

*At the Bedside*

## How Clinicians Can Reduce “Bullied Acquiescence”

*Edmund G. Howe*

### ABSTRACT

Clinicians and patients and their families may disagree about a course of treatment, and the ensuing conflict may seem intractable. The parties may request mediation, or use mediation-based approaches, to help resolve the conflict. In the process of mediation, and at other times, parties in conflict may feel so pressured to accept a resolution that they acquiesce unwillingly—and such resolutions often unravel. In this article I investigate how “bullied acquiescence” might happen, and how to avoid it.

In this issue of *The Journal of Clinical Ethics*, Laura Guidry-Grimes, with the assistance of staff from the Medstar Washington Hospital Center for Ethics, propose a new precedent. In “The Case of Ms D: A Family’s Request for Posthumous Procurement of Ovaries” and commentaries, they argue that, in some circumstances, a person should be able to have a child “with” a partner who has died, even when the deceased did not give prior consent.<sup>1</sup> (For the sake of simplicity, I will refer to the article and commentaries as Guidry-Grimes’s work.)

Also in this issue of *JCE*, Haavi Morreim, in “Story of a Mediation in the Clinical Setting,” presents mediation approaches that she calls “Mediation 101,” suggesting these approaches can be used

by those who are not trained in mediation.<sup>2</sup> Morreim introduces the phrase used in the title of this article, “bullied acquiescence,” to describe how medical staff can pressure patients and family members to make a decision they don’t want to make. She gives the example of staff pressuring a family to agree to a do-not-resuscitate (DNR) order, only to have them rescind the DNR order shortly thereafter. The two articles suggest ways to reduce bullied acquiescence.

### ASSIGNING GREATER MORAL WEIGHT TO PATIENTS’ AND FAMILIES’ FEELINGS

In this issue of *JCE*, Guidry-Grimes presents a case in which the family and partner of Ms D, who experienced sudden whole-brain death, asked the medical team to preserve Ms D’s ovaries for possible later use in conceiving a child. The standard position in such cases is for staff to not assist unless the deceased had explicitly consented to postmortem reproduction, or there is evidence of specific conversations indicating this was desired. Such cases are rare, but I commend Guidry-Grimes’s innovative thinking and courage in arguing for a new model.

In the case analysis, Guidry-Grimes pursues arguments both for and against posthumous extraction of Ms D’s ovaries, and this may be how such arguments must be made, particularly when they set a new precedent. What I find most affecting in the case is, however, the intensity of Ms D’s partner’s desire to have a child with her. In the face of such intense feelings, should the manner and method of discussion change? If so, how? For example, it may be appropriate to acknowledge “intense feelings” explicitly, and recognize their moral weight in con-

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siderations that more typically would include only reason-based pros and cons.

Placing such weight on emotions is uncommon in ethical analysis. As Martha C. Nussbaum states, however, “If emotions . . . contain in themselves an awareness of value or importance, they cannot easily be sidelined in account of ethical judgment, as so often they have been in the history of philosophy.”<sup>3</sup> Rather, she says, emotions must be “parts of this creative reasoning itself.” Including the moral weight of emotions in ethical analysis is, she notes, “complex and messy.” She is right. Emotions can enlighten or mislead, and we can never identify the role that feelings play in our thinking.<sup>4</sup> I will not review here the extensive history of thinking and controversy regarding emotions and reasoning.

Ms D’s partner’s intense feelings about having a baby may indicate what he needed to be happy—what he needed to *flourish*. The combination of intense feelings and the need to flourish may be key criteria on which the medical team might have considered giving greater moral weight to his request.

#### **According Greater Moral Weight to Feelings**

Ms D’s partner and her family asked the team to extract her ovaries. Ms D’s partner had planned to use his retirement savings to pay for *in vitro* fertilization (IVF) with Ms D. He expressed deep regret they had not taken this step sooner and had a child together before her death. He produced paperwork from their visit to a fertility clinic as evidence that Ms D would have wanted to harvest her ovaries after she died. His hope and regret are poignant. The strength of his feelings and of the feelings he evokes in us may be a first clue that we should consider making an exception to the usual way of doing things, as Guidry-Grimes argues.

Perhaps patients’ and families’ feelings should be viewed as existing on a sliding scale. On this scale, feelings would be accorded moral weight when they reflect what is most meaningful in the patient’s or family member’s life. In this case, the previous efforts of Ms D and her partner to begin IVF could be seen as indicating what they held to be most meaningful in their lives. Giving moral weight to their feelings would respect their sensibilities, regardless of the reasons underlying their feelings. If assigning greater moral weight to patients’ and family members’ feelings affects what the medical team will do, it would result in a much greater good, in the eyes of patients and families.

