

2019

Mediation in Medical Treatment: A More Effective Way to Manage Disputes

Caitlin McClay

Follow this and additional works at: <https://scholarship.law.edu/lawreview>

Recommended Citation

Caitlin McClay, *Mediation in Medical Treatment: A More Effective Way to Manage Disputes*, 68 Cath. U. L. Rev. 525 (2019).
Available at: <https://scholarship.law.edu/lawreview/vol68/iss3/8>

This Comments is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Catholic University Law Review by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

Mediation in Medical Treatment: A More Effective Way to Manage Disputes

Cover Page Footnote

J.D., The Catholic University of America Columbus School of Law, 2019; B.A. Christopher Newport University, 2016. The author would like to thank Professor Lucia Silecchia for her invaluable guidance, and the Catholic University Law Review for its support in the publication process.

MEDIATION IN MEDICAL TREATMENT: A MORE EFFECTIVE WAY TO MANAGE DISPUTES

Caitlin McClay⁺

The right for competent persons to refuse medical treatment is based on their due process rights guaranteed by the Fifth and Fourteenth Amendments.¹ However, this right is not absolute.² A person's liberty interest must be balanced against state interests.³ Further, incompetent patients are unable to consent to medical treatment.⁴ In a process called "substituted judgement," guardians or legally authorized persons are required to consent to treatment on behalf of the incompetent person.⁵ Incompetent patients may either be minors or adults who legally cannot make decisions for themselves. Those under the age of eighteen are presumed automatically to lack "maturity, experience, and capacity for judgement required for making life's difficult decisions."⁶ Adults are incompetent when they "lack[] capacity to understand and weigh the available options regarding critical medical decisions."⁷ Further, "the level of mental incapacity needed to be deemed incompetent depends on the nature of the medical decision at hand."⁸ When there is disagreement amongst guardians and physicians over the incompetent patient's proper medical treatment, the parties often turn to the court system for answers.

The adversarial nature of court proceedings is an inefficient and often ineffective way to resolve disputes. Court proceedings apply legal principles

⁺ J.D., The Catholic University of America Columbus School of Law, 2019; B.A. Christopher Newport University, 2016. The author would like to thank Professor Lucia Silecchia for her invaluable guidance, and the Catholic University Law Review for its support in the publication process.

1. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 281 (1990).

2. *Id.* at 279.

3. *Id.*

4. John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 904 (2006).

5. Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS L. REV. 1193, 1201-02 (1996).

6. *Parham v. J.R.*, 442 U.S. 584, 602, 620 (1979) (holding that the Georgia statutory procedures for admitting juveniles to mental health care facilities did not violate the minor's due process rights).

7. Cantor, *supra* note 5, at 1201.

8. *Id.* at 1201 n.23. The standard of mental capacity required to make life and death decisions will be higher than the capacity standard required for patients to make more minor decisions. It is a sliding scale and the analysis is made according to the facts on a case by case basis, so there is some variance in results. *Id.*

that fail to understand the deep layers of emotion underlying medical decision-making.⁹ Advanced directives are often encouraged by hospitals, but the documents are often not an accurate reflection of what the patient wants.¹⁰ The court is no better situated to make medical treatment decisions than the patient and those closest to them.

In these situations, conflict often centers on a failure of communication between patient, patient representatives, and doctors and therefore, a lack of information.¹¹ A better solution to these problems is mediation. Bioethical mediation that bridges the gap amongst the parties 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.”¹²

Bioethical mediators, employed by the courts, with training in palliative care are the solution to resolving the dispute. Mediation is not a viable solution in every case. There are instances where improved communication will not help parties reach a decision. However, even in these instances, mediation guarantees the parties have discerned the issue before resorting to a judge. This creates a more efficient judicial process because the parties have a clear understanding of the situation prior to court proceedings.

Part I of this Comment will examine four different scenarios in which courts order medical treatment. The different scenarios include minor children, competent adults, pregnant women, and incompetent adults. Minor children are considered incompetent to make medical decisions, so their parents or the state must consent to treatment on their behalf.¹³ However, some courts have applied the mature minor doctrine to allow minors to make their own medical decisions.

9. Alisa L. Geller, *In the Aftermath of the Terri Schiavo Case: Resolving End-of-Life Disputes Through Alternative Dispute Resolution*, 6 PEPP. DISP. RESOL. L.J. 63, 66 (2006).

10. Thaddeus Mason Pope, *The Maladaptation of Miranda to Advanced Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139, 140, 156 (1999) (explaining that the Patient Self-Determination Act (PSDA) requires federally funded hospitals to provide patients with information about advanced directives and laws and policies that govern advanced directives. In addition to informing patients of their right to create an advanced directive, the PSDA also requires hospitals to honor the advanced directives). It is important to note that the PSDA has no requirements about the contents or quality of the advanced directives. This is a major criticism of the law because it can force hospitals to use poorly thought out or written documents that have life and death consequences. *Id.* at 140–41.

11. Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 9 (2007).

12. Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U.L. REV. 1091, 1097 (1999).

13. *Parham v. J.R.*, 442 U.S. 584, 602 (1979); Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 170 (1983).

Competent adults do have the right to refuse medical treatment.¹⁴ The right to refusal will be weighed against state interests on a case by case basis to determine whether the courts can compel medical treatment.¹⁵ Pregnant women are a subcategory of competent adults in a unique position.¹⁶ Courts consider the competent adult's right to refuse medical treatment balanced against state's interests, which in these cases include the interests of the unborn child.¹⁷ Lastly, this part of the Comment examines how medical decisions are made in the case of incompetent adults.

Part II examines the current methods the legal system uses to solve disputes. First, the use of court orders to compel patients to undergo a particular treatment or to prevent patients from undergoing a certain medical treatment is examined. Second, the doctrine of substitute judgement as a method of decision-making is examined. Next, the Comment discusses the use of advanced directives to keep medical decisions out of courts and in the hands of the person undergoing treatment. Finally, Part II examines the current models of alternative dispute resolution (ADR) in place to make medical decisions, specifically reviewing the use of medical futility statutes in hospital mediation.

Part III proposes a model of ADR that can be used to aid in medical decision-making. First, Part III addresses which cases are best suited for mediation and which cases are not. Then discussed is the necessary features of an ADR model mediating medical treatment cases and how the ADR model should be implemented. Lastly, the benefits and drawbacks of using this ADR model to make medical decisions is explained.

I. TYPES OF CASES IN WHICH COURTS ORDER MEDICAL TREATMENT

A. *Minor Children*

The Supreme Court stated, “[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.”¹⁸ However, when parents are unable or fail to make such decisions,

14. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 277–79 (1990).

15. *Superintendent of Belchertown St. Sch. v. Saikewicz*, 370 N.E.2d 417, 424–25 (Mass. 1977).

16. *See Cohan, supra* note 4, at 896–97 (discussing the extensive debate on the rights of women versus the rights of fetuses).

17. *Roe v. Wade*, 410 U.S. 113, 162 (1973).

18. *Parham*, 442 U.S. at 603. Except in emergency cases, doctors must obtain consent from the minor's parents in order to perform medical treatment. Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. CONTEMP. HEALTH L. & POL'Y 233, 245 (2006). This policy behind this law “rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the

courts will intercede in the private interests of the family when the health and well-being of a minor is involved.¹⁹ The Supreme Court said in *Stanley v. Illinois*, that the state may only intervene when there is a “powerful countervailing interest” to protect.²⁰

Especially in the case of minors, it is important to recognize the difference between “medical treatment . . . important to the child’s well-being” and life-sustaining medical treatment.²¹ Courts usually will not interfere with decisions to decline life-sustaining treatment “when there is uncontroverted medical evidence that a child is terminally ill or is in an irreversible and persistent vegetative state.”²² In these cases the state’s interest in protecting the child’s well-being is ensuring that the child suffers as little as possible, which is already being accomplished by the parents and the physicians.

