

Conflict Resolution at End-of-Life Relative to Life Support

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I. INTRODUCTION

End-of-life issues are indeed some of the most difficult and powerful in healthcare. These issues must be approached carefully and appropriately. Conflict in end-of-life healthcare is not uncommon. There is often misunderstanding, mistrust, lack of education, miscommunication, and confusion among the participants in such decisions. Healthcare providers must recognize the importance of conflict resolution in the provision of care at the end of life. Such resolution requires participation of the patient, when able, surrogates, and healthcare providers of multiple disciplinary backgrounds.

According to the Code of Medical Ethics of the American Medical Association's Council on Ethical and Judicial Affairs' Opinion 2.20, "[l]ife-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition."¹ The Council on Ethical and Judicial Affairs' opinion goes on to say that "[l]ife-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration."² Wide use of life-sustaining treatments began in the United States in the 1960s and 1970s.³

Withholding and withdrawing life-sustaining therapies are actions through which medical interventions are either not given or are removed from patients.⁴ In intensive care units in the United States, most patient

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¹ American Medical Association Council on Ethical & Judicial Affairs: Code of Medical Ethics, Op. 2.20 (2006).

² *Id.*

³ Sarah E. Shannon, *Damage Compounded or Damage Lessened? Disparate Impact or the Compromises of Multiculturalism?*, 6 AM. J. BIOETHICS 27, 27 (2006).

⁴ John M. Luce & Ann Alpers, *Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them*, 162 AM. J. RESPIR. & CRIT. CARE MED. 2029, 2029 (2000).

deaths follow a decision to stop, withdraw, or not start, withhold, life-sustaining treatments.⁵ Medical ethical principles of autonomy, beneficence, and nonmaleficence support such actions.⁶ No ethical distinction is made between withholding and withdrawing life support.⁷ These actions are also legally supported by principles of informed consent and informed refusal.⁸

II. HISTORICAL DEVELOPMENT

Legal cases relative to aspects of withholding and withdrawing life support exist in the United States. The first such case was *In re Quinlan*, in 1976.⁹ Karen Ann Quinlan was a twenty-two-year-old patient in a persistent vegetative state.¹⁰ In this case, the New Jersey Supreme Court held that the patient had a right to refuse any therapy and that right could be exercised through the surrogate(s).¹¹ In another legal case, *Barber v. Superior Court*, the California Court of Appeals took a similar position in ruling that permission from the surrogates to remove nutrition and hydration from a comatose patient was appropriate.¹² Therefore, the physicians involved were not guilty of murder.¹³

While other legal cases subsequently evolved, the United States Supreme Court did not address the issue of withdrawing life support until the *Cruzan* case, in 1990.¹⁴ In this case, the parents of Nancy, a patient in a persistent vegetative state, requested that the feeding tube be withdrawn from their daughter.¹⁵ The patient resided in Missouri, where the law required "clear and convincing evidence" of a patient's wishes before withdrawing or withholding life support.¹⁶ The Supreme Court held that states, including Missouri, could require "clear and convincing evidence" of a patient's

⁵ Shannon, *supra* note 3, at 27.

⁶ Luce & Alpers, *supra* note 4, at 2029.

⁷ AMA Council on Ethical & Judicial Affairs, *supra* note 1.

⁸ Luce & Alpers, *supra* note 4, at 2029.

⁹ *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

¹⁰ *Id.* at 651.

¹¹ *Id.* at 664.

¹² *Barber v. Super. Ct.*, 147 Cal. App. 3d 1006, 1022 (Cal. Ct. App. 1983).

¹³ *Id.*

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

¹⁵ *Id.* at 265.

¹⁶ *Id.*

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wishes.¹⁷ This decision potentially limits the roles of surrogates in making decisions for incompetent patients without advance directives. However, the Supreme Court did uphold the principle of a competent patient's right to forgo medical treatments, including medically provided nutrition and hydration, as a liberty interest under the Fourteenth Amendment to the Constitution.¹⁸

III. THE WITHDRAWAL OF LIFE SUPPORT

As noted above, most of the early legal cases relative to life-sustaining treatments were predicated on issues relating to the patient's or surrogates' wishes to have such therapy withdrawn. Withdrawing life support is indeed recognized to be ethically and legally appropriate in the provision of healthcare.¹⁹ Discontinuing life-sustaining treatments is appropriate when burdens of the therapy substantially outweigh the benefits.²⁰ As stated earlier, medical literature recognizes that life-sustaining therapy can be interpreted to include many kinds of interventions and such decisions are individualized to the patient's values and wishes.

