communication problems because the process of communication is orchestrated by the mediator instead of the physician.[109] Each party must listen to the other without interrupting so the patients' stories are heard. In addition, mediation requires disputants to explain their positions so that each may understand the other. Because mediation resolves disputes through mutual agreements, disputants have an incentive to persuade the other by explaining her or his position. Thus, as a practical matter, a physician cannot expect a patient or patient's family to agree to resolve an EOLT dispute without understanding the reasons supporting the resolution. Accordingly, mediation is likely to be effective in resolving physician-patient EOLT disputes because it restructures communication and identifies ways in which conflict is based on poor information exchanges and misunderstandings.

Informed Consent Forms for Use with Iodinated Contrast Media, 187 RADIOLOGY 279, 279 (1993) (finding vocabulary in radiology consent forms requires a high school education).

[106] *See* Laura C. Hanson et al., *What Is Wrong With End-of-Life Care? Opinions of Bereaved Family Members*, 45 J. AM. GERIATRICS SOC. 1339, 1342 (1997); *cf.* Harriet Able-Boone, *Parent-Professional Communication Relative to Medical Care Decision Making for Seriously Ill Newborns*, *in* DOCTOR-PATIENT INTERACTION 227, 238-39 (Walburga von Raffler-Engel ed., 1989) (discussing parents' need "for more [truthful and accurate] information when making treatment decisions for their child").

[107] *See* Hanson et al., *supra* note 106, at 1342.

[108] *See* ROBERT BUCKMAN, HOW TO BREAK BAD NEWS: A GUIDE FOR HEALTH CARE PROFESSIONALS 21, 29 (1992) (explaining that physicians find discussing death with patients uncomfortable because physicians mistakenly believe that death only results from a failure of the "medical system or staff").

[109] See *supra* text accompanying notes 67-787 for a review of mediation techniques.

Other characteristics of physician-patient EOLT disputes reveal a second reason why mediation is likely to be effective in resolving disputes while preserving patient trust in physicians. Physicians and patients in EOLT disputes often identify their need for third-party assistance by requesting ethics consultations early in the life of the disputes.[110] Ethics consultations in physician-patient EOLT disputes are routinely requested immediately after one or more of the disputants believes that a dispute cannot be resolved by the parties alone but before the patient or patient's family has filed a lawsuit.[111] In these instances, hostility is relatively low, and the chance for reconciliation is high. The physician and the patient are in the midst of a treatment relationship at the time they are seeking dispute resolution assistance, and they continue that relationship after at least one attempt by a third party to resolve their dispute.[112]

These two characteristics of EOLT disputes between physicians and patients suggest that mediation could be effective at preserving a patient's trust in her or his physician. Because a request for an ethics consultation indicates that a dispute is ripe for assisted resolution and because such requests occur when reconciliation is still possible, it is likely that a foundation of trust exists upon which the collaborative techniques of mediation may build. In other words, physician-patient EOLT disputes often identify themselves for assisted resolution while the parties can still cooperate with each other. Furthermore, patients and physicians in EOLT disputes are likely to adopt the collaborative attitude necessary for successful mediation because they know that they must cooperate as long as it takes to complete treatment or to transfer the patient to another physician. Thus, the parties to such an EOLT dispute have an interest in preventing unnecessary escalation of hostility.

Collaborative techniques of mediation and the opportunity for early intervention in EOLT disputes certainly make mediation a more attractive dispute resolution method than adjudication. It is less obvious, however, that mediation is an improvement over ethics consultation. Indeed, one might

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[110] *See e.g.*, West & Gibson, *supra* note 9, at 68 (finding that ethics committees "seem generally wary of referring to the matters dealt with in case consultations as 'disputes' or 'conflicts,'" suggesting that consultations occur at so early a stage in a physician-patient disagreement that they cannot be accurately labeled as "disputes"); JOHN LA PUMA & DAVID SCHIEDERMAYER, ETHICS CONSULTATION: A PRACTICAL GUIDE 139-202 (1994) (presenting twenty-five different case studies of ethics consultations all of which suggested that the consultations occurred during the patient's treatment shortly after the dispute arose).

[111] Telephone Interview with Kristen Tym, Center for the Study of Bioethics at the Medical College of Wisconsin (Oct. 18, 1999) (finding, in a survey of Wisconsin ethics committees, that 80% of the committees responded that they had never consulted on a case in which litigation had been threatened, which suggests that ethics consultations generally occur before litigation is even considered). *See also* LA PUMA & SCHIEDERMAYER, supra note 110, at 139-202 (presenting twenty-five different case studies of ethics consultations, none of which mentioned an ongoing lawsuit).

[112] *See supra* note 19.

argue that ethics consultation is a form of mediation[113] and that ethics consultants are poised to intervene as early as possible in EOLT disputes. But close examination of ethics consultation, as commonly practiced, reveals that it is quite different.

While ethics consultations may be conducted by an individual ethics consultant, consultations are more commonly conducted by an ethics committee.[114] The committee members generally are physicians and employees of the institution providing care.[115] When assistance is requested, an ethics committee typically gathers information about a particular ethical dispute, deliberates among its members and communicates a recommendation to those involved.[116] To gather information, committee members might meet with the attending physician and other members of the patient's health care team and review the patient's medical chart.[117] While some committees also meet with the patient or the patient's family,[118] many ethics consultations occur without patient or family participation.[119] Finally, an ethics committee

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[113] *See* West & Gibson, *supra* note 9, at 69 ("To the extent that the committee members are without independent interests and views concerning the issues, and to the extent that they see their roles as helping the parties work toward resolution, their actions may resemble those of a neutral mediator or facilitator.").

[114] *See* Wilson, *supra* note 9, at 357 (observing that 84% of hospitals with more than 200 beds have an ethics committee) (citing AMERICAN HOSP. ASS'N, HOSPITAL STATISTICS 212 (1994)).

[115] *See* Hoffmann, *supra* note 6, at 847 ("Virtually all committees are composed almost entirely of hospital or nursing home staff.") (citing Hoffmann, *supra* note 9, at 110).

[116] For an overview of ethics consultation, *see* LA PUMA & SCHIEDERMAYER, *supra* note 110, at 1-36 (providing an outline of the consultation process). For criticism of the informality of ethics consultation process, see Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 803 (1991) (arguing that ethics consultation denies a patient's due process rights by failing to give notice, and an opportunity to be heard, "much less other tools a patient might need to participate effectively"). *See also* Wilson *supra* note 9, at 391-92 ("The due process protection afforded by judicial review but lacking in committee proceedings include uniform procedural guidelines, notification to all involved parties of a hearing, an appeal process, and the mandatory inclusion of an advocate for the patient's interests.").

[117] *See* LA PUMA & SCHIEDERMAYER, *supra* note 110, at 6-11 (asserting that the consultant is not properly prepared to see the patient until he or she has met with members of the patient's health care team and has reviewed the patient's medical records).

[118] *Id.* at 11-17 ("The consultant should personally see the patient to gather data because this method seems to improve the process and outcome of consultation."). A list of ten reasons why a consultant should personally meet with a patient is found at page 12.

