Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation

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Medical decisionmaking in pediatrics is characterized by three features: a refutable presumption of parental decisionmaking authority, the use of the best interests standard, and the increasing participation of children in decisionmaking as developmentally appropriate.[1] Children generally lack an adult's level of self-determination and their parents or guardians are responsible for their well-being. The presumption that parents or guardians, as opposed to the state, bear primary responsibility for children is justified by both philosophical reasons and social convention. Justifications include families generally know children better and are better positioned to make decisions on their behalf, as well as families typically bear the burdens of decisionmaking and therefore should have freedom to make them.[2]

The standard of parental medical decisionmaking is typically characterized as the "best interests" standard.[3] This standard focuses attention on the child's rather than the parents' or the family's interests. The presumption favoring parental decisionmaking may be overcome in situations in which parents themselves lack decisionmaking capacity or act contrary to their children's best interests. The standards for judicial intervention in cases of medical neglect generally include the imminent risk

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[1] RICHARD B. MILLER, CHILDREN, ETHICS, AND MODERN MEDICINE 13, n.4 (2003).

[2] *Id.* at 38–40. *See also* Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEOR. MED. BIOETH. 243, 244 (2004); Robert H. Mnookin, *Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy*, 39 LAW & CONTEMP. PROBS. 226, 266–68 (1975).

[3] *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 102 (5th ed. 2001).

of death or serious disability that can be prevented with a high likelihood of success by a discrete intervention. The classic example is transfusing the child of Jehovah's Witness parents who has suffered significant blood loss.[4]

While young children lack self-determination, children's development of self-determination should be recognized and respected. Children begin to develop the knowledge, intelligence, and voluntariness necessary for competence at thirteen to fourteen years of age and their consent should be sought. Absent the capacity to consent, children should still participate in medical decisionmaking as appropriate. The goals of participation include instructing children in self-care and cultivating children's responsibility for health care.[5] States have different regulatory regimes for emancipating minors or granting them authority to make particular types of medical decisions, such as those related to reproduction.[6]

This model contrasts with medical decisionmaking in adults. Competent adults have the right to refuse medical treatment. If they lack decisionmaking capacity, a surrogate makes decisions on their behalf according to the "substituted judgment" standard. Proxies should make decisions based on what the individual would have wanted.[7] Mechanisms, such as durable powers of attorney for healthcare and living wills, exist to facilitate the identification of proxies and to guide decisionmaking.[8] If the adult never had capacity or his wishes are unclear, decisions should be made on the basis of the best interests standard.[9]

Uncertainty or conflict in medical decisionmaking has been addressed through ethics consultation. Ethics consultation is "a service provided by an individual or group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding

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[4] *See id.* at 314; Diekema, *supra* note 2, at 245–49.

[5] *See* American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995); MILLER, *supra* note 1, at 71–81.

[6] *See* Angela R. Holder, *Minors' Rights to Consent to Medical Care*, 257 JAMA 3400, 3400 (1987); Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATR. 520, 521–22 (1991).

[7] *See* BEAUCHAMP & CHILDRESS, *supra* note 3, at 99–100.

[8] *See id.* at 152–54.

[9] *See id.* at 98–103. *See also* Lynne Sims-Taylor, *Reasoned Compassion in a More Humane Forum: A Proposal to Use ADR to Resolve Medical Treatment Decisions*, 9 OHIO ST. J. ON DISP. RESOL. 333, 345–49 (1993–94); Michele Yeun, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 595–600 (1991–92).

value-laden issues that emerge in healthcare."[10] Ethics consultation developed concurrently with ethics committees but is not identical with their development. Ethics committees are multidisciplinary institutional committees with several functions including education, policy development or review, and ethics consultation or review of consultation.[11] Consultation can be performed by ethics committees, but may also be conducted by small groups or individual consultants. In such cases, consultations are frequently reviewed by the full committee.[12]