On the other hand, according greater weight to patients’ and families’ feelings would make it harder for clinicians to “draw the line” and deny a request,

should that be necessary. Clinicians would have to sort out feelings that should be given greater moral weight from feelings that should not, or assign different moral weights to feelings, flourishing, and other relevant criteria, on a sliding scale. In some cases these distinctions may be highly arbitrary. Yet making such distinctions may be not only ethically justifiable, it may be *most* justifiable. That is, if placing increased weight on feelings could make a very important difference to patients and family members, most of the time, this approach may be preferable to using only reasoning, even though staff may sometimes have to draw an arbitrary line. Ethics often relies mostly, or only, on objective reasoning.

Guidry-Grimes takes into account Ms D’s partner’s feelings and the degree to which they are meaningful to him. She states that intentional reproductive decisions are “of our most intimate nature, our sense of self, and our family identity.” Are there any aspects of who we are or any of our needs that are more precious? Lorraine Code goes so far as to argue it would be irrational to not place ethical weight on what we feel. She states, “theorists of knowledge” need to engage in critical analyses of the “suppression of subjectivity.”<sup>5</sup> To know other people, she says, we can’t possibly be “unresponsive, emotionless, and neutral.”<sup>6</sup> She spells out how clinicians could put the importance of subjectivity into medical practice: a doctor, she says, must be willing to explain whatever a patient wants to know, to indicate other directions a patient might want to take, to respect a patient’s decisions even when they conflict with the doctor’s advice, and, most importantly, to not claim expertise “where [the doctor] has none.”<sup>7</sup> In some respects such interventions are commonplace, in that they are what should be done to maximally respect patients’ autonomy. These interventions foster an interpersonal regard that goes beyond respecting autonomy, since clinicians, Code says, must be aware of their own fallibility in working with patients towards a solution that is “mutually plausible.”<sup>8</sup> We cannot, even if we wanted to, she concludes, become “mental monists.”<sup>9</sup> Such “mutual plausibility” is the goal of mediation-based approaches, which I discuss later in this article.

#### **Taking Feelings into Account**

Perhaps the best reason clinicians should take patients’ and family members’ subjective feelings more into account is because, if clinicians don’t, it is more likely that family members might experience abject terror. For example: family members come to the ward to visit their loved one, who then has a cardiac arrest before their eyes. To their hor-

ror, no one comes to provide cardiopulmonary resuscitation (CPR), despite their frantic calls. They are not aware that the patient enacted a do-not-resuscitate (DNR) order and told the staff not to tell the family. This is unusual, but it has happened.

In such cases, staff may not inform family that a patient has a DNR because the patient requested they not be told. Staff may then feel that they must, above all, respect the patient's request.<sup>10</sup> Staff may especially want to abide by a patient's request due to recent laws that, under some circumstances, make violating confidentiality a criminal offense. Not knowing the specifics of the law, staff may err by overly respecting confidentiality when in doubt. But family members who see a loved one suddenly have a cardiac arrest and call for help, who don't see CPR begun immediately, may find the experience terrifying. Moreover, staff probably could have anticipated the family's feelings of terror in this situation. This example illustrates the need for staff to do more than consider the feelings of patients and family members. It is possible that staff could *anticipate* harmful feelings, and they could anticipate the measures needed to prevent them.

When clinicians foresee harmful feelings, what can they do? In the above situation, for example, staff might try to persuade the patient to inform loved ones. If this fails, staff might go so far as to insure that all patients' visitors know that any patient might have a DNR order, without informing anyone but staff. This could be achieved by posting a notice that can be seen by anyone getting off the elevator onto the ward, so no one would escape knowing: "Visitors should know that patients on this ward may have a DNR order, and may ask staff not inform visitors that they do." Loved ones could then ask the patient about it, and, in this situation, it is implausible that any family member or loved one would not want to know. In taking this almost unprecedented initiative, staff would be able to anticipate the almost unimaginable emotional pain that a loved one might experience in this situation, and accord appropriate weight to it. This example, involving terror, clearly involves harm. I used it to indicate how important emotions may be. In this case, feelings may be so important that they suggest an innovation that is not routinely considered.

Another example is the so-called slow code—deliberate slowness in responding to a request for CPR when it would not benefit the patient—a practice most of us thought had been abandoned forever. Years ago, clinicians who merely mentioned the possibility of responding with a slow code in response to a family's request for CPR were greeted

with contempt—as they would be today. Yet, in 2011, John Lantos and William L. Meadow offered a credible exception based on family members' feelings: in an extreme, rare instance, a slow code might be ethically optimal, and they spell out what the circumstance might be.<sup>11</sup> For example, family members may have been fully informed and thus aware that a slow code won't succeed, but they still want it. Wanting a slow code may not be rational, as the family knows it won't succeed, but it is what they want. Family members can make the same kind of emotionally based requests under other circumstances. For example, an ambulance arrives at a patient's home long after the patient's heart has stopped. The emergency medical technicians examine the patient and explain to the family that their findings are conclusive: their loved one has died and can't possibly be revived. But families still ask the EMTs to try resuscitate, and irrationally, perhaps, families later report that they feel relieved by the effort.

Given this, it might be warranted—and may be even preferable, in some circumstances—to respond to a request from a patient or family member, even when the request is "objectively" wholly irrational. In the instance of providing CPR, responding takes up staff time. But this "downside" may be outweighed by the exceptional respect that responding may connote to the patient or family member.

