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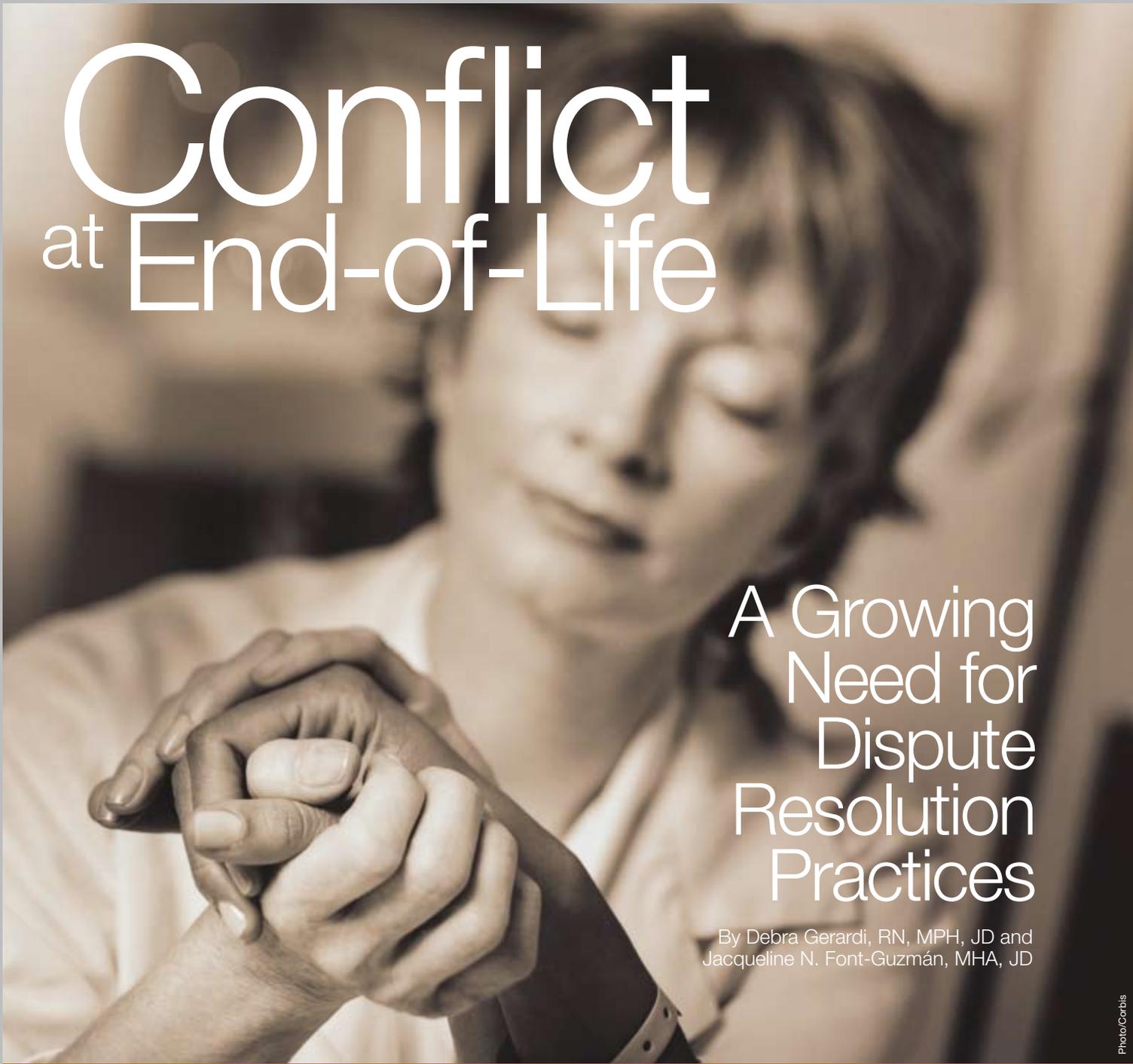
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Conflict at End-of-Life

A Growing Need for Dispute Resolution Practices

By Debra Gerardi, RN, MPH, JD and
Jacqueline N. Font-Guzmán, MHA, JD

“To write prescriptions is easy,
but to come to an understanding
with people is hard.”¹

Kafka (1952) *A Country Doctor*

Improving End-of-Life Care

There are persistent calls for improving end-of-life care in the United States. The current system for delivering end-of-life care is fragmented and complex.

A recent Hastings Center report cites three areas that require rethinking of our assumptions regarding end-of-life care, which include paying greater attention to the end-of-life care delivery system; our approach to advance directives and surrogate decision-making; and how we manage conflict and disagreement.²

Our disjointed and complex system for providing end-of-life care is costly, and does not always reflect the cultural needs of an increasingly diverse population. There is a growing emphasis on development of culturally appropriate conflict management processes within

accompany difficult decisions. The dispute resolution field has much to offer to expand possibilities for effective management of end-of-life disputes.