[119] *See* Kelly et al., *supra* note 9, at 141 ("[I]n three of . . . nine cases, the patient and family were not included in or informed of the ethics consultation."); West & Gibson, *supra* note 9, at 69 ("[C]ommittees may meet with one party without meeting with the other, or may invite one party to the committee meeting, while meeting with the other only outside the framework of the committee."). My own experience as an ethics committee member confirms that this is the way some committees consult on cases. One committee relied on a

typically does not decide cases. Instead, it acts as a medical consultant that makes a non-binding recommendation about how a dispute should be resolved.[120]

This model of ethics consultation bears a closer resemblance to non-binding arbitration than to mediation. Unlike mediators, ethics committees do not merely facilitate a negotiation between the disputants. Instead, they hear cases and recommend resolutions of the disputes that the disputants are free to accept or reject, just as an arbitrator rules in non-binding arbitration. If consultations by ethics committees were mediations, then both disputants would be present, and the committee would assist the disputants in crafting their own resolution of the disagreement. In reality, one disputant—the patient or the patient's decision-maker—may not be present at an ethics consultation. It strains credulity to call such a consultation an "assisted negotiation."[121] Furthermore, even if both disputants participate, they are not communicating with each other. Instead, they present their cases to the committee, and deliberations occur only among the committee's members. Moreover, ethics committees do not assist disputants to reach resolutions of the disputants' own design. Rather, they provide the disputants with proposed resolutions crafted by the committees' members.

Because ethics consultation results in a non-binding decision by a third party rather than in a mutual agreement between the disputants, it is not as well suited as mediation to prevent the unnecessary deterioration of the physician–patient relationship during efforts to resolve a physician-patient EOLT dispute. Like adjudication, ethics consultation in physician-patient EOLT disputes pits the physician and the patient or the patient's decision-maker against each other. As adversaries, they compete for an ethics committee's opinion. Consequently, the fear is that ethics consultation will erode the trust of patients in their physicians and in the process by which EOLT disputes are resolved.

Medical malpractice mediation panels provide an instructive example of this point.[122] Despite their names, these panels provide non-binding arbitration. After the parties present their cases, panelists deliberate and offer a non-

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member who had interviewed the patient or the patient's family members outside of the committee process to describe the interests, preferences and arguments of those parties while the committee as a whole heard the other party, the patient's attending physician, describe his or her position in the dispute.

[120] *See* Hoffmann, *supra* note 6, at 845-46 ("In most cases, the ethics committee members deliberate among themselves and arrive at a recommendation."); Hoffmann, *supra* note 9, at 111 (finding that 100% of surveyed institutional ethics committee members interviewed reported that the typical consultation process involves the committee's identifying and making a recommendation).

[121] *See supra* text accompanying note 67 (describing mediation as assisted negotiation).

[122] *See* Johnson *supra* note 103, at 45 (arguing that medical malpractice mediation programs mandated by statute "were never meant to serve as mediation because the purpose did not contemplate the peaceful and mutual resolution of claims to the mutual satisfaction of both parties" but instead were designed to dispose of frivolous malpractice claims).

binding assessment of how the case should be decided. Such a procedure promotes adversarial competition, rather than collaboration, between disputants. As one attorney observed about Michigan's medical malpractice mediation panel, "[t]here is nothing in the Michigan procedure that resembles mediation.... In actual practice, attorneys vigorously advocate for their clients in this 'mediation' and do not view it as a cooperative process meant to settle the case. *The procedure is just another competition which somebody wins and somebody loses.*"[123]

In addition to more closely resembling non-binding arbitration than mediation, ethics consultation is not well suited to resolve physician-patient EOLT disputes because the members of a typical ethics committee are not effective mediators. Most members of ethics committees are practicing physicians.[124] As such, they may be less sensitive to the patterns of poor communication that are causing physician-patient EOLT disputes to persist. This does not mean that physicians cannot effectively mediate physician-patient EOLT disputes; rather, it suggests that physicians should be trained to identify and address the poor communication practices that may be at work in physician-patient EOLT disputes.

The typical structure of an ethics committee also creates conflicts of interest that undermine the neutrality of the committee and any dispute resolution service it offers. The members of ethics committees are disproportionately employees of the health care institution or members of its medical staff.[125] Similarly, individual ethics consultants are typically employed by the institution in which the dispute is taking place.[126] The health care institution in a physician-patient EOLT dispute may have an interest in the outcome of the dispute either because it is a disputant or because it perceives risks of liability and unfavorable publicity. When the institution has a significant stake in the outcome of the dispute, that interest could create a bias among the institution's medical staff and employees who staff an ethics consultation service.[127] This does not mean that institutional ethics consultation services can never function as a mediation service in physician-patient EOLT disputes. Instead, ethics committees should be restructured—perhaps with greater lay representation—in order to guard against institutional threats to their neutrality. Additionally,

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[123] *Id.* at 46 (emphasis added).

[124] *See* Wilson, *supra* note 9, at 389 n.186 (observing that committees contain a higher percentage of physicians than any other group, and a physician chaired 65% of the committees) (citing Hoffmann, *supra* note 9, at 108).

[125] *See supra* note 115. *See also* Hoffmann, *supra* note 6, at 847 ("Some committees include community representatives but this is often a token gesture – typically one such person sits on the committee, rarely two or more.").

[126] *See* LA PUMA & SCHIEDERMAYER, *supra* note 110, at 74 (stating that ethics consultants are often salaried employees of a health care institution).

[127] *See* George J. Annas, *Ethics Committees: From Ethical Comfort to Ethical Cover*, 32 HASTINGS CENTER REPORT 18, 19 (May-June 1991) (observing that hospital ethics committees tend to function primarily to protect the institution).

disputes should be referred for external resolution when a conflict of interest is too great to overcome.[128]

Improving the process by which physician-patient EOLT disputes are resolved requires more than assuring that patients and their decision-makers have access to ethics consultation. It requires access to mediation so that parties might attempt to negotiate their differences. Additionally, it would not be enough for mediation techniques to be incorporated into ethics consultation. Ethics committees and consultants also must be prepared to address the communication problems that characterize EOLT disputes between physicians and patients, and they must develop ways of addressing the institutional conflicts of interest that might undermine the effectiveness of mediation.

III. CONFRONTING CONCERNS ABOUT MEDIATING PHYSICIAN-PATIENT *EOLT* DISPUTES

While mediating physician-patient EOLT disputes will likely prevent the erosion of patient trust in physicians, it is not a panacea. Several concerns about mediating EOLT disputes must be addressed. Arguments include that the power imbalance between a physician and patient will persist in mediation, that mediation will fail to protect the legal rights and interests of patients and that mediation is incapable of resolving disputes about moral beliefs.[129] While these concerns are legitimate, they are overstated. As explained below, mediation can offset the communicative power imbalance that typically exists between physicians and patients, can protect the legal rights of all parties, can protect patients' interests utilizing the same mechanisms used to protect those same interests in medical decision-making and can de-escalate disputes involving a clash of moral beliefs. When viewed in proper perspective, concerns over mediating physician-patient EOLT disputes are outweighed by the benefits.