How withdrawal of life support is implemented certainly varies from case to case depending on the needs of the patient and family. Important aspects when considering withdrawing or withholding life-sustaining treatments are discussed in the medical literature. Suggestions from the medical literature relative to such discussions follow.

The healthcare team should reach a consensus about the appropriateness of withdrawing or withholding life-sustaining treatments.²¹ Consensus should include the multiple disciplines that make up the healthcare team, as well as consultants participating in the patient's care.²² All team members, particularly those providing direct patient care, should have meaningful input into the plan.²³

¹⁷ *Id.* at 284.

¹⁸ Luce & Alpers, *supra* note 4, at 2029.

¹⁹ Thomas J. Prendergast & Kathleen A. Puntillo, *Withdrawal of Life Support: Intensive Care at the End of Life*, 288 JAMA 2732, 2733 (2002).

²⁰ Lewis M. Cohen et al., *Practical Considerations in Dialysis Withdrawal: To Have That Option Is a Blessing*, 289 JAMA 2113, 2113 (2003).

²¹ John M. Luce & Carol Fink, *Communicating with Families About Withholding and Withdrawal of Life Support*, 101 CHEST 1185, 1185 (1992).

²² *See id.*

²³ Gordon D. Rubenfeld, *Principles and Practice of Withdrawing Life-Sustaining Treatments*, 20 CRIT. CARE CLIN. 435, 438 (2004).

Physicians should communicate clearly to the patient or surrogates the medical facts and prognoses relative to the clinical condition. The goals and benefits of particular interventions should be explored, as well as risks and range of treatment options.²⁴ The potential for return to the previous state of health, as well as the likelihood of achieving future patient goals for state of health or quality of life should be examined.²⁵

Physicians should then elicit any previous advance directives, statutory as well as non-statutory, or current patient wishes relative to possible interventions.²⁶ Shared decision-making should then be framed by the patient's goals and values.²⁷ It should be noted that discussions are most often between physicians and surrogates as most patients at such times are unable to participate in the communications.²⁸

Discussions about life support should be honest, straightforward, informative, and consistent.²⁹ Meetings should be held in private, quiet places with an atmosphere that is comfortable and conducive to conversations.³⁰ Physicians should be aware that hospitals in general, and intensive care units in particular, can be foreign and frightening places for patients and family members.³¹ Simple explanations, drawings, radiographs, and other visual aids may be helpful.³² Participation in these discussions by non-physician healthcare providers such as nurses, clergy, patient representatives, and social workers can be useful to all involved.³³

Physicians should provide clear recommendations, based on disease-specific data, prognostic indicators, and clinical experience, when suggesting withdrawal of life-sustaining interventions. Those involved should be allowed time to consider the recommendations.³⁴ Physicians should solicit questions and concerns. There should be frequent, consistent, and continued

²⁴ See Roger C. Bone et al., *Ethical and Moral Guidelines for the Initiation, Continuation, and Withdrawal of Intensive Care*, 97 CHEST 949, 949-50 (1990).

²⁵ See *id.* at 950-52.

²⁶ See *id.* at 952.

²⁷ *Id.* See also Rubinfeld, *supra* note 23, at 449.

²⁸ Jenny Way et al., *Withdrawing Life Support and Resolution of Conflict with Families*, 325 BRIT. MED. J. 1342, 1342 (2002).

²⁹ Luce & Fink, *supra* note 21, at 1185.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ Luce & Fink, *supra* note 21, at 1185-86.

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communication relative to the patient's evolving prognosis and the goals for the patient should be developed focusing on what the patient would want.³⁵

The healthcare team should provide support for the psychosocial needs of the patient and surrogates. It is critical that multiple healthcare disciplines be available for such support.³⁶ Spiritual care of the patient and surrogates has been found to be key at such times. In end-of-life medical care of patients, many patients and families want physicians to ask about spirituality.³⁷ Approximately ninety-five percent of Americans report belief in God, and many Americans state that religious faith is the strongest influence in their lives.³⁸ Critical illness is a time of crisis that may challenge those families involved to find meaning in the midst of suffering.³⁹ Patients or surrogates may wish to have clergy or spiritual care advisors present and involved.⁴⁰