There is a growing demand for health services in the United States driven by an increasing proportion of elderly. Projections by the U.S. Census Bureau indicate that the older population (65+) will double from 36 million in 2003 to 72 million by 2030.³ The composition of this population will continue to expand in diversity, reinforcing the need for culturally competent professionals and culturally appropriate dispute resolution processes.

Growth in demand is in sharp contrast to a growing shortage of health care providers, particularly nurses, which is already impacting access to acute care facilities. Such stress on an already

End-of-life disputes occur daily and most are managed quietly by teams of professionals who work collaboratively with families to foster agreements that are reflective of what patients would want if they were capable of deciding. Advance directives have become a common means for expressing wishes prior to becoming incapacitated.

Unfortunately, despite such safeguards and the best efforts of clinicians, there are frequently situations in which there is not agreement as to the best course of action. These disagreements can be among members of the family, among members of the health care team or between the family and the clinical professionals. With a context of high stakes and high emotion, the disputes can be particularly disruptive and painful for those involved. Compounding the difficulty faced by those receiving and those who are providing end-of-life care are cultural differences, productivity pressures, mistrust of the health care system, disparities in care for minorities and polarized beliefs related to the sanctity of human life.

The complexity of the health care environment makes it difficult for patients and families to obtain information and often the information that is provided is difficult to comprehend under the best of circumstances.

Increasingly, there are language barriers that impede access to our understanding of complex medical processes. Additionally,

Our disjointed and complex system for providing end-of-life care is costly and does not always reflect the cultural needs of an increasingly diverse population.

health care organizations to address disputes that may arise within families or across health care teams. Expanding options beyond litigation or traditional bioethics consultation are essential to address the strong emotions, family dynamics and opposing views that

overburdened system will create fertile ground for conflicts ranging from disputes over whether and when to withdraw or withhold treatment to differences of opinion regarding futility of care and quality of life.

1 Kafka, Franz (1952) *Selected Stories of Franz Kafka*. USA: Random House, Inc.

2 Jennings, Bruce, Gregory E. Kaebnick and Thomas H. Murray (2005) *Improving End of Life Care: Why has it been so Difficult?* A Hastings Center Special Report.

3 Projections indicate that by 2030, the composition of the older population will be more diverse: 72 percent non-Hispanic White, 11 percent Hispanic, 10 percent Black, and 5 percent Asian. 65+ in the *United States US Census Bureau* (2005) found at: www.census.gov/prod/2006pubs/p23-209.pdf.

there is a multitude of varying belief systems associated with health, approaches to dying, and the roles of the patient and family in the face of serious or terminal illness. Navigating these layers of complexity takes time and often there are pressures within the health care system to resolve issues quickly so that more resources can be made available for the next patient. In addition, long-term conflicts and difficult family dynamics often surface or escalate when the stress of a dying loved one is added to strained relationships.

Health care providers are often ill-equipped to manage these conflicts or do not have the time to adequately address the complexities associated with protracted issues. It is common for nurses or physicians to refer a patient's case to the ethics committee for assistance or request that a social worker intervene. There are often entanglements of both legal and ethical questions that need sorting on top of the emotions and grief experienced by the family members. Equipping bedside practitioners with skills in conflict management and negotiation is a means for improving interactions and fostering productive outcomes.

Health care organizations are required to provide a means for accessing bioethics consultants. Larger organizations maintain an interprofessional bioethics committee that meets regularly to review cases and whose consultants are available to work with particular cases or service areas. Smaller organizations provide access to an on-call practitioner with ethics expertise or will cross train an employee to provide consultation in addition to other duties.

The core competencies recommended for those who provide bioethics consultation are highly congruent with the skills of trained mediators. In addition to ethics assessment skills, consultants are expected to be competent in process skills and interpersonal communication including: the ability to facilitate informal meetings, identify key decision-makers and relevant concerned parties, set ground rules, define the role of the ethicist, create an atmosphere of trust that respects privacy and confidentiality and encourages parties to express their concerns freely, the ability to build moral consensus, help individuals analyze the values underlying their assumptions and the possible consequences of their decisions, negotiate between competing moral views, recognize areas of conflict between one's personal moral views and your role in the consultation. They are also expected to be able to recognize and resolve various relational barriers to communication and ensure that all parties are heard.⁴

them to more adequately address the difficult family dynamics and team disputes that affect the ability of clinicians to work together. Adapting the mediation process as an adjunct to traditional bioethics consultation has shown to be an effective means for addressing conflict while balancing the need for provision of ethics expertise.⁵

Team Disputes at End-of-Life

Several recurrent issues make end-of-life care suboptimal. Among these are disputes among members of the health care team. Difficulties for clinicians in providing end-of-life care include: variability in practice, poor communication among providers, lack of consensus regarding plan of care, incomplete documentation, and differences of opinion regarding the definition of futility.