Courts will, however, intervene when parents refuse “medical treatment . . . important to the child’s well being . . . particularly if the treatment is necessary to save the child’s life.”²³ When parents withhold consent to certain medical treatments for their children, they usually do so on religious grounds.²⁴ In these cases, the Supreme Court has stated that the child’s welfare interest outweighs the religious liberty interests of the parents and their right to raise children the way they choose.²⁵ Most often, the state advocates for the conventional medical approach, while parents advocate for “an alternative treatment that can range from taking no action to using different forms of unorthodox medical care.”²⁶ When there is no clear superior medical treatment, it is up to the discretion of the judge to decide.²⁷

best interests of their children.” *Parham*, 442 U.S. at 602. Parents make these decisions because minors need time to develop their own decision-making skills and parents are presumed to have the best interest of the child in mind when making such decisions on the child’s behalf. *Id.*

19. Sher, *supra* note 13, at 157.

20. *Stanley v. Illinois*, 405 U.S. 645, 651, 657–58 (1972) (holding that the state cannot presume that unmarried fathers are unfit).

21. Cohan, *supra* note 4, at 860–61. “[L]ife sustaining medical treatment” are protocols that prolong life, but do not save life. *Id.* at 853. Common examples of life-sustaining medical treatment includes ventilators and breathing tubes for mechanical respiration and tubes that provide artificial hydration and nutrition. *Id.*

22. *Id.* at 860–61.

23. *Id.* at 861. “[T]he state will invariably succeed in overriding the right of parents to act as surrogate decision makers, even if this means violating the parents’ deeply held religious beliefs that prohibit the treatment in question.” *Id.*

24. *Id.*

25. *Prince v. Massachusetts*, 321 U.S. 158, 166–67, 170 (1944) (holding that the state has an interest in protecting a child from street preaching on a highway, and that equal protection is not violated in this case because public highways cannot be considered church property).

26. Sher, *supra* note 13, at 190. This presents a challenge for the courts to decide between multiple medical experts giving conflicting testimony. *Id.*

27. *Id.* at 193.

B. Mature Minor Doctrine

Ordering medical treatment for minors is further complicated when the child is older and capable of thinking deeply about his situation and develops his own treatment preferences. The mature minor doctrine states that “some minors have sufficient maturity to understand and appreciate the benefits and risks of proposed medical treatment of all kinds, and thus mature minors should have the right to give or decline to give informed consent regarding all health care decisions.”²⁸ The Supreme Court of Tennessee recognizes the mature minor doctrine and reaches a decision in such cases by considering

[w]hether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor’s ability to appreciate the risks and consequences are to be considered.²⁹

Additionally, states have passed statutes that allow unemancipated minors to make medical decisions for themselves, so long as certain criteria is met.³⁰

In re E.G., the Supreme Court of Illinois heard an appeal of the trial court’s order that found E.G. was a neglected minor because she and her mother refused blood transfusions.³¹ E.G. was seventeen when she was diagnosed with Leukemia and doctors informed her that a necessary part of life saving treatment was blood transfusions, and if she refused the blood transfusions she would likely die.³² At a neglect proceeding in juvenile court, a guardian was appointed

28. Cohan, *supra* note 4, at 872.

29. *Id.* at 874; *see also In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (N.Y. 1990) (recognizing the mature minor doctrine, but finding that the minor in this case did not meet the criteria of a “mature minor”); *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989) (holding that a minor may make her own medical decisions if adjudged sufficiently mature); *Cardwell v. Bechtol*, 724 S.W.2d 739, 755 (Tenn. 1987) (recognizing the mature minor doctrine).

30. Will, *supra* note 18, at 259 n.166–67 (noting that the South Carolina statute allows minors over the age of sixteen to consent to medical treatment, the Louisiana statute allows minors to consent to treatment and provides that minors may not refuse treatment a parent has consented to, the Arkansas statute allows minors of sufficient intelligence to consent to treatment, the Idaho statute allows anyone competent to make medical decisions to make such decisions even if they are a minor, the Alaska statute allows minors who receive counseling about the treatment to consent without parental approval, and the Nevada statute allows minors who understand the treatment and its purpose to make medical decisions as long as providers work with the minor to keep parents informed where possible).

31. *In re E.G.*, 549 N.E.2d at 323.

32. *Id.* “As Jehovah’s Witnesses, both E.G. and her mother desired to observe their religion’s prohibition against the ‘eating’ of blood.” *Id.* Her mother did consent to all treatment that did not require blood transfusions. *Id.*

who consented to the blood transfusions on E.G.'s behalf.³³ On appeal, the Supreme Court of Illinois recognized "a mature minor may exercise a common law right to consent to or refuse medical care."³⁴

C. Competent Adults

Competent adults have the right to refuse medical treatment on multiple legal grounds. The right to refuse medical treatment is recognized as a part of a person's due process rights guaranteed in the Fifth and Fourteenth Amendments.³⁵ The right to refuse medical treatment also implicates the right to privacy, as medical choices are considered to be deeply personal and fundamental to the self-determination of individuals.³⁶ The Supreme Court has also recognized that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."³⁷ However, the right to refuse medical treatment is not unlimited; exercise of it must be weighed against state interest in "the preservation of life."³⁸

In applying such a balancing test, the court employs the common law doctrine of necessity, which "holds that certain conduct, though it violates certain rights, is justified because it averts a greater evil and hence produces a net social gain or benefit to society."³⁹ Additionally, the balancing test considers the state interest in preventing harm to its citizens.⁴⁰ States and private individuals are allowed to act when a person poses a danger to themselves or others. For

33. *Id.* at 323–24.

34. *Id.* at 328. *But cf. In re Thomas B.*, 574 N.Y.S.2d 659, 659–60 (N.Y. Fam. Ct. 1991) (holding that a fifteen-year-old has no right to refuse medical treatment as the mature minor doctrine is not recognized, and therefore he should undergo the biopsy procedure because a legal guardian determined that it was in his best interest); *O.G. v. Baum*, 790 S.W.2d 839, 842 (Tex. App. 1990) (holding that Texas has not adopted the mature minor doctrine, and therefore the minor could not refuse a blood transfusion necessary to save his life after he was struck by a train and required arm surgery).

35. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 281 (1990) (holding that a state may require clear and convincing evidence for a guardian to withdraw life-sustaining treatment from an incompetent adult).

36. *Cohan*, *supra* note 4, at 857.

37. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

38. *Superintendent of Belchertown St. School v. Saikeicz*, 370 N.E.2d 417, 425 (Mass. 1997) (recognizing that the state claims a state interest in the preservation of life, and stemming from that "the protection of the interests of innocent third parties; . . . the prevention of suicide; and . . . maintaining the ethical integrity of the medical profession.").

39. *Cohan*, *supra* note 4, at 858 (noting that this principle is rooted in the utilitarian idea of the "ends-justifying-the-means," where the totality of public policy considerations justifies the violation of individual rights).