Here is another example. A patient was dying because the bleeding from an organ inside his body couldn't be stopped. He needed blood so regularly the hospital blood bank was being depleted. His medical team knew that he had only a few days, or a week at most, to live. The hospital blood supply was not so depleted that it placed other patients at risk. Still, some staff saw the use of blood as unwarranted, as giving blood under these circumstances was prolonging dying, not prolonging life. They contacted the ethics consultant and asked him to discuss the situation with the patient, hoping that the consult might cause the patient to agree to not have more blood.<sup>12</sup> The consultant took a mediation approach. He asked the patient whether he was presently finding value in his life, to be sure that he was. The consultant reasoned that it would make more sense to bring up the choice of stopping blood transfusions if the patient wasn't finding value in his life. The patient responded that he was finding his life valuable, although he knew he would be dying in a few days. The consultant thanked him and left.

The consultant could have tried more to do what the staff wanted—to persuade the patient to stop using blood. If he realized this was the staff's underlying agenda, though, the consultant could have cho-

sen not to do the consult. He might have told the staff, “You’re asking me to do something other than ethics. My skill in is resolving ethical conflict, not persuading a patient to do something or giving bad news.” On the other hand, the ethics consultant might have been more skilled in giving bad news than the staff were. Then perhaps he could have said, “Yes, I’ll give the patient this bad news.”

But I wish to consider an alternative even more nuanced: the ethics consultant might have chosen not to do the consult because of what agreeing to do it might connote to the patient. That is, the patient knew he was dying and continued to lose blood. He might infer from the consultant’s visit that the staff wanted him to stop using blood, even though they knew that, if he agreed to stop, he would probably die sooner. Inferring this, the patient might feel emotionally abandoned by the medical staff. It could be argued that the patient might not have imagined his using this much blood was a concern. Or that whether the patient should have been told should depend on whether his use of so much blood could harm others. Another argument would be that saying this to the patient would respect his autonomy.

I explored the possibility that the patient might have felt abandoned by role playing with a colleague, which I often do to test out how others may respond emotionally. I was the consultant and she was the patient. I did what the real consultant had done, and, after the role play, I asked my colleague how she felt, as the patient. “Defeated,” she said. If the ethics consultant had considered this possibility before agreeing to do the consult, and assessed the relative gains versus the harms of consulting, he might have decided not to do the consult.

### ADDING MORE EXCEPTIONS

In addition to making exceptions based on patients’ and family members’ strong feelings, clinicians may want to place greater value on how some patients differ from others, which may lead to making additional exceptions. Here are some examples of how making this relatively small change may improve outcomes for patients and family members.

#### Responding to Subtle Differences

Ethical analysis relies on reason, and, to reason, it may be necessary to see each person within a group as essentially the same. We do this when speaking of respecting a person’s autonomy or of treating people equally—in such instances, we treat two persons as if they have only common traits, or as if they were one. But in the clinical context, all persons are

different. Thus, there is justification to tailor our treatment of each person based on their individual needs. When we make ethical conclusions that require us to generalize about people, we risk going too far, and, in the process, missing the individual’s important, different needs. This may be another ground on which an ethicist like Guidry-Grimes may respond to a person like Ms D’s partner by making an exception: his need and situation may be different. Thus our best response to him may be different.

The need to take difference into account to a greater extent when making ethical decisions is expressed well by Seyla Benhabib, who identifies and contrasts what she calls the “generalized self,” used in conventional ethical discourse, from what she calls the “concrete self,” which is always unique.<sup>13</sup> She writes, “The standpoint of the generalized other requires us to view each and every individual as a rational being entitled to . . . rights and duties. . . . The standpoint of the concrete other, by contrast, requires us to view each and every rational being as an individual with a concrete history, identity and affective-emotional constitution.” Further, she writes, “In contemporary universalist moral psychology and moral theory, it is the ‘generalized other’ that predominates.”

The problem with this, Benhabib states, is that ethical concepts such as fairness then become “thereby identified [only] with the perspective of the ‘disembodied and disembodied generalized other.’ ”<sup>14</sup> Individuals have unique needs and motives that “carry within them the traces of early childhood experiences, phantasies, wishes, and desires as well as the self-conscious goals of the person. . . . The non-relational theory of the self, which is privileged in contemporary universalist moral theory . . . removes such needed interpretations from the domain of moral discourse.”<sup>15</sup>

To add ways that persons may be significantly unique in our ethical judgements, we might scrutinize each patient and family for such differences; if they are present, we can try to take them more into account. One way to do this might be to make exceptions for the patient or family, or both.

#### Examples

In medicine, as in ethics, it is often necessary to establish categories to best proceed. A clear example is triage. During a large-scale disaster, when large numbers need treatment, it might be best to first determine which patients could live if given the right treatment, and which patients, even with treatment, will die. Such triage allows staff to prioritize treating patients who could live, saving many more lives.