A. *Mediation Can Account for the Power Imbalance Between Physicians and Patients in EOLT Disputes*

Because mediation is structured as a negotiation, critics argue that it preserves any power differential between the parties and allows the power imbalance to dictate the terms of any settlement.[130] Professor Diane Hoffmann argues that physicians are more powerful than patients, that mediation cannot cure this power imbalance and that mediating EOLT disputes will result in settlements that are tainted by the inequality inherent in the physician-patient relationship.[131]

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[128] *See infra* Part IV.B. for a proposal that health care institutions should be required to provide patients and their decision-makers with access to outside mediation and to disclose institutional affiliations of any mediators staffing an internal mediation service.

[129] *See supra* text accompanying notes 29-32.

[130] *See* Hoffmann, *supra* note 6, at 865.

[131] *Id.* at 865-66 (asserting that the amount of technical expertise that a physician has

This argument incorrectly assumes that mediators cannot effectively neutralize power advantages. In fact, mediators routinely employ several techniques that tend to neutralize unequal bargaining power.[132] Mediators may enforce ground rules, such as parties may not interrupt each other and must cooperate in answering questions asked of them.[133] These rules assure that each party has an opportunity to be heard and to receive answers to questions. This is effective in preventing one party from dominating or avoiding communication with the other. A mediator might also initiate caucuses.[134] A caucus enables a weaker party to express to the mediator what the party cannot express in the presence of the stronger party. Yet another technique is to suspend negotiations for a period of time to allow parties to reflect on the negotiation and their claims.[135] This might give a weaker party an opportunity to consult with others, gather information, identify new questions and formulate stronger arguments. Finally, the mediator can challenge the claims of the stronger party using BATNA, WATNA and reality-testing techniques.[136] These techniques force the stronger party to reconsider a position in light of challenges that the other party might not have made.

The power-neutralizing techniques of mediation are well suited to address the communication-controlling practices that physicians employ when speaking to patients.[137] Ground rules assure that patients or their decision-makers have an opportunity to tell their stories without fear of interruption and to receive answers to questions that might otherwise be ignored. Moreover,

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makes it difficult to challenge that physician's opinion, unless the patient or family brings a medical expert to the table).

[132] *See generally* Lerman, *supra* note 72, at 102-06 (examining how different mediation techniques permit mediation of disputes between spouses despite the power imbalance caused by a history of spousal abuse between the parties). Techniques relevant to the mediation of EOLT disputes include beginning mediation by meeting with each party, reaching a consensus about the nature and scope of the disagreement, and bringing an advocate to the mediation. A third party, who is not necessarily an attorney, may be better able to articulate the patient's needs in a situation where unequal bargaining power is present. *See also* notes 67-787 and the accompanying text for a general review of mediation techniques.

[133] *See supra* note 70 and accompanying text.

[134] *See* Lerman, supra note 72, at 103-04 (suggesting that, to offset power imbalances between perpetrators and victims of spousal abuse, mediators might begin a mediation by meeting separately with each party).

[135] *See* Metzloff et al., *supra* note 72, at 117 ("[I]n complex situations such as malpractice, multiple sessions would be expected because the parties would grapple with a series of issues and then adjourn to obtain additional facts or to reflect upon the arguments made by the opposition;" although most court ordered mediation involved only one session); KOVACH, *supra* note 70, at 128 (recognizing that "after a relaxing break or private time to reconsider, parties see things a little differently").

[136] *See supra* text accompanying notes 74-76 (explaining these techniques).

[137] *See supra* text accompanying notes 104-08.

these rules place control over the conversation in the hands of the mediator and thus out of the control of the physician. These rules would also enable the mediator to ask questions necessary to each party's full understanding of the dispute, such as asking the physician for an explanation of certain medical information. In addition, the mediator's use of caucusing and suspending the mediation for a period of time can prevent patients or their decision-makers from being intimidated by the physician's professional status. The mediator can prevent such intimidation by meeting separately with the patient or decision-maker and by giving the patient or decision-maker additional time out of the presence of the physician to formulate questions and concerns. Finally, mediators can meet separately with physicians and challenge the physicians' claims if the mediator perceives that the patient or the decision-maker was unable to do so. This technique places the onus of confronting a physician on the mediator rather than on the patient or decision-maker.

A skeptic might respond that, if mediation can be so successful in neutralizing a physician's power, physicians will simply not agree to mediate EOLT disputes.[138] However, physicians are likely to agree to mediation if a patient chooses it because of the opportunity to settle the dispute out of court. Physicians are highly motivated to avoid lawsuits in part because they do not want to be listed in the National Practitioners Data Bank ("Data Bank").[139] Federal regulations requires that any entity, including an insurance company settling a claim or judgment on behalf of a physician, report the physician and settlement to the Data Bank.[140] That information is then available upon request to, among others, boards of medical examiners, hospitals, and other health care entities.[141] If physician-patient EOLT disputes are mediated when parties request an ethics consultation, then physicians could choose to mediate *before* a lawsuit is filed, when settlements are not subject to Data Bank reporting. Thus, physicians in EOLT disputes have an incentive to mediate and give up their power advantage in exchange for the opportunity to avoid Data Bank reporting.

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[138] Hoffmann, *supra* note 6, at 863 (speculating that physicians looking for an official affirmation of their position may distrust mediation that equalizes the power between parties).

[139] "As one plaintiff's lawyer put it, '[m]ost physicians will do anything to avoid being listed in the Data Bank . . . .'" Metzloff et al., *supra* note 72, at 150 (finding that the Data Bank is a significant obstacle to mediation once a lawsuit is filed).

[140] *See* 45 C.F.R. § 60.7 (requiring the reporting of the healthcare practitioner's name, work and home addresses, social security number, date of birth, names of professional schools attended, professional license numbers, Drug Enforcement Agency registration number, and names of all hospitals affiliated with).

[141] *See* 45 C.F.R. § 60.11 (providing that hospitals, healthcare practitioners, boards of medical examiners and state licensing boards, healthcare clinics, and attorneys may request information).

B. *Mediation Can Enforce Legal Rights and Duties in Physician-Patient* EOLT *Disputes*

A second concern of mediating physician-patient EOLT disputes is that, by its very nature, mediation permits potentially unjust resolutions of disputes. Critics claim that mediators cannot enforce any values that are not "generated" by the disputants themselves without violating the disputants' autonomy and the principle of a neutral mediator.[142] Accordingly, they conclude that mediation cannot protect against resolutions of disputes that fail to incorporate important values embodied in the law.[143] In a physician-patient EOLT dispute, a physician and patient might not know, or they might not agree, that a patient has the ultimate authority to refuse unwanted treatment even if the patient will die without the treatment. Instead, they might agree that the physician determines what life-sustaining treatments a patient receives, in violation of well-established law protecting patient autonomy.[144]

The fear that mediating disputes will lead to injustice is largely unwarranted.