40. *See id.* at 859 (discussing how authorities can use force to prevent individuals from harming themselves or others).

example, in the incident of a drug overdose,⁴¹ medical professionals are permitted to aid the individual, even if the overdose was caused by a suicide attempt and the individual is incapable of consenting to treatment.⁴²

I. State Interest

The Supreme Court recognized the right to privacy in *Roe v. Wade*, stating that even though, “[t]he Constitution does not explicitly mention any right of privacy . . . the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.”⁴³ The Supreme Court has also recognized that the state has an interest in protecting citizens from potential abuse, upholding the integrity of the judicial proceeding, and above all, the preservation of human life.⁴⁴ Some state courts have also found a state interest in protecting children from abandonment by forcing their parent to undergo treatment.⁴⁵

D. Pregnant Women

While competent adult’s right to refuse medical treatment is well recognized, case law is inconsistent on whether the right is extended to pregnant women.⁴⁶ Courts in Illinois and New York have grappled significantly with this issue.⁴⁷ In Illinois, the rights of pregnant women are superior to the rights of the fetus, so “women have an absolute right to refuse medical treatment.”⁴⁸ However, the Supreme Court has recognized that the state has an “important and legitimate interest in protecting the potentiality of human life.”⁴⁹ There is case law that

41. *Id.* at 859–60 (explaining the court is more reluctant to interfere with the patient’s wishes as the required intervention becomes more invasive).

42. *Id.* at 859.

43. *Roe v. Wade*, 410 U.S. 113, 152–55 (1973) (holding that the right to privacy is derived from the substantive due process guarantee of the Fourteenth Amendment and that right to privacy encompasses abortion subject to limitations justified by a compelling state interest); *see, e.g.*, *Winston v. Lee*, 470 U.S. 753, 766 (1985) (holding that the state interest in obtaining evidence for a criminal trial did not outweigh the patient’s privacy interest in refusing treatment, and the defendant shot during a robbery could not be forced to undergo surgery to remove a bullet that the state wanted to use as evidence against him at trial).

44. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 281–82 (1990).

45. *Cohan*, *supra* note 4, at 881–82.

46. *Id.* at 896.

47. *Id.* at 897.

48. *Id.* at 898. *See also* *Stallman v. Youngquist*, 531 N.E.2d 355, 361 (Ill. 1988) (holding that there is no cause of action for prenatal negligence by a fetus against its mother); *In re Baby Boy Doe*, 632 N.E.2d 326, 326 (Ill. App. Ct. 1994) (holding that a competent woman has the right to refuse medical treatment even if it poses risks to her viable, unborn child).

49. *Roe v. Wade*, 410 U.S. 113, 162 (1973).

holds that the mother's right to choose her own medical treatment can be outweighed by the rights of the fetus.⁵⁰

Further, courts have yet to consider the parental rights of the father when compelling pregnant women to undergo medical treatment.⁵¹ The rights of the father have not been recognized in the abortion context, but they have been recognized in the adoption context.⁵² Cases involving court-ordered medical treatment can be distinguished from abortion cases because the result of the former imposes a duty on the father to provide for the child that is not present in abortion cases.⁵³ Courts must balance the rights of the father with the intrusion on the mother, but thus far, courts have not addressed this issue.⁵⁴

E. Incompetent Adults

Competent adults have the right to refuse medical treatment as a part of their right to privacy, right to self-determination, and right to substantive due process.⁵⁵ An issue arises when competent adults are no longer competent and able to exercise these rights. Courts have wrestled with the extent that the rights of incompetent adults can be effectuated by a guardian.

In re Quinlan was a case before the New Jersey Supreme Court regarding Karen Quinlan, who was in a "chronic persistent vegetative state[.]" but did not meet any of the criteria for brain death.⁵⁶ Karen's father asked the court to declare her incompetent and then appoint him as guardian, which would allow

50. See *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457, 459–60 (Ga. 1981) (granting temporary custody of the unborn child to the state, so state officials could consent to medical treatment on the child's behalf against the mother's wishes); see also *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537, 538 (N.J. 1964) (holding that "the unborn child is entitled to the law's protection.") The Court based its reasoning in part on New Jersey case law that allowed children to sue their parents for injuries that occurred before birth as a result of negligence. *Id.* The reasoning is in part based on the recognition of the courts that the unborn are entitled to certain rights. *Id.*

51. David C. Blickenstaff, *Defining the Boundaries of Personal Privacy: Is There a Paternal Interest in Compelling Therapeutic Fetal Surgery?*, 88 Nw. U. L. Rev. 1157, 1161 (1994).

52. *Planned Parenthood v. Casey*, 505 U.S. 833, 893–96 (1992) (holding that spousal notification imposes an undue burden on a married woman's ability to get an abortion); Blickenstaff, *supra* note 51, at 1181. Courts have held that in some cases the father can even prevent the mother from giving the child up for adoption. *Id.* at 1181–82.

53. *Id.* at 1197–98.

54. *Id.* at 1158. "The outcome of the balancing test depends on the severity of the contemplated intrusion and the nature of the asserted interest; if the intrusion is minor and the benefit great, the state may prevail The father would assert his interest through the state" *Id.* at 1161.

55. See *In re Quinlan*, 355 A.2d 647, 663–64 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) (discussing how the right to privacy exists under the Constitution and encompasses the right to decline medical treatment).

56. *Id.* at 654.

him to remove life-sustaining treatment.⁵⁷ The Supreme Court of New Jersey appointed Joseph Quinlan as guardian of Karen and was specific in their opinion that

should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability.⁵⁸

In *Cruzan v. Director, Missouri Department of Health*, Nancy Cruzan was deemed incompetent after she suffered severe injuries in a car accident.⁵⁹ Her parents, as guardians, sought to withdraw her artificial nutrition when it was determined that Nancy would not recover cognitive function.⁶⁰ Here, the Supreme Court held that while guardians may refuse medical treatment on the part of an incompetent adult, a state is within its right to impose an evidentiary standard that guardians must satisfy in order to refuse medical treatment on behalf of the incompetent patient.⁶¹

1. Standards Employed by the Courts

Courts attempt to determine the choice that the incompetent patient would make if he were able using the "substituted judgement" approach.⁶² Under this method, the court hears evidence that sheds light on what the patient would likely desire, and then makes a subjective determination based on the facts before it.⁶³ Evidence to be heard includes living wills, statements from family or friends, and anything else that could indicate what the incompetent person's

57. *Id.* at 651.

58. *Id.* at 671–72.

59. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 265 (1990).

60. *Id.*

61. *Id.* at 286–87. The Cruzan's could withdraw Nancy's artificial hydration and nutrition if they could prove by clear and convincing evidence that this is what she would have wanted. *Id.*

62. *Death by Right: A Call for Change to Michigan's Health Care Decisions Law*, 72 U. DET. MERCY L. REV. 927, 932 (1995).

63. *Id.*

intent would be.⁶⁴ In most states, the burden of proof is clear and convincing evidence, however some states require a lower standard.⁶⁵

An alternative approach used by the courts has been the “best interests approach,” which uses an objective standard to determine whether or not the medical treatment serves the best interest of the incompetent person.⁶⁶ The court looks at three factors when making its determination: “1) [r]elief from pain and suffering; 2) the preservation and the potential restoration of the patient’s ability to function normally; and 3) the quality and extent of the patient’s life if life-support is or is not removed.”⁶⁷ A significant issue with this approach is that it assumes there a single objectively correct approach, while in actuality, doctors frequently disagree on treatment and there may be multiple treatment options which produce the same effect.⁶⁸

II. CURRENT METHODS OF RESOLUTION

A. Court Orders

In issuing orders requiring or preventing patients from receiving certain medical treatments, Courts begin by balancing the patient’s rights to autonomy with state’s interest. The state interests considered are “(1) preservation of life, (2) prevention of suicide, (3) protection of third party interests, and (4) maintaining the ethical integrity of the medical profession.”⁶⁹ How courts balance these interests varies by state, so the same case may have many different outcomes based only on geography.⁷⁰ This shows the lack of a uniform standard

64. *Id.*

65. *Id.* “For example, in the case of Superintendent of Belchertown Schools v. Saikewicz, the court employed a ‘reasonable person substituted judgement’ standard” *Id.* The best interests approach or a combination of standards have also been used by courts. *Id.*

66. *Id.*

67. *Id.* Some states combine the substituted judgement and best interests approaches by first looking for clear and convincing evidence of intent, but if the clear and convincing burden cannot be met the courts can employ a “‘limited best interests test,’ which permits the court to withdraw treatment if the sustaining of the patient’s life is outweighed by the patient’s pain and suffering. Otherwise, if there is no evidence of the patient’s wishes, the court will employ a purely objective, best interests standard.” *Id.* at 932–33; see, e.g., *In re Conroy*, 486 A.2d 1209, 1229, 1232, 1236, 1241–43 (N.J. 1985) (describing this process, focusing on what evidence courts should look to and weigh when deciding what the patient would have wanted, and concluding there was insufficient evidence to demonstrate the patient would have refused the treatment under the subjective test).