Another example is categories regarding which patients can be admitted to the intensive care unit (ICU), that allow staff to prioritize the treatment of patients who will most likely benefit from admission. Following this concept, some hospitals do not allow patients with a DNR to be admitted to the ICU. But some patients may have conditions that require admission to the ICU if they are to be treated successfully and continue to live.<sup>16</sup> They may have pneumonia and only survive if admitted to the ICU.

In these cases, staff could make an exception. Rather than simply follow the policy that a patient with a DNR cannot be admitted to the ICU, the staff could ask the patient or family why the DNR was originally written. Then the staff could inform the patient or family that the reason for the DNR has changed, as it would, for example, if the patient needed treatment for pneumonia in the ICU. Once informed, the patient or family would have the option to rescind the DNR order and be admitted to the ICU for treatment. Lorraine Code, whom I quoted above, describes this kind of informing of patients and family members as necessary in every case. Then and only then can a DNR be applied as intended.<sup>17</sup>

This example indicates the gains that clinicians may be able to achieve by seeing patients as individually embodied, as Benhabib puts it. With this awareness, clinicians may better see the importance of making an exception.

Here is another example. A young girl with a genetic disorder, Werdnig-Hoffman's disease, was dying. This condition involves progressive, ascending paralysis. The child's paralysis had seeped up her body so that she was paralyzed from her feet up to her waist, and the muscles in her lungs were weak as well. She had developed pneumonia, and it would progress. As a result, even though she had been successfully treated with antibiotics on this admission to the hospital, her care team wanted to decide, before she was released from the hospital, what they should expect to do on her next admission. Specifically, they feared that she might need to be on a respirator to be treated successfully and survive, and should they plan to do this on her next admission? they asked the ethics committee. The pediatric pulmonary experts who were called in all said the team should not consider placing her on a respirator, even though she would die without it. They believed she was too young to understand what the respirator was and why she needed it, and she would have frequent pain from the suctioning. Finally, the experts said, she wouldn't be able to hug her parents.

I was a member of the ethics committee, and I went to her ward and bed after the committee meet-

ing because I felt especially ambivalent about the meeting. I heard peals of laughter coming from her room as I entered. It surprised me, as this young girl, after all, was dying. All the experts agreed that she would die within months. "How come?" I wondered. Our committee had imagined that she and her family would be grieving because of the findings of the committee, and because she was dying. They weren't. The family, I think, was highly different from what the committee had imagined. They rolled, I might say, as if they were having a party. I thought: If any child could experience joy while being hospitalized and on a respirator, it would be this girl. I wondered: Should I contact the ethics committee and ask them to gather again? But I did not. Since the experts were so convinced that being on a respirator would harm the girl, I thought that my new perception wouldn't change their minds. Perhaps, I thought, I was being overly optimistic.

I may have been wrong to not seek to reconvene the committee. Perhaps we should have seen this child as an exception—this is my story's point. It is paradigmatic of the kind of case in which we should consider individualizing treatment and go in a direction different than the usual. Ms D's partner, who wanted to have a child with her after she died, might be another. These examples show how we might identify the unique needs of patients and families by recognizing their individual lives and life histories, as Benhabib would describe it. We could alter our usual practice with even just one patient, in the same way that we might alter an ICU policy that does not allow admission of a patient with a DNR.

#### USING MEDIATION-BASED APPROACHES

In this issue of *JCE*, Haavi Morreim reports on a case in which she was the mediator. When she was first consulted, two security guards were posted outside the hospital room of baby "Henry," to prevent his parents from taking him home against the staff's medical advice (AMA). His pediatrician was about to call child protective services. Fortunately, he called Morreim instead. Morreim suggests that clinicians must, above all else, avoid causing "bullied acquiescence" in patients and their families. If clinicians use force, she says, sooner or later patients and families will "push back."

But "bullied acquiescence" presents greater risks. Patients may not return for treatment when they need it. Worse, they may feel bitter about their experiences with medical staff, and that may cloud the rest of their lives. At worst, like patients with posttraumatic stress disorder, they may suffer from

repetitive, intrusive flashbacks that prevent them from regaining joy in their lives. An additional risk is less well known: some people, recent research indicates, see others as threatening even when their facial expression is neutral.<sup>18</sup> This means that when we conduct a traditional ethics consult, they may see us as threatening. This may occur even when we are trying to help them, for example, in presenting a new option that may not be what they want.

When we encounter this kind of fearful or angry response, consciously or unconsciously, we may reciprocate. In turn, this may cause patients and family members to respond even more adversely, triggering an ever-increasing negative cycle that neither party understands nor can stop. Feelings that are this strong—especially fear and anger—may so wholly occupy our awareness that they cut off our capacity to think rationally, and even to compromise. As a result of this kind of cycle, clinicians may call child protection agencies, and families may surround a loved one's bed to shield a patient from staff.