Comfort, dignity, and privacy should be priorities for the patient and surrogates.⁴¹ Life-sustaining measures, as agreed upon relative to the patient's values and goals, should be removed humanely and expeditiously once all involved are ready for such action.⁴² The patient may need to be moved to a place more conducive to needs of the patient and family.⁴³ Monitors, lines, tubes, drains, and other interventions may also be removed if this does not cause significant discomfort.⁴⁴ While non-palliative medications may be stopped, the healthcare team should provide the patient with palliative treatment as needed for pain and suffering.⁴⁵ The psychosocial needs of the surrogates should be met as well.⁴⁶ The surrogates should be assured that the patient is receiving palliative care as needed.⁴⁷ All those involved should be made aware of the range of outcomes upon withdrawal of life-sustaining treatments. The family should be allowed to spend as much time as they wish with the patient, and they should be allowed

³⁵ See Prendergast & Puntillo, *supra* note 19, at 2736.

³⁶ Bone et al., *supra* note 24, at 951.

³⁷ Richard J. Wall et al., *Spiritual Care of Families in the Intensive Care Unit*, 35 CRIT. CARE MED. 1084, 1088 (2007).

³⁸ *Id.* at 1089.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ See Rubinfeld, *supra* note 23, at 439.

⁴² Luce and Fink, *supra* note 21, at 1186.

⁴³ Rubinfeld, *supra* note 23, at 439.

⁴⁴ *Id.*

⁴⁵ Luce & Fink, *supra* note 21, at 1186.

⁴⁶ Bone et al., *supra* note 24, at 951.

⁴⁷ See Luce & Fink, *supra* note 21, at 1186.

to be present for the patient's death if they choose.⁴⁸ The physician and other members of the healthcare team should be available for the patient and surrogates as needed during this time.⁴⁹ By addressing the comfort and needs of the patient and surrogates, the physician and other members of the healthcare team may transcend their medical roles and perhaps go a long way to developing trust.⁵⁰ Such depth of commitment is often recognized and appreciated by the patient or surrogates at a powerful time in life.

The goal of withdrawing life support is to remove those treatments no longer desired or indicated which do not provide comfort to the patient.⁵¹ Withholding and withdrawing life support is ethically and legally recognized as appropriate.⁵² Any treatment, including medically provided nutrition and hydration, may be compassionately, ethically, and legally withheld or withdrawn in the appropriate setting.⁵³

IV. ADDRESSING CONFLICT OVER FUTILITY DURING END-OF-LIFE CARE

In the majority of cases where withdrawal of life support is contemplated, consensus develops among the patient—when able—surrogates, and healthcare providers.⁵⁴ This consensus may take time to develop. Allowing sufficient time for such powerful decisions is ethically appropriate.⁵⁵ Conflict in end-of-life care does arise and may occur among health care providers, among surrogates, and between staff and surrogates.⁵⁶ Such conflict and debate can center around the concept of medical futility.⁵⁷

Whether or not futility can be defined is itself debatable. Many have tried to define medical futility, but in the opinion of others, futility has no clear

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ James L. Hallenbeck, *Intercultural Differences and Communication at the End of Life*, 28 PRIM. CARE: CLINICS IN OFFICE PRACT. 401, 409 (2001).

⁵¹ Way et al., *supra* note 28, at 1344.

⁵² Prendergast & Puntillo, *supra* note 19, at 2733.

⁵³ Rubinfeld, *supra* note 23, at 436.

⁵⁴ Prendergast & Puntillo, *supra* note 19, at 2736.

⁵⁵ See Luce & Fink, *supra* note 21, at 1186.

⁵⁶ Way et al., *supra* note 28, at 1343.

⁵⁷ Council on Ethical and Judicial Affairs, American Medical Association, *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937, 937 (1999).