68. See Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 118 (1993).

69. Cohan, *supra* note 4, at 851.

70. See David M. Shelton, *Keeping End-of-Life Decisions Away From Courts After Thirty Years of Failure: Bioethical Mediation as an Alternative for Resolving End-of-Life Disputes*, 31 HAMLINE L. REV. 103, 110 (2008) (noting that some scholars believe that the difference in outcomes reflects courts inserting their own personal and political views into end of life decision-making cases).

for medical disputes, and the need to define more clearly the patient rights and state interests.⁷¹

Allowing courts to resolve these issues is supported by arguments that “courts can conduct a ‘detached and passionate investigation’ in order to determine whether to continue or terminate treatment.”⁷² However, many people correctly argue that courts are the inappropriate party to decide these cases. The objective approach offered by courts fails to consider deeply-rooted personal feelings of the patient and his loved ones that should be accounted for when determining the best interests of the patient.⁷³ In these highly emotionally charged situations, judges lack the intimacy with the patient that the disputing parties often have. These decisions should be resolved by the people closest to the patient. Further, escalating the dispute to litigation adds increased tension to an already sensitive situation.⁷⁴ The adversarial nature of our court system will result in damaged relationships amongst the parties. Trust between the patient’s family and the patient’s care-giver is vital in creating an optimal atmosphere for these delicate circumstances.⁷⁵

The burden placed on patient’s familiesfamily’s to prove the patient’s wishes is also a frequently criticized consequence of resolving these disputes with litigation.⁷⁶ Courts hold that “the burden [is] on the patient, guardian, or family to prove that termination or continuation of life-sustaining treatment truly reflects the patient’s interests. However, physicians, health care institutions, or hospital ethics committees may make decisions to continue or terminate life-sustaining treatment without much potential for repercussion.”⁷⁷ However, this burden is likely not difficult to meet in most situations, as patients and their guardians are most likely to be aware of the patient’s wishes.⁷⁸ This burden serves as a safeguard to situations in which the patient’s family or guardians advocate for a decision contrary to the true desires of the patient. In that case, the courts would play a vital role in protecting the rights of a patient who could not advocate on their own. Further, it makes sense that hospitals and doctors do not carry this burden, because while the patient has a right to refuse treatment, the hospital and doctors are not obligated to provide a certain kind of treatment.⁷⁹

Courts are not the ideal decision makers in these disputes. But, they undoubtedly must be a part of these disputes. It is the job of the court systems to protect the rights of individuals. Sometime that protection is in the form of

71. *Id.*

72. *Id.*

73. *Id.* at 110–11.

74. *Id.* at 111.

75. Gatter, *supra* note 12, at 1095.

76. Shelton, *supra* note 70, at 112.

77. *Id.*

78. *Id.*

79. *Id.*

upholding patient wishes when the doctors feel differently, but in other situations the courts might need to protect the patient from their own family acting contrary to the patient's best interests.

B. Surrogate Decision Makers

Most states have statutes that allow a surrogate to make medical decisions when someone is incapacitated without an advanced directive.⁸⁰ The statutes often establish a priority list of family members authorized make medical decisions for the incapacitated person, starting with spouses, immediate family, and then extended family.⁸¹ If family members are not available, some statutes allow another adult "who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, [and] who is reasonably available" to serve as a surrogate.⁸² Finally, if no such unrelated adult is available, the doctors are permitted to make health care decisions based off what a majority of people would elect.⁸³

1. Benefits of Surrogate Decision Makers

The benefits of designating a surrogate to make health care decisions are that it is an efficient decision-making process, it yields a clear answer so parties know exactly who has authority, and it keeps family matters out of the courts.⁸⁴ Most Americans seem to agree that immediate family members are the group of people that should make decisions on behalf of an incapacitated person.⁸⁵ While surrogate decision-making with priority lists may be effective, the ultimate question should be whether the decisions made by surrogates are consistent with what the incompetent patient would have wanted.

Priority lists are criticized for accommodating the unique structure or dynamics that some families have.⁸⁶ This is a fair criticism, but it does not

80. Nina A. Kohn & Jeremy A. Blumenthal, *Designating Health Care Decisionmakers For Patients Without Advanced Directives: A Psychological Critiques*, 42 GA. L. REV. 979, 984 (2008).

81. *Id.* at 984–85. Some states allow for domestic partners or close friends to be surrogates, some states involve the incapacitated patient's doctors in the selection process of the decision maker, and some states allow the interested parties to select the surrogate amongst themselves. *Id.* at 985. The Uniform Healthcare Decision Act also establishes a priority list that is similar to most states and provides that if a surrogate is not available, a health care provider may obtain consent from "any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate: (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; or (4) an adult brother or sister." UNIF. HEALTH-CARE DECISIONS ACT § 5(b) (1993).

82. Kohn & Blumenthal, *supra* note 81, at 985 (quoting TENN. CODE ANN. § 68-111-1806(c)(2) (West 2006)).

83. *See id.*

84. *Id.* at 987–88.

85. *Id.* at 989–90.

86. *See id.* at 990–91.

diminish the need for decision-making statutes. It is not possible to create a statute that encompasses all unique family structures and dynamics. The decision-making statutes are intended to serve as default rules. They are a starting point, and any competent adult is free to designate a different choice than what the statute may require. Additionally, considering how few adults contemplate such decisions ahead of time, there is a great need for default rule.⁸⁷

Decision-making statutes could be improved by accounting for other factors that often influence decision-making. For example, age may play a significant role in one's decision on who should be a surrogate, but age is not considered in the statutes.⁸⁸ Culture is also not accounted for in the decision-making statutes, but different cultures within the United States have values and norms regarding care of one of their members that is not contemplated in statutes.⁸⁹

2. Criticism of Surrogate Decision-Making

The major drawback to surrogate decision-making is when the surrogate makes a choice inconsistent with the desires of the incapacitated. This may occur in two likely scenarios. First, studies show that surrogates have a hard time making decisions for incompetent adults when their wishes are unknown.⁹⁰ Surrogates "often do not know the wishes of the person on whose behalf they are making decisions, even if they think that they do."⁹¹ The second scenario, is when surrogates outright refuse to effectuate the wishes of the incompetent patient.⁹² One study found that one-third of surrogate decision makers would consent on behalf of the principal to a medical study when they knew that is not what the principal would have wanted.⁹³

Surrogate decision makers and the statutes that authorize them provide an efficient and clear solution when doctors require consent for an incompetent adult.⁹⁴ As default rules, they represent what the American public in general would want.⁹⁵ To better accommodate individual cases, the patient should designate a surrogate himself. The major drawback to surrogate decision makers

87. *Id.* at 986–87.