Despite a documented need for improved

A number of organizations have made use of mediators to train bioethics committee members in mediation techniques to enable them to more adequately address the difficult family dynamics and team disputes that affect the ability of clinicians to work together.

Training ethics committee members and direct care practitioners is a service that dispute resolution professionals can provide. A number of organizations have made use of mediators to train bioethics committee members in mediation techniques to enable

collaboration among health care providers, there is a continual struggle among health care professionals to work together, often to the detriment of patients, their families and more profoundly to the health care providers themselves.

4 American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities* (Glenview: American Society for Bioethics and Humanities, 1998)

5 Dubler, N. and Liebman, C. *Bioethics Mediation, A Guide to Shaping Shared Solutions* (2004), United Hospital Fund, N.Y.

The nursing literature has well documented the impact of moral distress on nurses and its impact on their desire to leave their job. Moral distress has been described as, “a psychological disequilibrium that occurs when the ethically right course of action is known but cannot be acted upon.”⁶

This situation occurs most frequently for nurses who believe that continued aggressive treatment will not benefit the patient but who feel powerless to change the course of treatment. Such conflict within the team only confounds the ability of patients’ families to make decisions they can feel comfortable with.

Cultural Competency at End-of-Life

It used to be that we were afraid of dying ... now we are afraid that someone will not allow us to die.

Justice Stevens expressed his dissenting opinion in *Cruzan v. Director 497 US 261*, (1990): “Medical advances have altered the physiological conditions of death in ways that may be alarming: Highly invasive treatment may perpetuate human existence through a merger of body and machine that some may reasonably regard as an insult to life rather than as its continuation.”⁷

In recent years, it is not uncommon for ethics committees in health care facilities, family members, patients, and health care professionals to have to address the extremely difficult ethical questions regarding end-of-life decisions that are further complicated by the fact that in many instances the health care



Members of a patient’s health care team and members of the family can often disagree about the best course of action when facing end-of-life care decisions.

professional is dealing with patients of diverse cultural backgrounds.

Health care organizations in the United States have been facing the growing challenge of having to provide medical care to an increasing number of culturally diverse patients. Culturally sensitive end-of-life communication is considered by many scholars to be an important factor in preventing disparities in care and higher costs. Much remains to be done, however, and there are calls for developing cultural competency in order to improve end-of-life care.

The Hasting Center has recently recognized the need for end-of-life care reform and cites improvement in communication to be a key factor. Likewise, the American Association for Critical-Care Nurses and the Joint Commission on the Accreditation of Healthcare Organizations is emphasizing, as

part of its standards for excellence in health care facilities, that health care facilities improve communication and dialogue.⁸

Health care professionals must become aware of the fact that not all cultures value and treasure individuality and self-determination in the same manner that many Westerners do. It is a well accepted fact that individuals with different worldviews communicate in different fashions. For example, Western culture tends to be on the high end of the low context continuum and non-Western cultures tend to be on the high context side.⁹

The salient differences for purposes of end-of-life decision-making are the emphasis on independence, autonomy, individuality, directness, separation of the person from the problem, and a future-time orientation in low context cultures.

6 American Association of Critical-Care Nurses. AACN Public Policy Position Statement: Moral Distress. Aliso Viejo, Calif.; American Association of Critical-Care Nurses; July 2004.

7 *Cruzan v. Director 497 US 261*, (1990).

8 Triola, Nora (2006) “Dialogue and Discourse: Are We Having the Right Conversations?” *Critical Care Nurse* 26(1): 60.

9 Hall, Edward T. (1989) *Beyond Culture*. New York: Anchor Books.



Photo/Stock

Advance directives or living wills have become a common means for expressing wishes prior to becoming incapacitated.