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[142] Classically, parties to a mediation generate the values that guide any settlement of their dispute. *See generally* Fuller, *supra* note 77, at 325-26. Yet, mediation often is used to address disputes that implicate principles of social justice, which the parties to the dispute should respect in their attempts to resolve the dispute by mutual agreement. *See e.g.*, Lawrence Susskind, *Environmental Mediation and the Accountability Problem*, 6 VT. L. REV. 1, 46 (1981) (exploring this issue in the context of environmental dispute mediation and concluding that mediated agreements must serve social values related to the environment as well as the interests of each party). Such an approach to mediation, however, conflicts with the traditional view that mediators must remain neutral in the process of assisting the parties in reaching an agreement and that the process and its outcome belongs to the parties. *See e.g.*, Joseph B. Stulberg, *The Theory and Practice of Mediation: A Reply to Professor Susskind*, 6 VT. L. REV. 85, 117 (1981) (arguing that the mediator who enforces an external viewpoint of the fairness of a mediated agreement is at odds with the traditional concept of mediation). The propriety of norm enforcement in mediation continues to be a matter of considerable debate, and it is usually discussed in the context of the mediator's obligation of neutrality. *See* Robert B. Moberly, *Mediator Gag Rules: Is It Ethical For Mediators To Evaluate or Advise?*, 38 S. TEX. L. REV. 669, 670 (1997) (addressing the propriety of mediators to (1) evaluate and (2) give advice or information). For a recent articulation of the role of social norms in mediation, *See* Waldman, *supra* note 25, at 707 (proposing that mediation processes be distinguished by their treatment of social norms); Ellen A. Waldman, *The Evaluative-Facilitative Debate in Mediation: Applying the Lens of Therapeutic Jurisprudence*, 82 MARQ. L. REV. 155, 165-66 (1998) (discussing the role of social norms in evaluative and facilitative mediation).

[143] *See generally*, Owen M. Fiss, *Against Settlement*, 93 YALE L. J. 1073, 1085-87 (1984) (arguing that settlement may serve the private motivations of the parties, but fail to secure justice).

[144] *See e.g.*, Hoffmann, *supra* note 6, at 870 ("[T]o the extent that mediation results in a patient or family member ceding legal rights to a health care provider or institution, it leads to violation of state laws and policy as well as constitutional principles.").

First, it reflects a misunderstanding about what the principle of respect for autonomy requires.[145] In fact, informing disputants about laws that their proposed settlements might violate serves the principle of respecting the autonomy of disputants to resolve their own disputes.[146] A disputant cannot autonomously agree to a proposed settlement of a dispute unless he or she understands that the settlement may be legally unenforceable. Without that information, a party cannot account for the risk that the agreement will be meaningless if the other party fails to honor it voluntarily. Because an uninformed consent to undertake risks of harm cannot be an autonomous consent,[147] the principle of respecting the disputants' autonomy is violated if the mediation process permits parties to enter into an agreement that, unknown to the parties, is unenforceable. Thus, mediators must assure that parties understand the legal limitations on their freedom to negotiate a resolution of their dispute.[148]

Second, mediators do not destroy their neutrality by identifying rules of law that proposed settlements might violate. The existence of a rule of law is a fact, and its content can be communicated in an unbiased manner.[149] Thus,

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[145] Mediators have a professional responsibility to respect the principle that parties determine for themselves whether or not to enter into any mediated agreement. *See* GRENIG, *supra* note 67, at 132 (summarizing the standards of conduct adopted by the American Arbitration Association, the American Bar Association, and the Society for Professionals in Dispute Resolution).

[146] *See* Jamie Henikoff & Michael Moffitt, *Remodeling the Model Standards of Conduct for Mediators*, 2 HARV. NEGOTIATION L. REV. 87, 104 (1997) ("[T]he principle of informed consent requires that parties understand the substantive content of any mediated settlement in light of that party's own interests.").

[147] *See* FADEN & BEAUCHAMP, *supra* note 45, at 251 (defining an autonomous act as one where the person adequately apprehends all of the relevant information that correctly describes (1) the nature of the action, and (2) the foreseeable consequences that might result).

[148] Whether a mediator should introduce social norms into the mediation process is a controversial question. *See e.g.*, John Feerick et al., *Standards of Professional Conduct in Alternative Dispute Resolution*, 1995 J. DISP. RESOL. 95, 100, 104 (1995) (discussing whether a mediator should ever give an opinion on a legal matter). However, there is a consensus that, at the very least, a mediator is the source of last resort for informing disputants that a social norm exists and about the weaknesses of each disputant's case under that social norm. *See e.g.*, Feerick et al., *supra,* at 103-07, 110-11 (finding that opponents of evaluative mediation concede that mediators should introduce social norms into mediation when the disputants would otherwise be uninformed about relevant social norms or when there is an imbalance of power that threatens to undermine the fairness of a mediated agreement).

[149] *See* Currie, *supra* note 81, at 74 (stating that mediators, as independent sources, can offer information to both disputants in a joint search for truth). Even opponents of evaluative mediation recognize that mediators can, in unbiased ways, provide information designed to help parties make an intelligent choice. *See e.g.*, Feerick et al., supra note 148, at 107-08 (commenting that the principle of informed consent may require the mediator to

there is nothing inherently biased in informing others about the law.

Finally, while application of a law to a particular set of facts may require interpretation of a legal rule, the interpretation can be accomplished in an unbiased manner. If the mediator makes a reasonable effort to predict a court's ruling and identifies viable alternative applications of the law, then the mediator acts in an unbiased manner.[150] One might argue that *any* interpretation necessarily introduces *some* bias even when the interpreter is attempting to be neutral and, thus, that interpretation is always inconsistent with neutrality. There are two problems with this claim. First, zero tolerance for interpretation would make any kind of mediation impossible. For example, the mediator must interpret a party's violation of ground rules. Similarly, the mediator makes an interpretive judgment when deciding to caucus, recess or conclude that there is an impasse.[151] All of these interpretations would be prohibited if the principle of mediator neutrality were absolute. Second, the claim that informing disputants about the law may introduce a bias assumes that bias occurs only by acts of commission. In fact, a mediator can destroy her or his neutrality by failing to help disputants understand their dispute. For example, a mediator's silence regarding a relevant law in the face of one party's exploitation of the other's ignorance creates a bias in favor of the manipulating party. Thus, the better strategy is to balance the need for parties to be well informed with the risk that a minimal degree of bias will enter into mediation.

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explore whether the parties have considered the risk of litigation and have evaluated the positions asserted). For example, a mediator might simply provide each party with a copy of a relevant statute prior to the mediation. *Id.* at 108 (commenting that key information provided in advance promotes informal self-determination).

[150] As one commentator puts it:

> Mediators have an ethical duty, of course, to be impartial. However, as Josh Stulberg has written, impartiality means "treat[ing] all parties in the same ways, both procedurally and substantively." [Citation omitted.] To my mind, the mediator who provides the parties the same access to legal information and advice—without favoritism or bias, and without regard for the potential effect of the information on the prospects for settlement—is being impartial, in the truest sense of the word.

James H. Stark, *The Ethics of Mediation Evaluation: Some Troublesome Questions and Tentative Proposals, from an Evaluative Lawyer Mediator*, 38 S. TEX. L. REV. 769, 796 (1997).