88. *Id.* at 990–91 (noting also that gender is a factor that is not considered by decision-making statutes, but females are disproportionately chosen as surrogates over their male counterparts). A person might prefer their brother make medical decisions over their elderly parent. While another person might prefer their elderly parent decide over their eighteen-year-old child. Statutes are not able to accommodate these more particular, yet important, considerations. *Id.*

89. *Id.* at 992–93 (explaining that some cultures, like Korean-Americans, have a more "family-centered" model of decision making that is less individualistic and more communal).

90. *Id.* at 996.

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.* at 987–88.

95. *Id.*

is that they do not always act according to the wishes of the incompetent patient.⁹⁶ Further, there are no safeguards that can require the surrogate to act according to the principal's intent, if the surrogate even knows what the principal's intent is at all.⁹⁷ Surrogate decision-making is an important first step in medical decision-making, but it is not enough to keep disputes out of court.⁹⁸

C. Advanced Directives

Advanced directives serve as an instrument for patients to record their wishes for end-of-life decisions in the event that they ever become incapacitated.⁹⁹ Implementation of advanced directives guarantees that the patient preserves his right to self-determination, even when incapacitated.¹⁰⁰ However, the major failure of advanced directives is how rarely they are created.¹⁰¹

Advanced directives, when properly utilized, allow a patient to maintain their autonomy in health care decisions. A competent patient is capable of contemplating what medical treatment that is in his best interest.¹⁰² Advanced directives allow a competent adult to ensure any end-of-life decisions made when he is incapacitated will respect his wishes, such as his religious beliefs.¹⁰³ Further, advanced directives shield medical providers from liability when acting according to the patient's advanced directive.¹⁰⁴

There are drawbacks to advanced directives. Many adults never create an advanced directive, which limits their benefit and utility as a solution for improving end-of-life decision-making as a whole.¹⁰⁵ It is also difficult for

96. *Id.* at 981.

97. *See id.* at 996–97. Research shows that surrogate decision makers frequently do not know what the incapacitated person would want, even if they believe that they do. *Id.* This makes medical decision-making very difficult for surrogates, even if they are trying their best to effectuate the incapacitated person's wishes. One study found that a spouse's ability to predict the other spouse's preference on CPR treatment varied from forty to ninety percent. *Id.*

98. In some cases, there are multiple surrogate decision makers, and they can disagree over treatment which may lead to a court dispute. Additionally, disagreements with medical staff or over a specific treatment can bring a dispute to court. *Id.* at 1010.

99. Shelton, *supra* note 70, at 127.

100. *Id.* at 128.

101. *Id.* at 129.

102. *Id.* at 128.

103. *Id.*

104. *Id.* at 129.

105. *Id.* It has been found that

less than 25 percent of individuals enact advanced directives or living wills. Perhaps this shockingly low rate of enactment is a testament to individuals feeling that their families and physicians will make the right decisions for them when that time arrives. Supporters of advanced directives and living wills cannot explain this phenomenon by arguing a lack of awareness by the public, especially in the wake of the increased publicity surrounding the formation of living wills following the Terri Schiavo dispute.

Id. at 129–30.

advanced directives to provide sufficiently detailed instructions that can be implemented by medical professionals even in the most unpredictable of situations.¹⁰⁶ Additionally, the frequent improvement of medical technology requires that advanced directives, to be easily administered, are routinely updated to account for the current state of technology.¹⁰⁷

Advanced directives are a strong solution for competent adults who take the time to fully contemplate what their choices would be, should they become incapacitated. Advanced directives remain effective as long as there is a periodic review of the document to account for improvements in medical technology and the person's current wishes.¹⁰⁸ However, despite being a well-know resource, many people never create an advanced directive.¹⁰⁹ Most people do not take the time to write down such decisions and discuss them with their caregivers or family members.¹¹⁰ And, often times, it is deficiencies and vagueness within the advanced directive that leads to a challenge in court.¹¹¹ Therefore, advanced directives are not a pratical solution to keeping medical disputes out of court.

D. Futility Statutes

Most states have enacted futility statutes, which allow doctors to refuse life-sustaining medical treatment in certain situations.¹¹² Futility statutes are intended to resolve situations in which the patient or his surrogate seek to continue treatment, while doctors recovery of the patient is impossible.¹¹³ It is often the decision of a surrogate to withdraw life support, and when faced with such a devastating decision, some surrogates refuse to withdraw life-sustaining treatment.¹¹⁴ Futility statutes permit doctors to unilaterally decide to withdraw care and shield them from liability.¹¹⁵

The proponent's arguments for the advancement of futility statutes is that they further "the goals and values of medicine."¹¹⁶ Futility statutes are argued to protect a level of professional integrity so that doctors are not forced to provide

106. *Id.* at 130–31.

107. *Id.* at 130–32.

108. *See id.* at 131–32.

109. *Id.* at 129.

110. *See id.* at 129–30.

111. *See id.* at 130.

112. Pope, *supra* note 11, at 3–4.

113. *Id.* at 9–10.

114. *Id.* at 10–12. Some surrogates feel guilty for withdrawing treatment, and are unable to deal with that grief. *Id.* Some surrogates believe that new medical technology will become available that will change the futility of their loved one's current situation. *Id.* In some cases, surrogates are even distrustful of the medical professionals giving advice. *Id.*

115. *Id.* at 4.

116. *Id.* at 16.

treatment that will fail to patients.¹¹⁷ Doctors want to foster an environment where resources are used prudently, patients' integrity is respected, and families have an accurate expectation for the future.¹¹⁸ This is why "standards of professional practice . . . [do not] include measures aimed solely at maintaining corporeal existence and biologic functioning. Under these circumstances providers feel that continued LSMT is . . . being used for the wrong ends. Moreover, health care providers find it gruesome, distressing, and demoralizing to provide treatment that harms patients."¹¹⁹ Doctors' recommendations are the product of strong and deliberate thought. Doctors often accommodate the surrogate's wishes initially "as a matter of sensitivity to religious, cultural, or moral values."¹²⁰ However, if there is continued disagreement over treatment methods and goals, resolution of the futility dispute will depend on hospital intervention or their legal channels.

E. Alternative Dispute Resolution Currently in Place

1. Futility Dispute Resolution

Hospitals have a process in place that works to settle disputes between doctors and patients or their decision makers. The first step in resolving these disputes is communication between the patient, the patient's caregivers or surrogates, and the medical staff.¹²¹ The second step is to bring in a mediator to help the parties come to a consensus as to a care plan.¹²² The next step is to go to the hospital ethics committee if a resolution cannot be reached with a mediator.¹²³ If the provider and surrogate are still unable to make a decision on patient care, then the provider may attempt to change the decision maker.¹²⁴ The provider can see if there is another person authorized legally to make a decision and evaluate if that person would be willing to withdraw life-sustaining measures at the objection of the first decision maker.¹²⁵ Alternatively, some medical providers have attempted to argue that the decision maker is abusing the patient by requiring him to submit to unnecessary medical treatment, and upon a finding of neglect, a new surrogate would be required to be appointed.¹²⁶ If the provider is

117. *See id.* at 15–16.

118. *Id.* at 17–18.

119. *Id.* at 15–16.

120. *Id.* at 20.

121. *Id.* at 22.

122. *Id.*

123. *Id.* at 23. "[T]he provider will typically ask the institutional ethics committee to intervene. The committee usually, though not always, agrees with the treating physician's recommendation to stop LSMT." *Id.*

124. *Id.* at 23–24.