While ethics committees were initially discussed in the 1970s, they were not widely implemented until the mid-1980s. In 1972, the New Jersey Supreme Court, citing an article by Dr. Karen Teel, recommended the development of ethics committees.[13] A decade later, a study commissioned by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research found that only 4.3% of hospitals with more than 200 beds had committees and 41% of the committees were in the state of New Jersey. These committees reviewed an average of one case per year.[14] The Commission itself endorsed ethics committees,[15] encouraging their development. In pediatrics, the Department of Health and

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[10] AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES, CORE COMPETENCIES FOR HEALTH CARE ETHICS CONSULTATION 3 (1998) [hereinafter ASBH]. *See also* Mark P. Aulisio, Robert M. Arnold, & Stuart J. Youngner, *Health Care Ethics Consultation: Nature, Goals, and Competencies. A Position Paper from the Society for Health and Human Values-Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation*, 133 ANN. INTERN. MED. 59 (2000) (distinguishing between clinical and organizational ethics consultation and characterizing clinical ethics consultation as focusing on issues in specific clinical cases and policies regarding patient care). In this article, I focus on clinical ethics consultation in specific clinical cases.

[11] *See* ASBH, *supra* note 10, at 1 (enumerating committee's functions as education, research, policy development, and consultation); ALBERT R. JONSEN, THE BIRTH OF BIOETHICS 364 (1998); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 160–64, 440–41 (1983) [hereinafter PRESIDENT'S COMMISSION].

[12] *See* ASBH, *supra* note 10, at 11–12; Cynda Rushton, Stuart J. Youngner, & Joy Skeel, *Models for Ethics Consultation: Individual, Team or Committee?*, *in* ETHICS CONSULTATION: FROM THEORY TO PRACTICE 88–95 (Mark P. Aulisio, Robert M. Arnold, & Stuart J. Youngner eds., 2003).

[13] *In re* Quinlan, 355 A.2d 647, 668 (N.J. 1976) (quoting Karen Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 809 (1975)). Although this committee was labeled an "ethics committee," its function was to determine prognosis. *E.g.*, PRESIDENT'S COMMISSION, *supra* note 11, at 162.

[14] PRESIDENT'S COMMISSION, *supra* note 11, at 446–47.

[15] *See infra* notes 139–47 and accompanying text.

Human Services' recommendation, following the so-called Baby Doe case,[16] that hospitals establish infant care review committees was particularly influential.[17] Ethics committees proliferated in the mid-1980s.[18] In 1992, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to have a mechanism to address ethical issues and provide education. This requirement does not mandate ethics committees, but is satisfied by them.[19] A recent study of a random sample of 600 U.S. general hospitals found that 81% of all general hospitals and 100% of hospitals with more than 400 beds had ethics consultation services.[20]

There is significant debate regarding the method of ethics consultation and the related issues of training and certification.[21] Regarding methodology, a number of authors have suggested ethics consultation incorporate alternative dispute resolution methods, principally mediation.[22]

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[16] *See* JONSEN, *supra* note 11, at 249 (describing the public and governmental response to the death of an infant with Down syndrome and esophageal atresia after the infant's parents refused permission for surgical correction of the esophageal malformation).

[17] *See* Child Abuse Amendments, 42 U.S.C. §§ 5101–5106 (1994). *See also* Ronald E. Cranford & A. Edward Doudera, *The Emergence of Institutional Ethics Committees*, *in* INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 5, 7–8 (Ronald E. Cranford & A. Edward Doudera eds., 1984); John J. Paris & Frank E. Reardon, *Ethics Committees in Critical Care*, 2 CRIT. CARE CLIN. 111, 112–16 (1986); Fred Rosner, *Hospital Medical Ethics Committees: A Review of their Development*, 253 JAMA 2693 (1985).

[18] *Ethics Committees Double Since '83: Survey*, 59 HOSPITALS 60 (1985).

[19] JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, 1992 ACCREDITATION MANUAL FOR HOSPITALS (1992). *See also JCAHO Spurs New Committees and Educational Needs*, 8 HOSP. ETHICS 7 (1992).