[151] Christopher W. Moore identifies twelve different ways that mediators' judgments affect the outcome of mediations. *See* MOORE, *supra* note 67, at 327-33 and accompanying text. He writes:

> In every dispute, the mediator exerts a specific degree of control over the sequence of negotiation and problem-solving steps and the management of individual agenda items. He or she must choose – on the basis of the situation, the parties, and the issues in dispute – whether to have limited influence and make few procedural suggestions (either general or specific); to be moderately influential and provide some structure; or to be highly influential, with much directiveness and a highly detailed procedure over which the parties have a low degree of control.

Id. at 327-28.

Even though a mediator's neutrality is not destroyed if he or she informs parties of their legal rights, this issue can be avoided by using a vehicle other than the mediator to inform parties about those rights. Prior to the mediation, the mediator can provide each party with a summary of relevant law written by someone other than the mediator.[152] This provides a uniform mechanism for informing parties about their legal rights, while avoiding the problem of mediator bias. In addition, it relieves non-lawyer mediators of the concern that they are providing legal advice. Of course, when non-lawyer mediators encounter questions that require professional legal interpretation, they will have no choice but to advise the parties to seek legal counsel concerning that question.[153]

Applying these arguments to the mediation of physician-patient EOLT disputes, there is good reason to believe that mediation can successfully protect against resolutions that violate applicable laws. If EOLT disputes arise in health care institutions subject to the Patient Self-Determination Act of 1990 ("PSDA"),[154] patients or their decision-makers and physicians will have a summary of patients' rights under state law to make life-sustaining medical treatment decisions. The PSDA requires that all hospitals and nursing homes receiving federal funding provide every entering patient or resident a summary of "an individual's rights under State law . . . to make decisions concerning . . . medical care, including the right to accept or refuse medial or surgical treatment and the right to formulate advance directives . . . ."[155] In other words, the PSDA mandates that a reasonably neutral summary of legal rights, relevant to most physician-patient EOLT disputes, be given to each patient. It is also available to any other person in the healthcare institution. Most importantly, this procedure does not rely on a mediator to explain the law.

In addition to the PSDA procedure for informing patients and physicians involved in an EOLT dispute about relevant law, mediators may also employ the technique of reality testing. If the proposed settlement is inconsistent with relevant law, the mediator can query one or both parties about the possibility of enforcing the agreement in court, thus introducing the law into the mediation.

If these techniques successfully inform physicians and patients about the laws applicable to any negotiated resolution of their EOLT dispute, the parties

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[152] *See* Feerick et al., *supra* note 148, at 108 (observing that in California, the American Arbitration Association advises parties in mediation to consult information about relevant law).

[153] Some argue that the best way to preserve mediator neutrality is for mediators to always advise the parties to consult legal counsel and to rely on the parties to get the legal information they need from their legal advocates. *See e.g.* Feerick et al., *supra* note 148, at 106-08 (commenting that advising parties to consult legal counsel does not violate the principle of mediator neutrality).

[154] 42 U.S.C.A. § 1395cc(f)(1) (requiring that healthcare providers "maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization . . .").

[155] 42 U.S.C.A. § 1395cc(f)(1)(A)(i).

will likely respect each other's rights when proposing settlements. Each party has an interest in reaching an agreement that not only serves her or his own interests but also is enforceable under the law. These techniques enable parties to fulfill both of these interests.

C. *The Interests of an Incapacitated Patient Can Be Adequately Protected in Mediation*

A third concern about mediating physician-patient EOLT disputes is that the patients are always weakened, if not incapacitated, by their illnesses.[156] Thus, they cannot represent themselves effectively, if at all, in the resolution of EOLT disputes. Instead, those patients are likely to be represented by family members.[157] A cautious view of mediation is that it may not assure adequate representation of a patient's interest if a family member is the representative.[158] Under this view, family members are not reliable representatives because they may have conflicting interests, lack the skills of an effective advocate, or both.[159]

A fundamental weakness of this view, however, is that it singles out EOLT disputes as the one occasion when family members of incapacitated patients are unable or too biased to represent the interests of those patients. This is despite our reliance on family members to make medical treatment decisions for incapacitated patients, including EOLT decisions, on other occasions.[160] The law, either by statute or based on a medical standard of care, recognizes family members as the representatives of incapacitated patients' interests in medical decision-making.[161] Furthermore, no jurisdiction prohibits a patient's

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[156] *See* Hoffmann, *supra* note 6, at 866.

[157] *See* Orentlicher, *supra* note 52 and accompanying text.

[158] *See* Hoffmann, *supra* note 8, at 776 ("[T]here are reasons to be cautious about delegating authority to family members to make decisions involving withholding or withdrawal of life support.").

[159] *See id.* (remarking that family members may (1) face financial and emotional burdens; (2) make decisions out of their emotional needs; or (3) be called upon to deal with patients whom they were not closely acquainted).

[160] *See* Orentlicher, *supra* note 52 and accompanying text.

[161] *See e.g.*, CAL. HEALTH AND SAFETY CODE, §§ 7185 to 7194.5 (West 1999); ME. REV. STAT. ANN. tit. 18-A § 5-805(b) (West 1996) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); MONT. CODE ANN. § 50-9-101 - 50-9-206 (1997) (enumerating in order of priority the family members that may act as surrogates in EOLT situations); NEV. REV. STAT. § 449.535 - 449.690 (1997) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); N. M. STAT. ANN. § 24-7A-5 (Michie 1996) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); OHIO REV. CODE ANN. §§ 2133.01 - 2133.15 (Anderson 1998) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); OKLA. STAT. ANN. tit. 63 §§ 3101.1 to 3101.16 (West 1997) (allowing the patient to designate any adult of sound

family member from being designated by a patient as her or his proxy for making EOLT decisions. Thus, state law recognizes the qualifications of family members to make EOLT decisions despite their lack of medical and legal training and despite the potential for conflicts of interest. If family members are qualified to represent the interests of incapacitated patients when there is no treatment dispute between the physician and the patient, they also are qualified to represent those interests during a physician-patient EOLT dispute.

In addition, the laws defining the authority of family members to act as surrogate decision-makers, health care proxies or guardians provide an additional source of protection against an unacceptable conflict of interest between the patient and the family member. First, the law requires that the patient's preferences be honored whenever discernible. Applicable statutes explicitly state, or have been interpreted to require, that decisions made on behalf of an incapacitated patient be made in accordance with the patient's known preferences or those that are reasonably discernible from the patient's conduct and statements prior to incapacity.[162] Only if it is impossible to identify the patient's preferences may the decision-maker make treatment decisions according to what she or he believes is in the patient's best interests. Second, the law requires that the decision-maker act in good faith and, in some instances, permits interested persons to petition the courts to remove a decision-maker who may not be acting in good faith or is acting beyond the scope of her or his authority.[163] Accordingly, summaries of these laws may be distributed to the parties in a physician-patient EOLT dispute prior to mediation, and the mediator may invoke those laws to challenge a family

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mind as a decision-maker); WASH. REV. CODE ANN. § 7.70.065 (West 1992) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); V. I. CODE ANN. tit. 19, §§ 185 - 200 (1995) (enumerating in order of priority the family who, as surrogates, may make EOLT decisions for incapacitated patients). *See also*, UNIFORM HEALTH-CARE DECISIONS ACT § 5(b) (1993) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 7(b) (1989) (enumerating in order of priority the family members who, as surrogates, may make EOLT decisions for incapacitated patients); Orentlicher, *supra* note 52, at 1263 (noting that physicians routinely rely on family members of incapacitated patients to make treatment decisions for the patient).