125. *Id.*

126. *Id.* at 24.

unable to change the decision maker, “then the health care provider should do one of the following: (1) find a new provider or (2) attempt to transfer the patient to another institution willing to comply with the surrogate’s treatment requests. While this is rarely successful, it does sometimes resolve a few additional disputes.”¹²⁷ The final step is for the hospital to unilaterally withdraw care.¹²⁸

This process handling futility disputes within hospitals has considerable room for improvement. Doctors and scholars tend to disagree over what information, how much information, and when to provide the information to the decision makers.¹²⁹ Patients facing a dispute over medical treatment are at a disadvantage because they lack the medical knowledge of the doctors, they are in a strange and unfamiliar setting, and they are facing significant amounts of physical and emotional stress.¹³⁰

2. Hospital Ethics Committees

In addition to a dispute resolution process, “[c]ourts and health care institutions have granted hospital ethics committees varying degrees of power, all of which allow the hospital ethics committee to maintain great control over patient decisions.”¹³¹ Hospital ethics committees have become increasingly popular since the New Jersey Supreme Court endorsed their use in *In re Quinlan*.¹³² The powers enjoyed by ethics committees include veto power over patient treatment, power over the appointment of a guardian, and power over whether or not to withdraw life-sustaining treatment.¹³³ Hospital ethics committees are composed of hospital employees, mostly nurses and doctors, and occasionally one member of the community.¹³⁴ Training and expertise of individuals varies by individual and by committee.¹³⁵ Some ethics committees have moved to a mediation model rather than a decision-making model.¹³⁶

127. *Id.* at 25.

128. *Id.* For instance,

[o]ne recent five-year study of sixteen hospitals found that in approximately sixty-five cases, the hospitals decided to unilaterally stop LSMT. Another study of nine hospitals found that they decided to unilaterally stop LSMT in 2 percent of 2,842 cases. Furthermore, there are strong reasons to suspect that the rate of intractability and unilateral hospital action will rise.

Id. at 26.

129. *See id.* at 22 n.90.

130. Thaddeus M. Pope & Ellen A. Waldman, *Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143, 162 n.89 (2007).

131. Shelton, *supra* note 70, at 113–14.

132. *Id.* at 113.

133. *Id.* at 114.

134. *Id.* at 115.

135. *Id.* (noting that some members of these committees lack sufficient training to make these decisions, whether it be medical or ethical).

136. Pope & Waldman, *supra* note 131, at 148–49.

However, ethics committees still have not been able to effectively reach resolutions, and usually the hospital ethics committees acquiesce to the decision makers wishes.¹³⁷

The major criticism of hospital ethics committees is that they put their own professional and institutional interests above those of their patients.¹³⁸ The committees are made up of medical professionals who naturally have an interest in protecting the institution that employs them. Even before disputes reach the courts, the process of the ethics committee is adversarial between the hospital and the patient, which causes problems for physicians still treating the patient in question.¹³⁹

Ethics committees make decisions on a spectrum. Their decisions range from taking unilateral action by the hospital to caving to patient's demands. The extent to which a hospital exercises power will depend on its own interest.¹⁴⁰

3. Bioethical Mediation

Some hospitals employ mediators to assist in disputes when patients, their families, and doctors cannot reach a treatment decision.¹⁴¹ In such cases a mediator steps in between doctors and patient decision makers to increase communication, and hopefully come to a consensus on a care plan for the patient.¹⁴² Opinions on mediation in medical disputes is mixed. Those that advocate for mediation believe that it is a "forum for fully understanding the interests of the parties involved, as well as a forum for dealing with bioethical concerns."¹⁴³ Some argue that mediation impedes on a patient's right to autonomy because it creates a procedural barrier that patients or their decision makers must work through before treatment can be administered or withdrawn.¹⁴⁴ The strongest argument against mediation in medical disputes is

137. *Id.* at 149. Hospitals often find it easier and more efficient for their own operation to give in to the surrogate decision maker, rather than pursue the course of action in conflict with the surrogate decision maker. For the hospital, it avoids potential lawsuits and saves time for the doctors and head administrators who no longer need to discuss the dispute. *Id.* at 149, 158–59, 159 n.81.

138. Shelton, *supra* note 70, at 113–15.

139. Gatter, *supra* note 12, at 1099. Adversarial disputes between patients, doctors, and decision makers threaten the trust enjoyed between doctors and patients and can cause problems for the doctor and the patient if the doctor must still provide treatment and information to the patient and surrogate decision makers involved in the dispute as it is being litigated. *Id.*

140. See Pope & Waldman, *supra* note 131, at 148–50; Shelton, *supra* note 70, at 113–15.

141. *Id.* at 143–45.

142. Pope, *supra* note 11, at 22–23

143. Shelton, *supra* note 70, at 132.

144. *Id.* at 134.

that the typical goals of mediation do not fit the typical medical dispute situation.¹⁴⁵

The typical goal of mediation is to reach some sort of compromise between the two parties where each party walks away with something bargained for.¹⁴⁶ That is not possible in most of these cases.¹⁴⁷ No compromise can be reached when only one of two scenarios can prevail: ending or continuing life-sustaining treatment.¹⁴⁸ Typical mediation in these cases have failed because it does not accommodate the unique nature of medical disputes.

First, the needs of the decision maker and the family of the patient need to be acknowledged and addressed in the decision-making process. Family members are often the surrogates in these cases and they may, at times, have different religious or moral views than the patient.¹⁴⁹ Family members also have to deal with the aftermath of the treatment decision in ways that the patient does not have to consider. If the choice results in the death of the patient, then grief may be a factor considered by the patient's family or decision maker, but not the patient.¹⁵⁰ The family is also responsible for providing for the patient. The patient's family unfortunately must consider finances when looking at treatment options, even when the patient might not consider such interests or even be able to.¹⁵¹ The family and decision makers surrounding the patient need to be considered in the mediation process.

Another problem with mediating medical disputes is that the mediator is often employed by the hospital. A common problem in medical disputes that doctors seek to avoid is that the patient and their family will distrust the doctors on their case.¹⁵² Part of this distrust stems from the dispute being the doctor against the patient. A mediator employed by the hospital will not remedy the situation, it will make it worse. Now it is the doctor and another employee against the patient. For mediation to work, the conflict of interest must be removed.

145. See Pope & Waldman, *supra* note 131, at 149. In many medical disputes, specifically those concerning end of life-sustaining treatment, there are only two choices: administer the treatment or not. In most mediation settings, the two parties can come together and form a mutually agreed to solution founded in compromise. In medical disputes, that kind of compromise is oversimplified. Glenn Cohen, *Negotiating Death: ADR and End-of-Life Decision-Making*, 9 HARV. NEGOTIATION L. REV. 253, 271 (2004).

146. Pope & Waldman, *supra* note 131, at 149.

147. *Id.* at 143.

148. See Cohen, *supra* note 146, at 271–72.

149. Shelton, *supra* note 70, at 121.

150. *Id.*

151. *Id.*

152. Gatter, *supra* note 12, at 1103.

III. IMPLEMENTATION OF MEDIATION

Mediation can be effective in resolving medical disputes because it allows the two parties to gain an understanding of the interests of each person involved. Mediation also gives an opportunity to the patient's decision makers to gain a better understanding of the medical issues and a realistic idea of how they can be solved.¹⁵³ Critics of mediation characterize the dispute as a simple "yes or no" question, but the decision being made is influenced by the interests of each individual involved and though the treatment might be simple, the consequences are far reaching and far more complicated.¹⁵⁴ Mediation provides a forum to discuss the medical decision and address the moral and ethical concerns that underlie such decisions.¹⁵⁵

Mediation must be "a fair process and seek to protect parties choosing to use ADR."¹⁵⁶ The mediator must be a neutral third-party with the requisite training to handle medical disputes.¹⁵⁷ Finally, litigation must be an option because some parties will not reach a solution.