Mediation approaches may help to prevent this. Absolute insistence that patients and family members have an equal voice in these interactions, as aforementioned, provides a structure in which such tragic outcomes are much less likely to occur. Our nonverbal expressions of emotions, and what we say, are more likely to stay within these same lines. Mediation approaches may be beneficial when we interact with people who are more likely to misperceive our intended neutrality. These people are worse-off than other patients and family members, due to their proclivity for misperceiving. By using these mediation approaches, we may be doing more to help this worse-off group.

When conflicts arise but aren't resolved, the rest of us may be worse-off, too. We may feel burned out and in time may even change profession. To the extent that these approaches enable medical staff to do better, they will benefit too. But there are three important questions to be considered before using these approaches: when to use them, what to say, and how much should be compromised.

### **When to Use Mediation Approaches?**

Overall, mediation approaches are particularly helpful when patients and family members are distressed due to an ethical conflict, and the conflict is unlikely to resolve itself with the passing of time. This is because these mediation approaches tend to be successful in reducing the distress experienced by the parties in conflict. As Morreim states, these approaches seek to build trust "at every turn." They seek resolutions not "from experts," but "by those

who are most deeply affected." Participation in mediation is "voluntary throughout," from the "first conversation." In some contexts, the need to consider using these approaches is urgent and more obvious. In the case that Morreim reports, the security guards were posted at Henry's door and his pediatrician was about to call child protective services.

Such an intervention—calling in protective services—sometimes is necessary. In other cases, though, it can do inordinate harm. For this reason, clinicians often choose to continue to see such families in the hope of resolving the problem, rather than making this call. Thus Morreim's case example does more than depict mediation approaches; it illustrates why clinicians might well use these approaches when they can. In other cases, such potential gains are obvious. Articles in *JCE* have described, for example, a family surrounding a patient's bed to protect him from clinicians, like a herd in the wild protecting its young. They have described a grandmother who threw herself over her grandson as he lay in his bed, for the same reason.

In addition, mediation approaches may be most beneficial in less obvious cases, for example, whenever people are distressed. Their distress may be the first sign that an ominous cycle, as described above, is beginning. Mediation approaches may prevent initial hostility from worsening.

Clinicians may want to consider using these approaches particularly when a patient has, to any degree, damage to the brain: from an injury, a previous coma, or early dementia. Patients with damage to their brain may, more than others, overrespond to what they see as threats. Further, those whom the patients feel they can trust may often be able to relieve the patients' angst more rapidly and effectively than for patients without brain damage.

For example, a patient who had some damage came to see me in a rage, because he had called his physician the day before and the physician hadn't called him back. The patient said he planned, after he saw me, to storm into his doctor's office and just lace into him. Suddenly interrupting his own fit of fury, he asked me, "What do *you* think?" I said, "I'd call him first and ask what happened." He said "Oh!" and his face softened. "Then I will." Clinicians who use these approaches may gain patients' trust much more than others using different approaches. Thus, they should especially consider using mediation approaches with these patients.

### **What to Say?**

Morreim notes that mediations can be court ordered. In these contexts, if the conflict isn't resolved,

the outcome may seem like the sword of Damocles, hanging over the heads of the patient and family—not an improvement. What happens next may be out of their hands, as decisions will be made for them, by others. As Morreim notes, one cannot say at the outset of a mediation, “I’m not here to tell anyone what they should do,” and then later be directive. The importance of making the best possible first step, then, can’t be overstated.

We should accept the profound importance that others may place on whatever it is that they feel, whether this makes sense from an objective perspective or not. Some people may respond profoundly to what others see as only trivial or slight losses. Thus patients may make choices that make little sense to others. A patient may feel, for example, that she or he would rather die than lose a toe, or prefer to be constrained and carried out of a hospital when he or she no longer needs care than to leave on his or her own. Likewise, some patients may feel that they want to live longer, even with the amount of time gained may be only a few minutes.

Clinicians must initially indicate, nonverbally as well as verbally, that they recognize these feelings, and respect them, regardless of what they believe from their own medical perspective. It might be optimal to acknowledge the importance of a patient’s feelings in our first words to the patient or family. For instance: “I’m sorry, I can’t give you what I know is what you want . . . for your loved one to live. . . .” After communicating we have this understanding, we can say what we *can* offer and what will be likely to happen, if, using mediation-based approaches, a resolution isn’t reached: namely, that others may make the decisions.

It may be best to clarify that it is possible to take this statement in two different ways. The first way is what is intended: to describe what can be gained by meeting. The second way may seem like a threat, even though it isn’t intended to be. If it is clear that the clinician is the ally of the patient and family, the reality, the sword that hangs over their heads, may provide the greatest incentive to accept some outcome other than what they initially most wanted. Clinicians may be explicit. They can say that they wholly understand why the parties in conflict may have no interest in meeting, but the parties may come out better through mediation than they would if they can’t agree—which would be that other people will decide what happens next. This is a core intervention I will discuss later. Clinicians should always tell patients and families *why* they will do what they will do, and then ask, “Would you be willing to participate?” Asking and then listening are essential.