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definition. The dictionary defines futile as "serving no useful purpose, completely ineffective."⁵⁸ In 1990, Schneiderman, Jecker, and Jonsen proposed a medical definition of futility that included both quantitative and qualitative parts.⁵⁹ The quantitative component of their definition stated that a treatment is futile if empirical data shows that it has less than a one percent chance of benefit.⁶⁰ The qualitative component of their definition stated that treatment that merely preserves permanent unconsciousness or cannot end dependence on life-sustaining intensive care measures should be considered futile.⁶¹ The Society of Critical Care Medicine's Ethics Committee has defined futile treatments as those not accomplishing intended goals.⁶² They have also stated that treatments very unlikely to be beneficial, extremely costly, or of uncertain benefit may be considered inappropriate and inadvisable, but not futile.⁶³

The American Medical Association's Education for Physicians on End-of-Life Care (EPEC) reports a range of possible approaches used, including those that will not achieve the patient's goal, those that serve no legitimate goal of medical practice, those that are ineffective ninety-nine percent of the time, and those that do not conform to accepted community standards.⁶⁴ EPEC also cites examples of medical interventions whose use may be questioned relative to value: life-sustaining intervention for patients in a persistent vegetative state, resuscitation efforts for life-threatening illness, use of chemotherapy in patients with advanced cancer, and use of antibiotics or artificial hydration for patients in advanced stages of illness.⁶⁵ EPEC also states that unequivocal cases of medical futility of interventions are rare and that the approach can be a fair process of resolution rather than defining futility.⁶⁶

What constitutes futile treatments indeed remains controversial in medical literature and in clinical practice. Since definitions of futile care are

⁵⁸ WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 500 (1987).

⁵⁹ Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANN. INTERN. MED. 949, 949 (1990); Lawrence J. Schneiderman et al., *Medical Futility: Response to Critiques*, 125 ANN. INTERN. MED. 669, 669 (1996).

⁶⁰ Lawrence J. Schneiderman et al., *Medical Futility: Response to Critiques*, 125 ANN. INTERN. MED. 669, 669 (1996).

⁶¹ *Id.*

⁶² Ethics Committee, Society of Critical Care Medicine, *Consensus Statement of the Society of Critical Care Medicine's Ethics Committee Regarding Futile and Other Possibly Inadvisable Treatments*, 25 CRIT. CARE MED. 887, 887 (1997).

⁶³ *Id.*

⁶⁴ AMA EPEC M9-4

⁶⁵ AMA EPEC M9-4

⁶⁶ AMA EPEC M9-5

value-laden, universal consensus on a definition of medical futility is unlikely to be accomplished.⁶⁷ There is sometimes even disagreement between physicians caring for a patient relative to what interventions may be considered futile. For example, an intensive care physician and hematologist caring for the same patient may not agree on what are or are not futile interventions.

Legal cases involving medical futility show that courts typically order continued treatment when asked to resolve disputes between surrogates wishing further interventions and healthcare providers opposing them.⁶⁸ However, courts have also seemed reluctant to rule against physicians who act within professional standards in refusing interventions they feel are not appropriate.⁶⁹ *Gilgunn v. Massachusetts General Hospital* raised the issue of the traditional medical malpractice test, which measures physicians' treatment decisions on the appropriate standard of care.⁷⁰ In this case, the Massachusetts jury did not find the hospital and physicians liable for removing a patient from the ventilator over objections of one of the surrogates.⁷¹

However, unilateral action to withhold or withdraw life support may not be wise. Negotiations almost always work to resolve even the most contentious disputes.⁷² Texas was the first state to provide a statute for an extrajudicial, due process mechanism for resolving medical futility disputes.⁷³ This transpired in 1999 when Texas combined three pre-existing laws regarding end-of-life treatments into a single law, the Texas Advance Directive Act.⁷⁴ Of note though, the majority of states' advance directive statutes include affirmation of healthcare providers' rights to decline to implement advance directives.⁷⁵ Some states also legally affirm that physicians may decline to provide medically ineffective or inappropriate

⁶⁷ Council on Ethical and Judicial Affairs, *supra* note 57, at 937.

⁶⁸ Luce & Alpers, *supra* note 4, at 2029.

⁶⁹ *Id.*

⁷⁰ *Gilgunn v. Mass. Gen. Hosp.*, No. 92-4830 (Mass. Super. Ct. 1995).

⁷¹ *Id.*

⁷² Luce & Alpers, *supra* note 4, at 2030.

⁷³ Robert L. Fine & Thomas W. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANN. INTERN. MED. 743, 743 (2003).

⁷⁴ *Id.* at 744.

⁷⁵ Martin L. Smith et al., *Texas Hospitals' Experience with the Texas Advance Directives Act*, 35 CRIT. CARE MED. 1271, 1274 (2007).