[162] *See e.g.*, Martin v. Martin, 538 N.W.2d 399, 405-06 (Mich. 1995) (establishing that a patient's decision to refuse medical treatment survives the patient's subsequent incompetence); COLO. REV. STAT. § 15-14-506(2) (1998) (legislating that an agent shall act in accordance with the known wishes of the principal). *See also* 1 ALAN MEISEL, THE RIGHT TO DIE § 7.2, at 345-46 (2d ed. 1995) (asserting that the overriding goal of decisionmaking for incompetent patients is the effectuation of the patient's right to self-determination).

[163] *See* NEV. REV. STAT. §§ 449.535 – 449.690 (1997) ("A decision to grant or withhold consent must be made in good faith. A consent is not valid if it conflicts with the expressed intention of the patient.").

member when a conflict of interest arises.

D. *Mediation Can Foster Collaborative Communication Even When Disputants' Moral Beliefs Clash*

A fourth argument against mediating physician-patient EOLT disputes is that mediation is unsuited to address ethical disputes. EOLT disputes, according to this argument, involve intractable conflicts about moral values that cannot be resolved through negotiation.[164] But this claim fails on two counts. First, physician-patient EOLT disputes, like other disputes between physicians and patients or their decision-makers, are not necessarily moral disputes. Second, mediation can de-escalate the hostility between parties over moral disputes and enable the parties to communicate in a respectful, cooperative and productive manner.

Physician-patient EOLT disputes tend to arise from poor communication rather than a clash of moral beliefs. Physicians generally do not communicate well with their patients.[165] This is particularly true in EOLT cases because physicians may avoid discussing end-of-life matters with dying patients.[166] Resolving a physician-patient EOLT dispute entails a process of correcting misunderstanding born out of silence or miscommunication. Mediation is suited to such disputes because it is designed to cure misunderstanding arising from poor communication.[167]

Some physician-patient EOLT disputes do involve a clash of moral values. For example, a physician may argue that it is morally wrong to provide life-sustaining medical care to a patient who is permanently unconscious because the physician believes such care wastes valuable medical resources. In contrast, the patient's family may argue that it is morally wrong to withhold such treatment from the patient because they believe life is worth sustaining regardless of its quality. In cases where the disputants' claims are based on conflicting moral beliefs that are deeply held, it is unlikely that mediation can completely resolve the dispute. Nonetheless, mediation can prevent the unnecessary escalation of hostility between the disputants and preserve the ability of parties to cooperate in identifying areas of agreement and in finding solutions that do not require them to resolve the moral issue. Moreover, even if mediation fails to produce an agreement and the disputants later litigate their dispute, the attempt at mediation may succeed in narrowing the focus of the litigation and in making the parties less likely to use the forum as a means of punishing each other.

Mediation already has shown that it can de-escalate the hostility of parties in

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[164] *See* Hoffmann, *supra*, note 6, at 866 (explaining a case in which a patient's spouse, acting on religious beliefs, argues that all life is worth maintaining, while the healthcare provider believes it futile to maintain patient in a persistent vegetative state).

[165] *See* notes 104-08 and accompanying text.

[166] *See* BUCKMAN, *supra* note 108.

[167] *See* note 109 and accompanying text.

a seemingly unresolved moral dispute, narrow the range of disagreement and identify ways for the parties to work together despite their disagreement. A dramatic example of this is the Common Ground Project, in which mediators facilitated discussions concerning abortion between pro-choice and pro-life advocates.[168] The mediators report that they succeeded in sustaining dialogue about abortion between these traditional adversaries.[169] Although participants did not change their moral beliefs about abortion, they found some areas of agreement. In addition, they reported having less stereotypical perceptions about those with whom they disagreed and feeling less prone toward using extreme tactical measures in the ongoing abortion debate. The success of mediation in creating an environment for collaborative resolution of a conflict as divisive as the abortion debate suggests that it could offer the same potential benefit in physician-patient EOLT disputes.

IV. IMPLICATIONS FOR PHYSICIAN-PATIENT *EOLT* DISPUTE RESOLUTION

In recent years, commentators have rightly criticized the lack of due process in consultations by ethics committees and called for the law to assure a fair and accountable process.[170] As part of their criticism, however, these commentators have not challenged the process of non-binding arbitration adopted by most ethics committees. Instead, they assume that an adversarial process is appropriate. But, as argued above, an adversarial process of dispute resolution is more likely to damage patients' trust in their physicians than a cooperative process would. Accordingly, ethics committees consulting in physician-patient EOLT disputes should not employ adversarial processes—including non-binding arbitration—without good reason. To do so is to undermine patient trust unnecessarily. Instead, ethics committees should assure that parties to a physician-patient EOLT dispute have access to mediation. Moreover, ethics committees should inform patients or their decision-makers of the option of mediation in addition to any other method of dispute resolution committees might offer, and committees should provide the style of dispute resolution chosen by patients or their decision-makers. Under such a system, patients or their decision-makers would determine whether their level of trust in their physicians is worth preserving at the risk of failing in an attempt to reach a mediated agreement. Furthermore, the policy of preserving patient trust despite a physician-patient EOLT dispute justifies incorporating a mediation option as part of due process in ethics consultation.

Current methods by which ethics committees consult on physician-patient EOLT disputes do not provide the parties with an opportunity to mediate their disputes. Instead, most ethics committees act as panels of arbitrators rather

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[168] *See* LaBaron & Carstarphen, *supra* note 90.

[169] *See id.*

[170] *See* Wolf, *supra* note 116, at 805 ("Most of these [ethics committees] accord nothing resembling due process."). *See also* Wilson, *supra* note 9, at 404-05 (discussing lack of procedural safeguards and need for courts to assume a greater role).

than as mediators.[171] Accordingly, physicians and patients who submit their EOLT disputes to ethics committees for consultation are forced into a process of dispute resolution that is more adversarial than necessary to resolve their disputes. The fear is that, because no alternative is as readily available as an ethics committee arbitration, parties will not attempt mediation. As a result, the ethics committee process, if left unregulated, will likely contribute to the erosion of patients' trust in their physicians when they are in conflict about an EOLT decision.