### **How Much to Compromise?**

If mediation approaches are to succeed, medical staff, like patients and families, may have to accept an outcome that differs from what they most hope for and want. If they can accept this in advance, they may be better prepared and so be more able to respond in a way that is conducive to compromise. The most difficult compromise for staff may be agreeing to give a patient suboptimal medical care. Patients can make this choice in other contexts, so long as they are competent. Greater problems may arise when they are not competent. Even then, using mediation approaches may be more important. When patients and families trust the staff, they may assent more readily to what they most need.

An example is a situation alluded to earlier, of a woman who had a gangrenous toe due to diabetes who refused an amputation. She also had early dementia. Some staff wanted her to be declared incompetent, and then, with her surrogate’s concurrence, they would cut off her toe without her permission. Staff feared that if they waited, her toe would become infected and the infection would spread throughout her body, possibly ending her life. Other staff believed that this risk, although real, was remote. Her toe, they thought, might possibly fall off on its own. Fortunately, one of the staff used a mediation-based approach. She found that the rest of the staff, even with their misgivings, were willing to give the patient more time. In time the patient accepted the surgery. But initially she had wanted to keep her toe more than her life.<sup>19</sup>

Sometimes a hospital’s interests or rules need to be compromised. Staff may not have the authority to make that kind of decision. A third party may need to be brought in who can—for example, an administrator. An example of possibly supporting a compromise that goes against a hospital’s interest is when a patient refuses to leave the hospital when he or she no longer needs hospital care. It is possible that, in time, the hospital may have to use force, invoking the law and physically forcing the patient to leave against his or her protests.<sup>20</sup> This is another instance when clinicians who use mediation approaches may do better. For example, they could bargain for time. They could indicate that they truly do appreciate the degree of the patient’s fear about leaving the hospital, and they recognize their inability to reduce the patient’s fear quickly or on their own. As a next step, they may be able to get a patient to agree to meet with a clinician who would be the best person to provide follow-up care for the patient after release from the hospital. What may be key is what is said to the patient as to why. A clini-

cian can explain that the meeting may not influence the patient's decision, but will give him or her "additional information." The clinician can add that, based on his or her own experience and expertise, more information is generally better than less information. (I will say more about clinicians' acknowledging expertise shortly.) In such instances, a clinician may be negligent in serving the patient if the clinician does less. The clinician can also explain this, and the patient will almost certainly agree.

Patients who are fearful may benefit a great deal from any additional knowledge we can give them that helps them decide what it is they want most. Making an early intervention such as this may make an immense difference in what subsequently occurs.

Another example is that of hospitalized psychiatric patients who usually benefit from timely follow-up care, after they are released. Early person-to-person conversations with these patients, while still in the hospital, may make the difference in whether or not they participate in follow-up care. The case of the woman with the gangrenous toe illustrates how mediation approaches may be likely to succeed if greater amounts of time are allowed, although this may require clinicians to agree to a compromise they don't want to make. Meeting with psychiatric patients before they leave the hospital must be arranged in such a way that the patients don't feel they are coerced. In reality, they aren't, as they can refuse follow-up care, and clinicians should try to insure they know it. Clinicians should ask whether they know it. When a clinician takes the time to assure a patient that the clinician accepts how the patient feels, and, still more importantly, acknowledges the patient may not be able to change how he or she feels, the patient may be more willing to accept noncoercive interventions that, based on the clinician's expertise and experience, the clinician would be negligent not to suggest.

### **Compromising a Hospital Rule**

A final compromise that clinicians might want to consider is going against hospital rules. An example is when a patient's loved one wants to stay with the patient while he or she is dying. The effect of not staying with the patient if she or he dies during the night hardly needs to be stated. This is a strong reason for clinicians, and others, to make an exception to a rule against a loved one staying the night. Loved ones who are shocked by a patient's sudden death may not recover for an exceptionally long time.<sup>21</sup> This may especially be the case when the loved one wasn't with the patient at death, whether this makes logical sense or not. This again

indicates the importance of subjective feelings. Often hospitals can make exceptions to the rules. An instance that moved me was a palliative clinician at a major institution who arranged for a patient's dog to join the patient in her ICU bed for a short time. This may be more common in some hospitals now.

Another consideration in conducting a mediation is being pro-active. In a previous issue of *JCE*, Edward J. Bergman gives an example of how to conduct a successful mediation.<sup>22</sup> He recommends calling in a third party to negotiate, if necessary. This represents not only compromise, but a willingness to be pro-active in asking others to compromise. When clinicians take initiative to further the interests of patients and family, it may add to their feelings of trust. Acquiring the trust of patients and family as early as possible, and then maintaining it, is a priority clinicians should strive for above all else. Clinicians should seek to maintain this trust even if a mediation fails—should it fail.