On the other hand high-context cultures emphasize interdependence and inclusion, connection with the broader community, indirectness, the interrelationship between the person and the problem, and present time orientation.¹⁰

As the Rev. Enrico Chiavacci, a moral theologian from Florence, Italy, has very eloquently stated, “Each people and each culture finds its own dignity within its own cultural identity. Moreover, cultural identities, if properly respected and understood, can offer new richness of thought to the whole human family. Therefore, each culture and religion with its own ethical perspectives must be respected and appreciated. Our Western culture is not the best: most of the papers and books on Bioethics are still strongly ethnocentric and seem incapable of accepting the simple truth that we Western people are only one of the components of the complex system which is the human family.”¹¹

Why should this be an issue? Why should we be concerned about the possibility that institutionalized moral principles, communication and dominant discourses are not culturally sensitive? Because research indicates that when cultural and linguistic differences are not addressed, the patient suffers the consequences of poor outcomes.¹²

Expanding Capacity and Cultural Competency

The field of dispute resolution offers a number of processes and techniques to improve individual skills and enables groups to work together in a culturally competent manner. Facilitation and mediation have traditionally been used to manage conflict and build agreement, particularly when there is a loss of trust or perceived differences that impede decision-making or problem solving. Dialogue is a process that enables groups to establish common purpose, surface assumptions,

and collectively develop deeper meaning while taking into consideration cultural differences. Coaching and mentoring processes create clarity and promote self-awareness by providing structured feedback in a supportive environment. Appreciative inquiry helps groups to identify patterns that exist when things are working well. By replicating the circumstances that enable success, groups are better able to move forward by avoiding the impasse created by either/or solutions. Integrating these tools into clinical practice is a practical means for improving how conflicts are managed at end-of-life and for advancing the level of cultural competency within health care organizations.

Enhancing Our Delivery Systems

Most health care organizations have a need to redefine their processes for responding to conflict and resolving disputes. Design of systems that enable people to productively engage with each other is a special area of application within the field of dispute resolution. Organizations can develop reliable methods for fostering collaborative problem solving and effective dispute resolution. Such processes can be designed to take into consideration the diverse needs of patients and health care providers. Expanding the scope of bioethics committees to provide mediation or building in access to outside mediators gives broader access to processes that can effectively engage people in complex discussions in supportive atmospheres. Utilizing principles of dispute resolution systems design that take into

10 Bowman, Kerry (2004) “What are the Limits of Bioethics in a Culturally Pluralistic Society?” *The Journal of Law, Medicine & Ethics* 32(4): 664, 665; and Augsburg, David W. (1992) *Conflict Mediation*.

11 Chiavacci, Enrico (1992). “From medical deontology to bioethics: the problem of social consensus of basis issue within Western Culture and beyond it in the human family.” In Edumno Pellegrino (ed.) *Transcultural Dimensions in Medical Ethics*. Frederick, MD: University Publishing Group, 99. As quoted in Kuhse, Helga and Peter Singer (Eds.) (2001) *A Companion To Bioethics*. USA: Blackwell Publishing Ltd. at p. 99.

12 Medrano, Martha A. et.al. (2005) “Self-Assessment of Cultural and Linguistic Competence in an Ambulatory Health System” *Journal of Healthcare Management* 50(6): 371, 384.

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consideration socially constructed diverse belief systems related to death, illness and health care helps to avoid narrow approaches that do not meet the needs of patients and families. Thoughtful design of processes by dispute resolution professionals creates a culturally competent means for addressing difficult conflicts while supporting patients, families and clinicians.

Conclusion

There is a growing need to improve end-of-life care including the need to improve how we manage conflict and

disagreement. There is an increasing demand for health services that will create a greater need for better skills and processes for addressing end-of-life issues in a culturally competent manner. Dispute resolution professionals have much to offer in the form of training, mediation, facilitation, dialogue and systems design to help health care organizations effectively address complex issues.

For More Information

The Werner Institute's Program on Healthcare Collaboration and Conflict

Resolution is the first university-based program designed to integrate emerging health care issues with the practice of alternative dispute resolution. The program's goal is to create education and research opportunities, which advance the field of health care dispute resolution. Drawing from an inter-professional community of practitioners and educators, the Institute provides professional development programs, academic courses, clinical training, research and dialogue, with a focus on the improvement of communication, collaboration and conflict management across the health care industry.

For more information on dispute resolution and health care, please contact the Werner Institute at 402.280.3852 or visit law.creighton.edu/wernerinstitute.



About the authors: Debra Gerardi, RN, MPH, JD'92, is chair of the Program on Healthcare at Creighton's Werner Institute for Negotiation and Dispute Resolution and also serves as an adjunct professor of law. With over 25 years of clinical and administrative experience in major health care organizations, such as UCLA Medical Center and Stanford Hospital and Clinics, she is a pioneer in health care conflict resolution, having provided mediation, facilitation, systems design and training in the field of health care, including intervention in complex, multi-party disputes. Among the organizations for which she has headed such projects are the American Medical Association, the Medical Group Management Association, the Health Insurance Forum, the American Association of Critical Care Nurses, the American College of Health Care Executives, Stanford Hospital and Clinics and Kaiser Permanente. Gerardi can be reached at debragerardi@creighton.edu.



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