[20] Ellen Fox, Sarah Myers, & Robert A. Pearlman, *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J. BIOETH. 13 (2007).

[21] *See generally* ETHICS CONSULTATION: FROM THEORY TO PRACTICE (Mark P. Aulisio, Robert M. Arnold, & Stuart J. Youngner eds., 2003).

[22] *See* Erica Wood & Naomi Karp, *"Fitting the Forum to the Fuss" in Acute and Long-Term Care Facilities*, 29 CLEARINGHOUSE REV. 621, 621 (1995) ("This article profiles a number of forums for addressing disagreements in hospitals and nursing homes in an effort to guide advocates to the right 'fit' and describes cutting–edge projects demonstrating the use of mediation."). *See generally* Linda C. Fentiman, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801 (1988–89) (having identified several ill effects of the autonomy model of substitute decisionmaking for incompetent, incurably ill adults, the author advocates for a conversation model, with sources including alternative dispute resolution, to account for autonomy as well as privacy and community); Yeun, *supra* note 9 (arguing that families should be the default

surrogate decisionmaker using the best interests standard unless the patient's wishes are clearly discernable and contends that in cases of conflict between the family and physicians, disagreements should be submitted to arbitration with a presumption of continued treatment); Mary Beth West & Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 CAMB. Q. HEALTHCARE ETHICS 63 (1992) (drawing parallels between case consultation and mediation and facilitation and making recommendations for conducting intake, consultation, and follow-up); Sims-Taylor, *supra* note 9 (arguing in part for a graduated system within hospitals, involving informal and formal mediation and mandatory non-binding arbitration prior to adjudication, to address disputes over cessation of medical treatment for incompetent patients); NANCY NEVELOFF DUBLER & LEONARD J. MARCUS, MEDIATING BIOETHICAL DISPUTES: A PRACTICAL GUIDE (1994) (arguing mediation is a useful tool to address bioethical disputes and describing Montefiore Medical Center's Bioethics Mediation Project); Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821 (1994); Erica Wood & Naomi Karp, *Mediation: Reframing Care Conflicts in Nursing Homes*, 18 GENERATIONS 54 (1994) (arguing mediation can be effective in resolving complex care differences in nursing homes, and describing a planned American Bar Association Commission on Legal Problems of the Elderly mediation project to address healthcare disagreements in nursing homes in the Washington, D.C. metropolitan area); Karen A. Bulter, *Harvesters: Alternatives to Judicial Intervention in Medical Treatment Decisions*, 1996 J. DISP. RESOL. 191 (1996) (arguing for the advantages of hospital ethics committees using ADR techniques, in contrast to judicial intervention, in deciding the treatment of patients who lack decisionmaking capacity); Mileva Saulo & Robert J. Wagener, *How Good Case Managers Make Tough Choices: Ethics and Mediation*, 2 J. CARE MANG. 8 (1996) (arguing that case managers require the skills of ethical case analysis, values history assessment, and mediation; and describing the mediation process using a case); Shoshana K. Kehoe, *Giving the Disabled and Terminally Ill a Voice: Mandating Mediation for All Physician-Assisted Suicide, Withdrawal of Life Support, or Life-Sustaining Treatment Requests*, 20 HAMLINE J. PUB. L. & POL'Y 373 (1998–99) (arguing that a combination of mediation and restorative justice "Peacemaking Circles" is a means for protecting vulnerable populations from being exploited by the legalization of deliberate methods of terminating a patient's life such as physician-assisted suicide and euthanasia); Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U. L. REV. 1091 (1999) (arguing mediation, rather than arbitration, is the most appropriate method for resolving physician-patient end-of-life treatment disputes because mediation's focus on facilitation and conciliation will protect the physician's and patient's relationship of trust); Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decisionmaking Model*, 41 ARIZ. L. REV. 329 (1999) (arguing that a mediation-style consensus-based decisionmaking model should be used in end-of-life decisionmaking to minimize anti-therapeutic effects and avoid unnecessary judicial involvement); Kimberlee K. Kovach, *Neonatology Life and Death Decisions: Can Mediation Help?*, 28 CAP. U. L. REV. 251 (1999–2000) (arguing that mediation may be helpful in the process of decisionmaking in the NICU for a variety of reasons including its ability to assure equal participation, enhance communication, and