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treatment.⁷⁶ However, most states also require a physician to attempt to transfer the patient when the physician is unable or unwilling to comply.⁷⁷

Of note, the United States Supreme Court has yet to address the concept of futility. Even though the Supreme Court in *Cruzan* supported withholding and withdrawing life support based on the principle of informed refusal, the Court did not address the concept of futility.⁷⁸

In summary, the definition of medical futility remains elusive. Despite much literature written to address such aspects of medical futility, consensus is still lacking. The EPEC Project has suggested that futility disagreements should identify the need for a step-by-step due process whereby such conflict might be resolved through communication and problem solving.⁷⁹

The Code of Medical Ethics for the American Medical Association's Council on Ethical and Judicial Affairs, in Opinion 2.037, also recommends a process-based approach to futility.⁸⁰ This approach stresses the concept of "fair process" between parties.⁸¹ This fair process approach in medical care of the patient is designed to provide a system to address ethical dilemmas regarding end-of-life care without need to resort to the court system.⁸²

With this process, the first step should be to negotiate prior understandings among the involved parties about what constitutes futile interventions for the patient and what falls within acceptable limits. Such discussion should include the patient's previously stated or statutory advance directions, if either exists. Second, joint decisionmaking should be made collectively by the physician, patient, and surrogates. This decision-making process should address the patient's goals for treatment and should employ medical outcomes data when possible. Other members of the healthcare team may be involved in such discussions. If needed, utilizing the assistance of a consultant may help facilitate discussions of an acceptable resolution. Involvement of an institutional committee, such as the ethics committee, might then be considered if disagreements are still unresolved. If the outcome of the institutional process is consistent with the patient's or surrogate's desires, but the physician still disagrees, arrangements may be made to transfer the patient to another physician within the facility. If the

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ Luce & Alpers, *supra* note 4, at 2029.

⁷⁹ AMA EPEC M9-16,17

⁸⁰ American Medical Association Council on Ethical & Judicial Affairs: Code of Medical Ethics, Op. 2.037 (2006).

⁸¹ Medical Futility in End-of-Life Care, Report of the Council on Ethical and Judicial Affairs, 281 JAMA 937-41 (1999).

⁸² *See id.*

outcome of the recommendations of the institutional committee is consistent with the physician's position, but the patient or surrogate disagrees, arrangements can be made to transfer the patient to another institution. Finally, from an ethical standpoint, the intervention in question need not be provided if another institution and physician will not accept the transfer. This model emphasizes seeking to meet the needs of the individual patient without attempting to define futility.⁸³

V. HOW TO DEAL WITH AND AVOID CONFLICT IN END-OF-LIFE CARE

Conflict in life is inevitable and conflict in end-of-life healthcare is prevalent.⁸⁴ Such conflict can be potentially destructive for surviving family members.⁸⁵ Skilled healthcare providers, who are committed to managing disputes appropriately, can be very helpful.⁸⁶ "[M]ost cases of disagreements and conflict in healthcare [can] and should be managed as part of good medical care."⁸⁷

In addition to mechanisms for addressing conflict and disagreements relative to end-of-life healthcare provision, other proactive mechanisms should be strengthened so that end-of-life care is provided in the best possible manner for all involved. Education and preparation of healthcare providers, surrogates, and patients should be enhanced.

Healthcare providers will be faced with powerful bedside interactions in which ministry to patients and families is imperative. While changes in medical school curricula now include more end-of-life training, the process is evolving slowly.⁸⁸ Effective medical ethics education depends not only on relevant curricula in medical school and residency programs, but also on appropriate role modeling relative to ethical decisionmaking.⁸⁹

⁸³ *See id.*

⁸⁴ Nancy N. Dubler, *Conflict and Consensus at the End of Life*, HASTINGS CEN. REP. S19, S25 (2005).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *See id.* at S23.

⁸⁸ *See* J. Randall Curtis, *Communicating About End-of-Life Care with Patients and Families in the Intensive Care Unit*, 20 CRIT. CARE CLIN. 363, 377 (2004).

⁸⁹ Risa P. Hayes, *Changing Attitudes About End-Of-Life Decision Making of Medical Students During Third-Year Clinical Clerkships*, 40 PSYCHOSOMATICS 205, 210 (1999).

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Death and the dying process, in which the needs of patients and surrogates must be paramount, should have a significant place in training of all healthcare providers. "The Institute of Medicine defines a good death as 'one that is free from avoidable suffering for patients, families, and caregivers . . .'"⁹⁰ Physicians and other healthcare providers must be reminded that death does not just happen to the patient, but affects people around the patient as well.