When in the hospital, patients and their family members may be afraid to say what they feel. Family may be especially afraid to ask if they can spend the night with a dying patient if they know it is "against the rules," and they may be afraid to "appeal" a decision if their request is denied. Clinicians may help them to overcome their reluctance to make a request by taking the initiative—often—to ask patients and family members, in an open-ended way, if there is anything else they feel they might want. When clinicians take this initiative and then pause, to further convey that they really want to hear what patients and family members want, it may enable patients and family members to newly express themselves in a number of situations, ranging from asking to stay with a loved one who is dying, to whether they can have more people with them during meetings. Clinicians may help further by supporting requests made by patients and family members after they voice one. For example, should they request something that hospital policy usually does not allow, a clinician may say something like, "Yes, it makes a lot of sense to me that you want to be with the patient tonight. Let's see."

### **Structuring Meetings**

Morreim considers several decisions to be made about how to best structure mediation sessions. These decisions include, for example, how many should be present, and whether clinicians should meet with one of the parties privately.

As an aside here, I would like to consider private meetings. Sometimes when a patient's family members are "difficult," the medical staff arrange

for the family to meet with only one staff member, who explains what is going on with the patient. This limitation is frequently recommended by clinicians to minimize “splitting,” a term used to describe how some individuals deal with emotional conflict and stress: they may fail to see other persons as having both positive and negative qualities, and see others as being “all good” or “all bad.” For example, a family member who wants to know how the patient is doing may talk to the doctor on night duty and then the doctor on morning duty, and receive different information from each. The family may come to see the one doctor as “good,” and the other doctor as “terrible.” If only one doctor talks with the family, the hope is that such splitting may be avoided.

But when staff “lay down the law” and tell family members that they will be limited to communicating with only one staff member, this may be perceived by the family as being told that they “can’t handle” talking with more than one staff member. Their perception may be that their ability to talk with other staff, who may have different views, has been taken away. Thus the pathology of splitting may be exacerbated by limiting contact with staff, and become instead an iatrogenic harm to the family.

Returning to the question of how many should be present during a mediation session, Morreim suggests the possible desirability of limiting the number of participants. I would add that perhaps the most important consideration is how many people the patient and family want with them who are “in their camp.” This decision is one they can only make for themselves. It may be that just one person is enough. With this one person, they may feel they have sufficient support to fully express and defend their interests against others. This person may be their clinician, which is another example of how important it is for clinicians to acquire trust.<sup>23</sup>

During a mediation (and at other times, as well), clinicians should carefully attend to where they sit. They should sit next to patients and family members, indicating by this arrangement that they do not plan, in any way, to abandon them. Clinicians should still ask, “Who would you want to be with you?” Clinicians can normalize all the possible responses they may receive before asking, which may make it easier for patients and family members to say what they really want, for example, “Some people want more people they know well with them besides just me. Who do you want to be with you?”

Morreim advocates meeting with one party privately, when this is necessary, to help enable the person to speak more freely. How this is done may make a difference. It may be helpful to discuss the

pros and cons regarding this, and then let the parties decide. Some persons may be able to speak more freely when speaking privately, but those who are excluded may have new fears; for example, What has a loved one said in meeting privately with a clinician that the loved one feels he or she can’t say to the whole group, and why?

The possibility that a loved one will feel excluded, or that another is being treated as exceptional, may be substantial and may cause personal friction later. The mediator can inform the parties of these risks, which may reduce the risks this will occur later, and may help the parties decide about whether a private meeting is warranted. After a private meeting, the mediator can ask all of the parties involved whether they have new concerns, before resuming the mediation. This dialogue introduces a “mini-mediation” about the advisability of any one person meeting with the mediator privately. The time and possible discomfort this involves may be more than worth it. The outcomes may not be the most important aspect of the private meeting; that the parties involved have an opportunity make decisions for themselves may mean the most to them. This approach treats them with greater equality.

Clinicians may encounter patients or families with whom they feel friction. The patient or family member may engage in “splitting,” as mentioned above.<sup>24</sup> To reduce the risk of splitting, some experts recommend that patients and family meet with only one member of the staff, who will update them on how the patient is doing. Experts believe this helps prevent patients and families from being as able to engage in the divisive and demoralizing splitting process. But this strategy, in itself, can be complex. Some staff speak with a disengaged tone or glare without knowing it, or may be seen as off-putting. Morreim notes that some clinicians sound like they are reading from a textbook. Families may perceive this consciously or unconsciously and react.

I noted above how some people may perceive a threat even when another person has a neutral facial expression. These people may pick up on subtle differences and responses and magnify what they may imply. Given this, clinicians who want to resolve conflict may undermine their goal if they push too hard. Should a patient or family member take offense at some aspect of the mediation, clinicians should attempt to address it, and ask, “Did I do or say something that made you feel angry?” If other party says “yes” and gives a reason, clinicians can try to discern whether they understand that concern, validate what the other party has said, and then say, “I’m sorry.”

### Further Interventions

There are numerous ways in which clinicians can seek to gain and maintain the trust of patients and family members. How they do this may be most important. Everything they do must be genuine. In this last section I will discuss some ways to be both genuine and effective. Morreim provides an example: she and one of baby Henry's parents sat side by side as they reviewed a video clip of one of Henry's test results. Such positioning, intended or not, implies an alliance. I still appreciate having this same opportunity with a patient: she wanted to become pregnant, and wondered whether, if she did, she should continue to take antidepressants. That's a complex question, so we sat side by side looking through a text for answers. These examples illustrate that clinicians should consider more than what they say when they meet with patients and family members. Clinicians should generally not sit opposite or on the other side of a desk when they meet with others. Here are similar key points clinicians may want to incorporate into their practice.