In this article, I argue that mediation is the most appropriate ADR method for ethics consultation in pediatrics based on the nature of ethical expertise and the best interests standard. In Part I, I review the spectrum of dispute resolution methods, including negotiation, mediation, arbitration, litigation, and hybrid processes, emphasizing their discriminating features. I emphasize that in mediation the parties are the principal decisionmakers and the orientation is collaborative, while in arbitration the third party is the decisionmaker and the process is adversarial. In Part II I examine the relative benefits and detriments of these methods relative to parties' goals. In both Parts I and II, I note the role of specialized knowledge, if any, in these practices. In Part III, I examine ethics consultation in terms of these alternative dispute resolution methods. I note that ethics committees and consultation developed as an explicit alternative to judicial review. I also argue that current methods for ethics consultation represent hybrid processes but fail to adequately address the due process protections required by adjudicatory processes or the alterations in the communication environment which occur when mediation and arbitration are combined. Acknowledging that individuals may weigh potential goals differently, I argue in Part IV that if one adopts a model incorporating arbitration to promote efficiency and a determinative outcome, one must implement certain minimum due process protections. In Part V I argue that the limitations of ethical expertise and the indeterminacy best interests standard make ethics consultation disanalogous to arbitration. I therefore conclude that mediation is a more appropriate model for ethics consultation.

I. DISPUTE RESOLUTION PRACTICES

Conflict management and resolution includes a spectrum of practices. Christopher W. Moore, for example, divides this continuum into four main categories: private decisionmaking by the parties, private third-party decisionmaking, legal (public), authoritative third-party decisionmaking, and extralegal coerced decisionmaking.[23] The primary practices on which I focus

include and consider parties' strong emotions); Glenn Cohen, *Negotiating Death: ADR and End of Life Decisionmaking*, 9 HARV. NEGOT. L. REV. 253 (2004) (proposing a design process, based in part on the regulatory negotiations literature, and sketching a possible ADR model, which includes negotiation, bioethics mediation, ethics committee arbitration, and litigation).

[23] CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 7 (3rd rev. ed. 2003) (differentiating processes in terms of the use of coercion by or on the disputing parties and the likelihood of a win-lose or either-or outcome); ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, THE PROMISE OF MEDIATION:

are negotiation, mediation, arbitration, litigation, and hybrid processes. (See Table 1.)

	Negotiation	Mediation	Arbitration	Litigation
Neutral 3d Party		X	X	X
Decisionmaking Authority			X	X
Adversarial			X	X
Public				X
Voluntary	X	X	X	
Substantive Knowledge		?	X	

Table 1: Characteristics of Dispute Resolution Processes

Decisionmaking by the parties includes informal discussion and problem solving, negotiation, and mediation. Negotiation is differentiated from informal discussion and problem solving in terms of formality. Negotiation is a temporary bargaining relationship.[24] Mediation is an extension of negotiation and is frequently referred to as "mediated" or "facilitated" negotiation.[25] Negotiation and mediation are distinguished by the involvement of a neutral third party.[26] Mediation can be defined as "the intervention in a negotiation or a conflict of an acceptable third party who has limited or no authoritative decisionmaking power, who assists the

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THE TRANSFORMATIVE MODEL FOR CONFLICT RESOLUTION 19 (rev. ed. 2005) ("[T]he mediation field is diverse and pluralistic."). I try to recognize this diversity by highlighting areas of disagreement as appropriate. This does not, however, mean that generalizations are not possible. *See id.* (contending that the dominant pattern of practice focuses on getting settlements).