One area of law where there has been increased use of mediation is in divorce proceedings.¹⁵⁸ Therefore, there is more research about the effectiveness of mediation in the divorce context. The successes and failure of mediation in the divorce context can be used in formulating a mediation process in the medical treatment context. Mediation in the divorce process allows parties to air concerns, provides a neutral third-party, and is less adversarial than traditional litigation.¹⁵⁹

The ability to air concerns in mediation aligns well with the medical treatment construct. The mediator can give the parties an opportunity to voice their concerns. Doing this through caucusing allows parties to vent their feelings and be exposed to opposite view points in an environment where they feel comfortable.¹⁶⁰ The mediator can facilitate this discussion and help parties understand the information they are lacking.

153. See Shelton, *supra* note 70, at 135–36.

154. *Id.* at 137.

155. *Id.* at 136.

156. *Id.* at 139.

157. *Id.* The mediator should not be employed by the hospital. See *id.* at 141. When the doctor is viewed as an adversary, introducing another hospital employee who wields greater power over the situation will not diffuse the conflict. Rather a neutral third-party who does not know the doctor or the hospital should come in. *Id.*

158. Connie J. A. Beck & Bruce D. Sales, *A Critical Reappraisal of Divorce Mediation Research and Policy*, 6 PSYCHOL. PUB. POL'Y & L., 989, 990–91 (2000) (noting an increase of alternative dispute resolution programs throughout the country, specifically in the family law context).

159. *Id.* at 996.

160. Shelton, *supra* note 70, at 134–35. Mediation allows the parties to discuss outcomes and ask questions without committing to a particular treatment. *Id.*

A neutral third-party is another characteristic of divorce mediation that translates well to medical treatment mediation. Mediation must protect the parties involved to be effective. The patient, first and foremost, needs to be protected from being coerced into making medical decisions against their interests.¹⁶¹ It is important for the mediator to “equalize power imbalances between the parties.”¹⁶² This can be done by ensuring the patient and the family understands the medical terminology used by the physicians.¹⁶³

The mediator must be a neutral third-party to avoid conflicts of interest.¹⁶⁴ When there is a medical dispute and the patient or their family distrust their doctor, having a mediator employed by the hospital is not helpful. The mediator is simply an extension of the doctor and the hospital at that point, and this further adds to the trust issues of the patient. The goal is for a neutral third-party to bring the two sides together so each party can better understand the other’s interests.¹⁶⁵ Mediators should not be employed by the hospitals because it is unlikely the mediator would remain neutral and not consider the interests of his employer. Even if the mediator could remain neutral, the appearance to the patient and their family would not be one of neutrality.

Some argue that a mediator employed by the hospital, though not neutral, is still beneficial because the mediator might better understand the hierarchy of the hospital and the different challenges the hospital presents.¹⁶⁶ However this argument underestimates the strain a patient or their decision maker’s distrust of the hospital, including its employees, might detrimentally effect the mediation process.¹⁶⁷ If the patient and family are not trustful of the mediator, then the entire process will likely be ineffective, because “in reality too many conflicts may arise from the mediator’s affiliation with one of the potentially interested parties.”¹⁶⁸ Therefore, the most practical alternative is to have the mediation run through the courts. The mediators do not necessarily need to be employed by the courts, but the courts need to be responsible for oversight.

161. All parties share an interest in the patient being as informed as possible, and if the patient lacks capacity, that the decision makers be as informed as possible. The patient is influenced by the doctors and by their own family, and in some cases, either could unduly influence the patient to make a choice they do not want. Doctors, medical staff, patients, family members, and surrogate decision makers all need to be working to best understand the situation and potential outcomes. Doctors and surrogate decision makers need to check the patient’s capacity. Has the patient regained capacity to make decisions by himself? How much is the incapacitated patient capable of understanding, and are they being given as much information as possible?

162. *Id.* at 139.

163. *Id.* at 139–40.

164. *Id.* at 141. Mediators in dispute resolution models currently in place may be employed by the hospital as part of the hospital’s mechanism to handle these disputes. *Id.*

165. Pope & Waldman, *supra* note 131, at 149.

166. Shelton, *supra* note 70, at 141.

167. *See id.* at 141 n.302.

168. *Id.* at 141.

It should be noted that everyone has biases that are brought into mediation and litigation.¹⁶⁹ Ideally these feelings will not impact decision-making, but no problem-solving mechanisms will be perfect. Mediation offers an opportunity for the mediator to disclose biases at the beginning so parties are aware at the outset how the mediator's judgement might be affected.¹⁷⁰

One concern that arises when considering power imbalances, even with neutral third-party decision makers, is the frequency players are involved in the process. The patient and the surrogate decision maker are likely to be involved only once, while the hospital is likely to be involved multiple times. It is important to note that such power imbalances happen whether the parties appear before a judge or a mediator. Mediation offers more flexibility in its process, so mediators are able to employ a variety of techniques aimed at correcting power imbalances.¹⁷¹

A neutral mediator is an important feature and vital to the success of mediation. However, the neutral position of the mediator must be paired with additional training to properly manage disputes. Mediators in these cases also need additional training. The first question to address is what profession these mediators will come from. Then, the additional training to be a mediator, and further to be a mediator in the medical treatment context, must be considered. Beyond standard mediation training, mediators of medical disputes need bioethical training.¹⁷²

It is of the upmost importance that the mediators understand the medicine within these disputes, so they can properly manage the mediation process.¹⁷³ There is some debate about whether mediators must be attorneys.¹⁷⁴ Some argue that mediators must be limited to attorneys because it is a natural extension of the legal profession, legal skills are required for mediation, and lawyers as mediators will give the mediation process a sense of legitimacy.¹⁷⁵ The argument against limiting mediators to attorneys is, in part, that it restricts the

169. Beck & Sales, *supra* note 159, at 1001, 1004

170. *See id.* at 1004–05.

171. *See id.* at 1004.

172. Shelton, *supra* note 70, at 140. Mediators need to understand the cultural, religious, and moral issues at play and how they interact with medical issues.

173. *Id.* It would be the role of the mediator in these instances to help the doctor and the decision maker better understand each other. Frequently, this will take the shape of the mediator helping the decision maker to understand the doctor and the medicine the doctor is trying to explain. One key role of the mediator in these cases is to make sure that patients and their families understand the medical terminology. *Id.* at 139–40.

174. Stephanie A. Henning, *A Framework for Developing Mediator Certification Programs*, 4 HARV. NEGOT. L. REV. 189, 201–02 (1999) (explaining that major players in the mediation movement have strongly emphasized that mediators do not need a law degree, but at the same time most court-approved lists of mediators are only composed of attorneys giving them a considerable advantage).

175. *Id.* at 202.

pool of mediators, which limits access to mediators.¹⁷⁶ Additionally, no studies indicate that having a lawyer as a mediator will lead to a better outcome.¹⁷⁷

In the context of medical disputes, having mediators from other backgrounds can be a benefit. The likely pool of mediators would be lawyers, doctors, nurses, and social workers. All of these professions require advanced education, making it more likely the entire mediation process is viewed with confidence and legitimacy. While legal skills may be required for mediation, medical knowledge would also be required for this type of mediation. No matter the original profession of the mediator, it is likely that they would need additional training. Doctors can certainly learn how to mediate, and lawyers can learn the medicine behind a certain dispute.¹⁷⁸ Though mediation is a natural extension of the legal profession, medical decision-making is not. Medical understanding and mediation skills are both critical qualities of an effective mediator in this context. Possession of a law degree or a medical degree will not indicate an automatic aptitude for mediation. The pool of potential mediators should remain open to non-lawyers and those with the requisite training should be able to serve as mediators.