We should say why we are doing what we do, before we do it. This is optimal, as it helps patients and families gain more from mediation and shows greater respect. It is particularly important because it treats the parties as equals. Early on, we should explain the reason for the mediation: the parties are in conflict without a clear path before them, and mediation is the best effort to try to come together on a "solution." If someone else makes the decisions, the outcome will be more uncertain. Explaining *why* enhances the autonomy of the parties, as does offering to provide additional information. We should share all of the medical, legal, and even ethical information we have during a mediation, whenever possible. We may be negligent if we don't.

Before proceeding in any activity that involves patients and family members, it is probably best to first ask them if proceeding would be okay with them. In the last issue of *JCE*, I gave the example a clinician who, prior to conducting a mediation, asked a patient if he could sit down beside the patient.<sup>25</sup> Morreim provides a second example: she asks a parent whether it would be okay if she jots down some notes. She even explains to the parent why she does this—so she won't miss anything.

A risk of asking is that patients and family may experience it as excessive, and wonder whether it is disingenuous: "Why would Haavi ask whether it is okay to jot down notes? Of course it's okay!" One answer to "Why?" and a justification for asking may be counter-intuitive: people may wonder about being asked, but, at the same time, feel respected by

being asked. Our feelings are likely to be much stronger than our thoughts in these situations. This is especially likely when we feel vulnerable, as when we or a loved one is ill. Feeling that a clinician respects us is more important than ever. Tone of voice is also critical. If it is perceived as perfunctory, patients and family may feel patronized. For example, when Morreim asked about taking notes, she conveyed that, in some contexts, it can be distancing.

Some approaches used in mediation may seem manipulative. One approach is "priming," which is mentioning a possibility to a person, with the hope that it will linger in the person's mind and will re-occur later, as a new idea. For example, a clinician might "share a thought" with a family member as a surreptitious way to later move that person to support a choice for the patient that the clinician prefers, without the family member fully realizing later why that choice seems appealing. Another approach is "parroting," repeating the last words another says, to indicate paying attention. In an article on mediation in the last issue of *JCE*, Autumn Fiester suggests that repeating another person's words solely for the purpose of gaining the person's trust is disingenuous, and might rightly be viewed by the other person as an expression of condescension.<sup>26</sup>

There are, however, ways to employ these techniques that will help patients and family. For example, Morreim reports that she primed Henry's parents early on, when she mentioned it might be possible for him to receive a treatment on a trial basis, on the condition it be discontinued without argument if it became clear that it didn't help him.

Clinicians also can share early on in a mediation, as Morreim did, that they won't favor one or another position, but if they have an idea that no one has thought of, they will share it, and that, if they didn't do so, they would be letting the patient and family down. This allows clinicians who have ethics expertise the opportunity to share it. But, should they share their expertise, they must distinguish, ever so carefully, between an insight that others hadn't considered and their own moral views. Morreim's suggestion of a time-limited trial of treatment became the key to finding a good outcome for baby Henry. She would have failed him if she had thought of it, but did not mention it.

### CONCLUSION

In her article, Guidry-Grimes may quite radically alter previous ethical thinking. She predominantly uses logic to do this, but she models two other strategies. First, she notes that Ms D's partner's feelings

are strong and deeply intimate, and thus exceptionally important “as is.” If other clinicians similarly recognize when the strong and deep feelings of patients and families warrant moral weight, in and of themselves, they will be following Guidry-Grimes’s courageous example. Second, Guidry-Grimes saw how Ms D’s partner may have differed from all others who made the same request. Seeing this, she considered what about him and his request was distinct from all of the others. Clinicians can likewise use her analysis to consider their own cases.

In her article, Morreim spells out several mediation-based approaches clinicians can use. The commitment she brings to these efforts mustn’t be missed, since it may be essential in using the approaches successfully. Morreim illustrates this commitment when she comments that she will write in the first rather than third person. She does this, she says, because she fears that the latter is too “stiff and artificial.” She also illustrates this with baby Henry’s parents. She initially asks them if they feel they have been heard, and indicates why she is asking: because families often report they do not feel they have been heard. She implicitly indicates her alliance with Henry’s parents by asking about this. Emphatically yes, they reply. No wonder.

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#### NOTES

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2. H. Morreim, “Story of a Mediation in the Clinical Setting,” in this issue of *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016).

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7. *Ibid.*, 290. See also, in regard to clinicians’ not knowing, S. Air, R. Rosenzeig, and D. Dunning, “When Knowledge Knows No Bounds: Self-Perceived Expertise Predicts Claims of Impossible Knowledge,” *Psychological Science* 26, no. 8 (August 2015): 1295-303.

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