[24] MOORE, *supra* note 23, at 6–8. *See also* Bruce Patton, *Negotiation*, *in* THE HANDBOOK OF DISPUTE RESOLUTION 279 (Michael L. Moffitt & Robert C. Bordone eds., 2005) ("Negotiation can be defined as back-and-forth communication designed to reach an agreement between two or more parties with some interests that are shared and others that may conflict or simply be different.").

[25] MOORE, *supra* note 23, at 8, 14. *See also* Leonard L. Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEGOT. L. REV. 7, 13 (1996).

[26] *E.g.*, Ann L. Milne, Jay Folberg, & Peter Salem, *The Evolution of Divorce and Family Mediation: An Overview*, *in* DIVORCE AND FAMILY MEDIATION: MODELS, TECHNIQUES, AND APPLICATIONS 8 (Jay Folberg, Ann L. Milne, & Peter Salem eds., 2005).

involved parties to voluntarily reach a mutually acceptable settlement of the issues in dispute."[27] The third-party is generally not involved in the dispute and the third party's participation must be acceptable to the involved parties. The process is voluntary and the settlement must be mutually acceptable.[28] In addition to addressing substantive issues, mediation may also address the relationship between the parties. This may involve either strengthening or terminating the relationship.[29]

Various authors identify components or stages of the mediation process and skills used by mediators. In comparison to other dispute resolution methods, the mediation process is relatively informal. Stages may include opening remarks, information gathering, option generation, and negotiation. The term "stages" is not intended to imply that every mediation includes each of the stages or that one stage inevitably follows the next in a predefined sequence. Mediation may also involve caucuses or private sessions with the parties. Skills used by mediators include identifying interests, as opposed to positions, reframing issues, and reality testing.[30]

In terms of specialized knowledge, all mediators must be knowledgeable about the mediation process, and in certain situations disputants may seek mediators with specialized knowledge of the subject matter.[31] In the

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[27] MOORE, *supra* note 23, at 15. *See also* BUSH & FOLGER, *supra* note 23, at 8 ("Across the mediation field, mediation is generally understood as an informal process in which a neutral third party with no power to impose a resolution helps the disputing parties try to reach a mutually acceptable settlement."); Kimberlee K. Kovach, *Mediation*, *in* THE HANDBOOK OF DISPUTE RESOLUTION 304 (Michael L. Moffitt & Robert C. Bordone eds., 2005) ("Mediation is commonly defined as a process in which a third party neutral, the mediator, assists disputing parties in reaching a mutually agreeable resolution. Mediators aim to facilitate information exchange, promote understanding among the parties, and encourage the exploration of creative solutions."); Riskin, *supra* note 25, at 11 ("[Mediation is] a process in which an impartial third party, who lacks authority to impose a solution, helps others resolve a dispute or plan a transaction.").

[28] MOORE, *supra* note 23, at 15–16.

[29] *Id.* at 15, 56. *See also* BUSH & FOLGER, *supra* note 23, at 218–21.

[30] *E.g.*, Kovach, *supra* note 27, at 308–09; MOORE, *supra* note 23, at 68–69; Ellen A. Waldman, *Identifying the Role of Social Norms in Mediation: A Multiple Model Approach*, 48 HASTINGS L.J. 703, 713–19 (1996–97). Interests are typically contrasted with positions. Positions are the tangible outcomes discussed in a negotiation such as money, goods, or time. Interests are the needs, desires, concerns, or fears that motivate people to take particular positions. ROGER FISHER, WILLIAM URY, & BRUCE PATTON, GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN 40–41 (2nd ed. 1991). Reality testing involves asking the disputants questions that raise doubts about the viability of potentially unrealistic or unimplementable agreements. *E.g.*, MOORE, *supra* note 23, at 330.