Developing competent communication skills is important for healthcare providers and this concept cannot be overstated. Patients and families appreciate the importance of skilled communication in end-of-life healthcare. It must be remembered that communication is both verbal and nonverbal. Nonverbal communication may be gestures and expressions, but may also be less obvious maneuvers such as the use of space. Nonverbal communication can have powerful meaning and can be a significant part of communication at the end of life.⁹¹

Patients and families deserve honest, consistent information, even if the information is borne out of uncertainty.⁹² Studies have shown that family members of patients in intensive care units rate communication with the healthcare team as one of the most important skills for these providers.⁹³ Many families find communication at least equally as important as clinical skills.⁹⁴ Therefore, early and consistent communication by the healthcare team is important in the course of end-of-life care of patients.

VI. KEYS TO NEGOTIATING CONSENSUS

First, introduction of discussions in a non-threatening, caring way is important. Finding out what the patient and surrogates understand is also important in order to establish a starting frame of reference, clear up misconceptions, and establish goals of care the patient would wish. Using active listening and responding to emotions of the patient and family is important. Discussions should always be framed in a way that is meaningful to the patient's life, and should focus on what the patient would want. Families often need to be reminded, especially when making difficult choices about the patient's course, that the treatment wishes sought by the healthcare team are the ones the patient would choose for himself if able to speak.

⁹⁰ David H. Gustafson, *A Good Death*, <http://www.jmir.org/2007/1/e6> (last visited Sep. 10, 2007).

⁹¹ See Hallenbeck, *supra* note 50, at 405–06.

⁹² Gustafson, *supra* note 90.

⁹³ Curtis, *supra* note 88, at 363.

⁹⁴ *Id.*

Silence should be well tolerated and can have a tremendous impact. The physician and other involved healthcare providers should be willing to spend the time needed with the patient and surrogates, and conversations should be unhurried.⁹⁵

For physicians leading dialogues about life-sustaining interventions, it is important to emphasize that life support does not reverse the underlying disease process, and that withdrawing life-sustaining interventions simply allows the disease to take its natural course. Emphasis should also be placed on the plan for aggressive palliative care to ensure patient comfort. The family should be educated about what will likely happen after life-sustaining interventions are withdrawn.⁹⁶

An important aspect of communication on the part of the physician leading end-of-life discussions is to discern the impact of surrogates' emotions on the situation, as well as how such emotions may affect what the surrogates express. It is not uncommon for surrogates to have feelings of guilt or grief. When recognized by healthcare providers, such burdens can often be eased. Once a decision has been reached about a plan for life support withdrawal, at times it is necessary for physicians to remind the surrogates that they are honoring the patient's wishes even though it may be difficult.⁹⁷

Physicians need to be conscious of and recognize their own feelings about the end-of-life care being offered.⁹⁸ Physicians may feel that patient deaths reflect poorly on their skills as a physician, and that death represents a failure on their part to save lives.⁹⁹ Physicians need to understand that although a "cure" is not always possible, caring should be a consistent provision for the patient and family. Often the best way to help navigate the process for the patient and family through the dying part of life is to emphasize and utilize aggressive palliative care.

Communicating and deliberating well with the patient or surrogates about end-of-life decisions are useful tools for preventing conflict. Negotiating skills, however, are not emphasized in medical education curricula. Negotiating skills could and should be improved in medicine. Medical ethicists could play a greater role in teaching effective communication skills, emphasizing conflict resolution and mediation skills.

⁹⁵ See *id.* at 368–72.

⁹⁶ See *id.* at 375.

⁹⁷ See *id.* at 373.

⁹⁸ See *id.* at 370.

⁹⁹ Curtis, *supra* note 88, at 377.

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Some argue that the ability to facilitate and mediate to consensus in disagreements is key to ethics expertise.¹⁰⁰

Another proactive mechanism to improve end-of-life care is placing more emphasis on the education, counseling, and support for surrogates involved. Focus should be not only on empowering surrogates, but also on enabling them to make the best decisions. Specific needs and burdens of surrogates should be addressed. This can be accomplished, at least in part, by participation of multiple medical disciplines, including social workers, nurses, pastoral counselors, and ethicists, in the care of the patient and surrogates.¹⁰¹

Advance directives are another well-intended proactive mechanism to improve and make smoother the end-of-life process relative to the goals and values of the patient. Advance directives were intended as a way for patients to retain control over decisions about their medical care once they are no longer able to express their wishes. It has become clear that statutory advance directives have not been as successful as originally intended.¹⁰² However, the goal of advance directives is still worthy.