A. *The Problems of Existing Law*

Current law encourages health care institutions to have a dispute resolution process for EOLT disputes, but it does not require that the process include an option for mediation. Federal law deems a health care institution as qualified for a Medicare contract when the institution has been accredited by the Joint Commission for the Accreditation of Healthcare Organizations (the "Joint Commission").[172] The accreditation standards of the Joint Commission, in turn, require that an accredited institution have written procedures for internally addressing ethical dilemmas that arise in the care of patients.[173] The Joint Commission's accreditation standards do not specify the form or methodology of this internal dispute resolution process, and the standards make no mention of mediation.[174] Thus, federal law encourages health care institutions to have some dispute resolution process, but it does not regulate the nature of that process. Most states do not regulate ethics consultation. Accordingly, in most states a health care institution has an incentive under federal law to adopt some assisted dispute resolution process for physician-patient EOLT disputes, but the institution has no incentive to avoid adopting an unnecessarily adversarial process.

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[171] *See supra* notes 113-21 and accompanying text.

[172] 42 U.S.C. 1395bb(a)(1) (West 1992) ("[I]f . . . an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals . . . , then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1395x(e) of this title . . . .").

[173] Joint Commission on Accreditation of Healthcare Organizations, 1995 Manual for Hospitals 66 (1995) (standard RI.1) (requires a "functioning process to address ethical issues" as a condition of accreditation and provides that "[p]atient rights mechanisms may include a variety of implementation strategies; for example, established ethics committees, the use of a formalized ethics forum, ethics consultations, of any combination of these or other methods").

[174] *Id.*

Statutes in Arizona,[175] Hawaii,[176] Maryland[177] and Montana[178] concerning consultation by ethics committees are even more troublesome. These statutes not only fail to protect against consultation procedures that are unnecessarily adversarial, they actually require or encourage adversarial dispute resolution. They do so by providing immunity to committees making decisions or recommendations or giving advice on the resolution of bioethical disputes, including EOLT disputes. Of these, Hawaii's statute is the most troubling. It provides criminal and civil immunity to ethics committee members who act in furtherance of their committee's purpose, and it defines an ethics committee as one "whose function is to consult, educate, review, *and make decisions* regarding ethical questions, including decisions on life-sustaining therapy."[179] An ethics consultation in which a third party decides for the physician and patient how to resolve their EOLT dispute is not a mediation; it is an arbitration. Similarly, statutes that define the purpose of ethics consultation as recommending or advising disputants about how to resolve their medical treatment disputes adopt a process of arbitration rather than a mediation.[180] By giving legal immunity to those who decide EOLT disputes or who recommend or advise on the resolution of such disputes, these statutes create an attractive safe harbor for ethics committee members. Accordingly, ethics committees in these states are likely to conduct their consultations more like arbitrations—deciding cases or recommending resolutions of cases—so as to qualify for the immunity promised by the statutes.[181] Because mediation of physician-patient

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[175] *See* ARIZ. REV. STAT. § 36-2284(F) (West 1993)(stating that members of infant care review committees are immune from civil and criminal liability for any "recommendations" made as a member of the committee); ARIZ. REV. STAT. § 36-3231(B) and (C) (concluding that any person who makes a good faith medical decision for an incapacitated patient with which an ethics committee concurs is immune from civil and criminal liability; an "ethics committee" is defined as a committee that "render[s] advice concerning ethical issues involving medical treatment").

[176] *See* HAWAII REV. STAT. ANN. § 663-1.7 (Michie 1995) (stating that members of ethics committees are immune from civil or criminal liability for conduct in furtherance of the purpose for which the committee was established, including "mak[ing] decisions" about life-sustaining medical treatment).

[177] *See* MD. CODE, HEALTH-GEN. II § 19-374 (Michie 1996) (requiring immunity from criminal and civil liability for members of patient care advisory committees who give "advice" concerning the treatment of patients with life-threatening conditions).

[178] *See* MONT. CODE ANN. § 37-2-201 (1997) (stating that members of ethics committees are immune from civil and criminal liability for "recommendations" made as a committee member).

[179] *See supra* note 176 (emphasis added).

[180] *See supra* notes 113-21 and the accompanying text.

[181] If the conduct of physicians in the face of safe harbor laws is any indication of how ethics committees in health care institutions will respond to statutory promises of immunity, then they will do what is necessary to qualify for the immunity. Empirical evidence supports the claim that physicians respond to safe harbor laws by conforming their behavior

EOLT disputes is very unlikely to qualify as deciding or recommending resolutions of those disputes, these statutes steer ethics committees away from the one form of assisted dispute resolution that is most likely to preserve patients' trust in their physicians.

While advising disputants about possible settlement options can be part of mediating a dispute, it is unlikely that this alone would qualify a physician-patient mediation process for immunity under any of these statutes. First, suggesting settlement options is only a small part of mediating a dispute. The mediator's central function is orchestrating a fair negotiation between the two disputants,[182] and this function is not part of what any of these statutes appear to protect. Second, even if it were possible for ethics committee members to receive immunity for some of the committee's work in mediating a physician-patient EOLT dispute, committee members likely would adopt a procedure that was assured of giving them complete immunity rather than taking the risk that a mediation would not be protected.

New York's Do-Not-Resuscitate (DNR) law is the only law in the country that requires health care institutions to mediate EOLT disputes.[183] The law requires hospitals to establish a "mediation system for the purpose of mediating" disputes about DNR orders, but it only applies to a certain kind of EOLT—cardiopulmonary resuscitation (CPR). Thus, if a physician-patient EOLT dispute concerns a feeding tube, respirator or life-sustaining medical treatment other than CPR, the law does not apply.

B. *A Proposed New Law*

If a goal of the law is to preserve patients' trust in their physicians despite EOLT disputes, then the law must change. At the very least, the law should not encourage ethics committees to adopt a dispute resolution process that is unnecessarily adversarial. Otherwise, the law contributes to the erosion of patient trust by turning physicians and patients into adversaries. This is particularly troublesome because ethics committees are in a unique position to intervene in physician-patient EOLT disputes at a relatively early stage in the life of those disputes when the parties may still be open to collaborative efforts at resolution.

At a minimum, the law must provide the same incentive to mediate physician-patient EOLT disputes that it provides to arbitrate them. States with immunity statutes can do this by redefining the protected process of ethics committee consultation to include mediation disputes. In the alternative, states can simply eliminate their immunity provisions all together.

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to that which is required in order to receive the protection from liability promised under the law. *See* Wilson, *supra* note 9, at 395 (observing that immunity "may compel caretakers to follow misguided committee recommendations in order to receive protection" and providing empirical support for the claim).

[182] *See* supra text accompanying note 69.

[183] *See* N.Y. PUB. HEALTH § 2972 (McKinney 1993).

Even these minimal solutions do not achieve the policy goal of better preserving patient trust. They simply eliminate any direct conflict between that policy goal and the conduct encouraged by the law. Rather than treating all methods of dispute resolution alike, the law should require health care entities to provide an option for patients or their decision-makers to choose to mediate physician-patient EOLT disputes. States or the federal government could impose this requirement by making it a condition of the health care entity's state license or participation in Medicare and Medicaid.