[31] *See* Waldman, *supra* note 30, at 762–64.

alternative dispute resolution (ADR) literature, a distinction is frequently made between process and product or outcome. The mediator's domain is the process.[32] Some authors suggest more specialized knowledge may be helpful in particular contexts. Margaret L. Shaw, for example, argues that general knowledge of the subject-matter is valuable for a variety of reasons, including not only obviating the need to stop and ask for clarification, but also to understand the implications of the communication and to raise relevant questions. Technical expertise may be relevant in particular cases to promote facilitation, including when parties are unusually hostile or passive.[33] While specialized knowledge may be helpful, expertise is generally not required and is potentially seen as detrimental.[34]

Private third-party decisionmaking includes both administrative decisions and arbitration. Moore characterizes arbitration as "a voluntary process in which people in conflict request the assistance of an impartial and neutral third party to make a decision for them regarding contested issues."[35] Like mediation, arbitration is a voluntary process. While arbitration may be required by a contract, it is nonetheless voluntary in the sense that one need

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[32] *E.g.*, Milne, Folberg, & Salem, *supra* note 26, at 14 ("The mediator is in charge of the process, whereas the parties retain responsibility for the product."); Lela P. Love & Kimberlee K. Kovach, *ADR: An Eclectic Array of Processes, Rather Than One Eclectic Process*, 2000 J. DISP. RESOL. 295, 303 (2000) ("[T]he mediator's expertise in these matters of process."); Riskin, *supra* note 25, at 46–47 (distinguishing expertise in the mediation process with expertise in the subject matter); Leonard L. Riskin, *Decisionmaking in Mediation: The New Old Grid and the New New Grid System*, 79 NOTRE DAME L. REV. 1, 26–28, 34–37 (2003–04).

[33] Margaret L. Shaw, *Mediator Qualifications: Report of a Symposium on Critical Issues in Alternative Dispute Resolution*, 12 SETON HALL LEGIS. J. 125, 132–33 (1988–89); *See also* Riskin, *supra* note 25, at 46–47; Kovach, *supra* note 22, at 288.

[34] Riskin, *supra* note 25, at 47 ("In fact, too much subject-matter expertise could incline some mediators toward a more evaluative role, thereby interfering with the development of creative solutions.").

[35] MOORE, *supra* note 23, at 9. *See also* ALAN MILES RUBEN, HOW ARBITRATION WORKS 3 (5th ed. 2003) ("Arbitration, to use the words of one writer, is a simple proceeding voluntarily chosen by parties who want a dispute determined by an impartial judge of their own mutual selections, whose decision, based on the merits of the case, they agree in advance to accept as final and binding."); Milne, Folberg, & Salem, *supra* note 26, at 8 ("*Mediation* is not *Arbitration*. In arbitration, a designated third person holds the responsibility for making a finding or providing a decision for the parties. In mediation a neutral third party is used, but the parties do not authorize the mediator to make decisions for them."); Sarah Rudolph Cole & Kristen M. Blankley, *Arbitration*, *in* THE HANDBOOK OF DISPUTE RESOLUTION 318 (Michael L. Moffitt & Robert C. Bordone eds., 2d ed. 2005) ("Arbitration is a process by which a private third-party neutral renders a binding determination of an issue in dispute.").

not enter into the contract. Agreements to arbitrate can be invalidated if they are part of a take-it-or-leave-it agreement.[36]

Like mediators, arbitrators are the third parties who are outside the conflict relationship.[37] Arbitration may be performed by either a single person or a panel, typically of three individuals. Parties may select arbitrators before or after a dispute arises and arbitrators may be selected on an ad hoc or permanent basis. If there is no prior agreement, arbitration-sponsoring organizations may assist the parties by providing a list of potential arbitrators. There are two common methods of selecting an arbitration panel. The first involve each party striking individuals from the list and rank ordering the remainder. The highest-ranked, mutually acceptable candidates are chosen. Alternatively, each party may select one arbitrator and these two then select a third, neutral arbitrator. Default procedures, to be used if the parties cannot agree within a specified time frame, are frequently included in arbitration agreements.[38]