Successful advance directives do not have to be limited to the contents of statutory forms. Many patients develop individualized plans for their wishes through ongoing interaction with healthcare providers or surrogates. Advance care planning can focus on good care for the individual patient. This is often facilitated by the patient's primary care physician at a time prior to an end-of-life medical condition for the patient. Such plans should be revisited periodically, especially with changes in health status or prognosis. Healthcare providers should initiate discussions about advance care planning and, specifically, about patients' end-of-life wishes. All advance care plans should be readily implemented across healthcare settings, such as clinics, emergency rooms, and long-term care facilities.¹⁰³

The case involving Terri Schiavo, a patient in a persistent vegetative state receiving medically provided nutrition and hydration, provides an important lesson regarding the need for end-of-life discussions among family members.¹⁰⁴ Such a case stresses the importance of conversations and

¹⁰⁰ Michael D. Fetters et al., *Conflict Resolution at the End of Life*, 29 CRIT. CARE MED. 921, 924 (2001).

¹⁰¹ See Thomas H. Murray & Bruce Jennings, *The Quest to Reform End of Life Care: Rethinking Assumptions and Setting New Directions*, 35 HASTINGS CEN. REP. S52, S56–57 (2005).

¹⁰² See Susan E. Hickman et al., *Hope for the Future: Achieving the Original Intent of Advance Directives*, 35 HASTINGS CEN. REP. S26, S26 (2005).

¹⁰³ See *id.* at S28–30.

¹⁰⁴ Lori A. Roscoe et al., *Implications of the Schiavo Case for Understanding Family Caregiving Issues at the End of Life*, 30 DEATH STUD. 149, 159 (2006).

documentation of individuals' advance directions about medical care.¹⁰⁵ Such discussions should at least be taking place around the dinner table or at family gatherings.

The Schiavo case also revealed the perils of involving the legal system in end-of-life medical conflicts and alerted individuals to the need for careful consideration about end-of-life wishes, as well as how they might be implemented with the least amount of family disruption and conflict so that legal involvement and media exposure can be avoidable.¹⁰⁶

Perhaps the outcome of the Schiavo case points us back to the 1976 ruling of the New Jersey Supreme Court in *Quinlan*, when it said:

The nature, extent, and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?¹⁰⁷

VII. CONCLUSION

Death is an inevitable part of life, but while it is inevitable, one does not need to die badly.¹⁰⁸ End-of-life care should be driven by partnership of patient, surrogate, and physician. The foundation of this partnership should be based on trust and open, effective communication. Potential conflicts in philosophy relative to end-of-life care should be addressed early.¹⁰⁹ Good communication by physicians as well as other healthcare providers is key to effective end-of-life care.

Essential components to addressing withholding and withdrawing life support are advocated for healthcare providers using consensus building while focusing on the goals and values of the patient. A mechanism for conflict resolutions relative to futility also exists as a medical "fair process" approach. Ministering to the patient and the family of the patient in end-of-life care is the role of healthcare providers from multiple disciplines. This is

¹⁰⁵ *Id.*

¹⁰⁶ Roscoe et al., *supra* note 104, at 157–59.

¹⁰⁷ *In re Quinlan*, 355 A.2d 647, 665 (N.J. 1976).

¹⁰⁸ Murray & Jennings, *supra* note 101, at S57.

¹⁰⁹ Ware G. Kuschner, *Lessons Learned from the Terminally, Critically Ill Patient Who Demands to Live as Long as Possible*, <http://www.medscape.com/viewarticle/408015> (last visited Sep. 10, 2007).

CONFLICT RESOLUTION RELATIVE TO LIFE SUPPORT

a powerful place to be in the lives of patients and their families and should not be taken lightly.

Although different physicians have different approaches that vary to match the needs of the patients and surrogates, providing sensitive, effective communication about end-of-life care requires training, practice, supervision, planning, and preparation. Participation on the part of healthcare providers should be compassionate, straightforward, consistent, medically appropriate, and respectful of patient and family goals and values. Positive aspects of care for the patient and surrogates should be emphasized at all times. Delivering good care to patients and families during the dying part of life is medical ministry and can be very rewarding for all involved.