Training is essential to a successful mediation program.¹⁷⁹ The amount of training for mediators is another large source of debate.¹⁸⁰ Some believe that training should amount to graduate level coursework in a variety of applicable fields, while others believe training should be short to allow volunteers to serve as mediators.¹⁸¹

In the medical dispute context, it is unrealistic to ask an attorney or doctor to obtain an additional graduate degree for a position that is may not be his full-time work. This is balanced with the complex nature of medical disputes that implicate legal, bioethical, religious, and financial concerns.¹⁸² A certificate program with smaller courses covering these areas would produce well-trained mediators. Additionally, mediators should call on their own experiences in their service as mediators.¹⁸³

As mentioned previously, courts provide a neutral forum to resolve disputes and as such should oversee mediation. Extending from this, the legal system should oversee quality control of mediators. Bar associations oversee quality of

176. *Id.*

177. *Id.* at 204.

178. Acting as a mediator is not for everyone. Some attorneys, especially those familiar with legal disputes arising in the medical context, may be well suited to serve as mediators. Additionally, some doctors with the requisite training in mediation and the applicable legal background may be well suited to mediate.

179. *Id.* at 216.

180. *Id.* at 215–17.

181. *Id.* at 218.

182. *See supra* Part II.

183. Henning, *supra* note 175, at 216–17

attorneys, a smaller but similar mechanism within already existing bar associations could set standards and manage mediators.

Finally, for mediation to be successfully implemented, litigation must remain an option. Some disputes will not be resolved through mediation. It is important that each party understands what rights they have, so they can use them if they feel it is necessary.

IV. CASES WHERE ADR WILL NOT BE EFFECTIVE

In some cases, mediation will not help settle the medical dispute, and the only solution will be to turn to the courts. One such case is a medical dispute where religious beliefs prevent a particular treatment option.¹⁸⁴ There is no misunderstanding that can be resolved. Another case arises when surrogate decision makers refuse to withdraw life-sustaining treatment, even with all available information. For example, one study found that in approximately 2 percent of end-of-life disputes, the hospital acted unilaterally by ending life-sustaining treatment.¹⁸⁵

V. CASES BEST SUITED FOR ALTERNATIVE DISPUTE RESOLUTION

The cases best suited for mediation are those in which the disagreement is over the type of treatment to provide. In these cases, the parties can often benefit from clarifying information.¹⁸⁶ The mediator can ensure that the parties understand the science behind the medical dispute, and then use an increased understanding to work toward a solution.¹⁸⁷ These cases arise when parents disagree with doctors over treatment of their minor child, or when the two parents disagree over treatment. These cases can also arise when the caregivers disagree with their elderly loved one or their doctor over treatment. An important part of mediation is that the parties come together and develop a care plan that both are comfortable with.¹⁸⁸

184. Pope, *supra* note 11, at 76. For example, if a Jehovah's Witness requires a blood transfusion, there is no amount of mediation or discussion that will change the minds of either party. The ability to compromise treatment is also limited. There may be some room to tailor the treatment, but ultimately if a blood transfusion is needed, there is currently no medical alternative.

185. *Id.* at 26 (finding that 2 percent of the 2,842 end-of-life dispute cases in a study conducted on nine hospitals resulted in unilateral action by the hospital to end treatment).

186. Sometimes, in addition to the provided information, parties need time to digest the information and accept the outcome. *Id.* at 20–23.

187. Shelton, *supra* note 70, at 135.

188. Pope & Waldman, *supra* note 131, at 157–58. Current models of mediation of end-of-life disputes have within their process discussion of shared goals, so parties can have a better idea of realistic outcomes, goals, and priorities. Participation by surrogate decision makers in the formulation of the care plan is also an important part of mediation, as all parties' needs are considered and planned for. The involvement of the family in formulating a care plan is also important for their ability to understand what is going on, as well as helping the family to accept what is going to happen, which is often an undesired outcome. *See* Pope, *supra* note 11, at 22–23.

VI. CONCLUSION

Mediation will not be effective in all cases, but that does not mean that a failed mediation attempt has no value. The process of mediation will bring parties to better understand the others' interests, so even if there is litigation there is better understanding.¹⁸⁹ The knowledge of the other party's interests makes litigation easier on an emotional level for the parties.¹⁹⁰ That kind of understanding cannot be achieved through litigation alone because those interests no longer matter.¹⁹¹

Mediation provides a forum for interested parties to be heard. Litigation is not concerned with the individual interests of doctors, hospitals, or surrogate decision makers. In litigation, the concern is only for the patient and the facts before the court.¹⁹² But, these cases have devastating impacts for all parties involved.¹⁹³ Mediation can make such a painful process easier.

Mediation will work in other cases and save the parties time and money by keeping the dispute out of court.¹⁹⁴ Mediation can play a valuable role in medical decision-making because it helps parties to better understand the issues and each other.¹⁹⁵ The neutral third-party mediator can shift the power balance so it is equal.¹⁹⁶ Patients and their families often need help understanding the medical issues and what their treatment options are.¹⁹⁷ Doctors need to better

189. Shelton, *supra* note 70, at 134. Mediation can also act to balance the rights of those from disadvantaged backgrounds that are more likely to be challenged asserting their rights in a legal dispute. The process of mediation can assist them in asserting their rights to choose or refuse care as the process is more personal with the mediator holding the hands of those involved. It adds an additional party to ensure everyone understands what is going on. *See id.*

190. *Id.* (stating that mediators can help parties recognize their feelings). As the conflict continues, parties tend to become more polarized in their positions and more adversarial, which leads to an escalation in conflict. Gatter, *supra* note 12, at 1109. Mediation offers the parties the opportunity to better understand the other party's position, and thus deescalate the situation. *Id.*

191. Shelton, *supra* note 70, at 138.

192. *Id.* at 137–38. In the courtroom, the judge is only able to consider the patient. A major drawback to this approach is that often times adverse consequences facing the care givers and surrogate decision makers will ultimately affect the patient. The patient in some cases can still feel the hardships on those closest to him or her, and those are often the decision makers involved in the dispute.

193. Larry H. Strasburger, *The Litigant-Patient: Mental Health Consequences of Civil Litigation*, 27:2 J. AM. ACAD. PSYCHIATRY L., 203, 203–04 (1999) (noting that all lawsuits have an element of loss, some more than others, but for both plaintiff and defendant the process is stressful and can even exacerbate the injuries the court is trying to solve).

194. *Id.* at 210 (noting that some clients turn to mediation in civil lawsuits to avoid the financial costs of trial, and additionally mediation is a solution to the massive amount of time individuals must devote to resolving disputes in court due to the lengthiness of trials and judicial proceedings as well as time they must dedicate away from their normal lives).

195. Shelton, *supra* note 70, at 134–39.

196. *Id.*

197. *See, e.g., id.* at 121 (referencing the case of Terri Schiavo to describe how families may have misunderstandings about treatment).

understand the motives behind a patient's decision. Doctors also have personal interests that need to be protected, such as avoiding liability.¹⁹⁸ The mediator can help both parties reach a solution that acknowledges both parties' interests.

198. See Pope, *supra* note 11, at 43. Doctors and hospitals have a large concern of civil and maybe even criminal sanctions if these conflicts are not resolved properly. They are exposed to lawsuits for failure to get informed consent, medical malpractice, negligence, wrongful death, criminal regulatory sanctions, statutory damages, and murder. *Id.* at 44–47. In *Barber v. Superior Court*, for example, the Los Angeles District Attorney's Office prosecuted doctors for murder because they removed life-sustaining treatment from a patient in a persistent vegetative state at the request of the family; the charges were rejected because the removal was done with the consent of the designated surrogate. *Id.* at 48. The seriousness and gravity of consequences for resolving disputes improperly creates a chilling effect on doctors, so they, along with hospital administrators and staff, are less likely to challenge surrogate decision makers and are often unduly cautious in their decision-making. *Id.* at 49–50.