A central objective of this change in the law is for all health care institutions to develop a procedure for mediating physician-patient EOLT disputes, informing patients or their decision-makers of that option and honoring the request of patients or decision-makers to mediate their disputes. While health care institutions would be required to develop such a mediation procedure, they should be permitted to offer other processes as well, including non-binding arbitration. In addition, the procedure developed by any institution should include a system for accessing a mediator unaffiliated with the institution when one or both of the parties believe that an institutionally affiliated mediator is too biased to perform effectively. The law should permit, but not require, health care institutions to have an internal mediation service—perhaps through the existing ethics consultation service—in addition to the required external service.

In all cases, health care entities should be required to inform patients or their decision-makers, as parties to a physician-patient EOLT dispute, that mediation is available. In addition, the institution would be required to explain that mediation is an assisted negotiation that attempts to reconcile the parties' differences but that it will not necessarily result in a resolution of the dispute. Further, it must identify who might mediate the dispute and any institutional affiliation those individuals have. Also, a health care institution should be required to disclose that the patient or patient's decision-maker may choose external mediation or any other dispute resolution process the health care institution makes available or choose options other than those offered by the health care institution. Finally, the law should require health care institutions to honor whatever choice is made by the patient or patient's decision-maker, and it should require that an institution's physicians, as a condition of employment or medical staff membership, attend an initial mediation session if a patient or patient's decision-maker chooses to mediate an EOLT dispute to which the physician is a party.

In any case where the patient or patient's decision-maker has chosen to mediate a physician-patient EOLT dispute, the law should also require that prior to the mediation the health care institution provide the parties to the dispute and the mediator with a written summary of the law relating to EOLT decisions. It should permit institutions to satisfy this requirement by distributing the same written summary it distributes pursuant to the PSDA.

Finally, the law should establish a set of minimal procedures that must be followed in mediating physician-patient EOLT disputes. These minimal

procedures should require that: (1) the mediation not proceed unless all of the interested parties are present; (2) each party receives an opportunity to explain the party's perception of the case and how it should be resolved; (3) each party have an opportunity to ask questions of the other parties and that those questions be answered; and (4) any resolution of the dispute be based upon the mutual agreement of the parties to the dispute.

The law could be enforced in two ways. First, it could be made part of a state's conditions for granting and maintaining a license to the particular health care entity. Second, it could be made part of the federal government's conditions for entering into a Medicare contract with an institutional health care provider. In either scenario, the law provides a business incentive for institutions to create and maintain the dispute resolution process.

Probably the most controversial aspect of the proposed law is that it requires physicians in EOLT disputes to mediate the dispute if the patient or patient's decision-maker wishes to do so, making mediation mandatory for the physician but not for the patient. Such a one-sided version of mandatory mediation is justifiable, however, because the public policy goal is to preserve the trust of *patients* in their physicians. Accordingly, it is rational for the law to require a collaborative dispute resolution process for any dispute in which the party whose trust it seeks to preserve prefers such a process. Similarly, it makes little sense for the law to force mediation on a patient who does not believe that any trust remains. Moreover, requiring mediation would delay the patient's ability to initiate a more adversarial dispute resolution process.

A second potential criticism of the proposal is that physicians are unlikely to adopt the cooperative attitude necessary to the success of mediation if they are forced to the mediation table unwillingly. This criticism overlooks the possibility that an initially unwilling physician will become a willing participant as a result of a brief but required exposure to the process. For example, a physician might refuse to participate in mediation so as to avoid a face-to-face conversation with the patient or patient's decision-maker about the underlying dispute. But once the physician has broken through that concern during the initial required meeting, the physician might willingly go forward. In addition, the requirement is unlikely to materially harm the physician or patient even if it does not result in a successful mediation. For example, a physician could satisfy her or his requirement by listening to an opening explanation of the mediation process by the mediator and the patient's initial statement and request for resolution. If, at that point, the physician is unwilling to participate further, the mediation would likely come to an end.

Another controversial aspect of the proposal is that it allows health care institutions to mediate some disputes through an internal mediation service and would permit biased mediators to oversee the resolution of physician-patient EOLT disputes. The proposal recognizes, however, that institutional dispute resolution processes can be designed to protect the mediators from the institution's interests in the outcome of the process. If hospitals and nursing homes already maintain ethics committees that provide ethics consultations, it

may be very efficient for them to meet the law's requirements by recruiting one or more trained mediators from the community to be members of the committee. If so, then the internal process may be sufficiently neutral so that no party to a dispute requests an outside mediation service. One goal of the proposal is to find the appropriate balance between promoting efficient and appropriately neutral mediation.

CONCLUSION

Disputes between physicians and patients or patients' decision-makers about EOLT routinely arise. While these disputes strain the trust patients place in their physicians, they do not necessarily destroy it. Yet, the process by which EOLT disputes are resolved may squelch any remaining trust by patients in their physicians if the process is unnecessarily adversarial. Litigation and arbitration pit disputants against each other in an effort to arrive at the truth through adversarial argumentation. But these processes undermine trust between the disputants by forcing them into adversarial roles. Thus, a policy of relying exclusively on adversarial dispute resolution mechanisms to resolve EOLT disputes between physicians and patients or their decision-makers may resolve those disputes at the cost of destroying patients' trust in their treating physicians.

Mediating EOLT disputes can prevent the unnecessary destruction of patients' trust in their physicians. Mediation is the only form of dispute resolution that pursues the goal of creating mutual understanding of a dispute among its participants through a process of collaboration. By encouraging disputants to converse with each other in a controlled environment that assures fair, respectful and productive communication, mediation involves the disputants in a cooperative venture. The by-product of such communication is the de-escalation of conflict and, potentially, the preservation of trust, which in turn enables the participants to resolve their dispute more peaceably and without destroying their relationship. Thus, mediation provides a unique alternative that is well suited to prevent the unnecessary destruction of patient trust while still providing a real chance of resolving the dispute.

It makes the most sense to mediate EOLT disputes at the time disputants indicate their interest in an ethics consultation. This is likely to be early in any escalation of the dispute, and, thus, patients and their decision-makers are most likely to feel some trust toward their treating physicians and believe that this trust is worth preserving. Moreover, mediation should be the methodology of an ethics consultation when a patient or a patient's decision-maker chooses it. This assures that the first attempt at assisted dispute resolution employs a collaborative process rather than an adversarial one resembling non-binding arbitration, which typically characterizes ethics consultations.

Currently federal laws and the laws of most states do not encourage mediation or any other kind of dispute resolution mechanism for physician-patient EOLT disputes. Instead, they simply encourage institutions to have some sort of dispute resolution mechanism available. A few state laws relating

to ethics committees have the unintended effect of discouraging the use of mediation to resolve these EOLT disputes by giving immunity only to those who participate in more adversarial processes, such as non-binding arbitration. Federal and state laws should be amended to eliminate disincentives for mediating physician-patient EOLT disputes and should instead require mediation for those disputes in which patients or their decision-makers believe that some trust exists, which is worth salvaging.

Good EOLT, like good medicine, depends upon patients' trusting their physicians. This is true despite conflicts that may arise in the physician-patient relationship at the end of life. Preserving patient trust while at the same time enabling consensual solutions to conflicts justifies a policy of mediating EOLT disputes between physicians and patients.