Unlike mediators, arbitrators have decisionmaking authority. Sarah Rudolph Cole and Kristen M. Blankley, for example, state, "Unlike mediation, however, arbitration is an adjudicative process. The arbitrator, like a judge, renders a decision based on the merits of the case."[39] Decisions are typically rule-governed and generally follow the law of the jurisdiction chosen by the parties or the collective bargaining agreement.[40] Decisions are, however, not narrowly constrained by the law and are not reversible on the basis of an error of fact or law.[41] Awards may, but need not, contain the reasons justifying the award.[42] Arbitrators' decisions may be advisory or binding.[43]

The arbitration process is more formal than mediation and less formal than litigation. For example, there may be an expedited discovery process, including subpoenas. The formal codes of civil procedure or evidence are not, however, adhered to.[44] Like mediation, hearings are confidential. They usually begin with the arbitrator's, then the disputants' opening statements.

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[36] *E.g.*, STEVEN C. BENNETT, ARBITRATION: ESSENTIAL CONCEPTS 59, 70–72 (2002).

[37] *E.g.*, RUBEN, *supra* note 35, at 142.

[38] *E.g.*, BENNETT, *supra* note 36, at 49–50, 79–80, 99–100; Cole & Blankley, *supra* note 35, at 326; RUBEN, *supra* note 35, at 171–75.

[39] Cole & Blankley, *supra* note 35, at 319.

[40] BENNETT, *supra* note 36, at 80–81; RUBEN, *supra* note 35, at 402–44, 1351.

[41] BENNETT, *supra* note 36, at 68–69, 80, 124; RUBEN, *supra* note 35, at 34, 489–96.

[42] BENNETT, *supra* note 36, at 54–55; Cole & Blankley, *supra* note 35, at 327.

[43] MOORE, *supra* note 23, at 9.

[44] BENNETT, *supra* note 36, at 52–53; RUBEN, *supra* note 35, at 341–42, 355–62.

Witnesses and evidence are presented and the arbitrator may ask clarifying questions.[45] The rules of most arbitration-sponsoring organizations preclude ex parte communication.[46] Hearings are open sessions and briefs and correspondence are copied to the other party. It is believed that the process is tainted when only one side is heard and the other party cannot confront the submissions and arguments.[47] The parties typically make closing statements and may submit posthearing briefs.[48] Arbitrators' skills include the ability to evaluate evidence and witnesses and to write findings.[49]

Qualifications for an arbitrator may include subject expertise. General qualifications may include knowledge of industrial matters or the law.[50] If a technical matter is involved, having an expert may be desirable. Expertise may include knowledge of custom or practice in an industry or knowledge of the history of the parties' relationship. Expertise may, however, conflict with impartiality particularly when expertise is developed by working in the industry and developing relationships with its members.[51]

While many authors distinguish mediation and arbitration in terms of whether the neutral has decisionmaking authority,[52] there is significant disagreement within the ADR community over whether mediators should evaluate and how evaluative mediation differs from arbitration. A nidus for this debate is Leonard Riskin's attempt to provide a system for categorizing and understanding approaches to mediation. He proposes a system characterizing the goals of the mediation or the scope of the problem(s) and

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[45] Cole & Blankley, *supra* note 35, at 319.

[46] BENNETT, *supra* note 36, at 106–07; Thomas J. Brewer & Lawrence R. Mills, *Med Arb: Combining Mediation and Arbitration*, DISP. RESOL. J., Nov. 1999, at 32, 35; Cole & Blankley, *supra* note 35, at 330–31.

[47] BENNETT, *supra* note 36, at 180. *But see*, RUBEN, *supra* note 35, at 363–65.

[48] Cole & Blankley, *supra* note 35, at 319.

[49] *E.g.*, Fed. Mediation and Conciliation Serv., *Becoming an FCMS Arbitrator*, http://www.fmcs.gov/internet/itemDetail.asp?categoryID=184&itemID=16436 (last visited Sept. 15, 2007); Nicole Buonocore, *Resurrecting a Dead Horse—Arbitrator Certification as a Means to Achieve Diversity*, 76 U. DET. MERCY L. REV. 483, 496–99 (1998–99).

[50] American Arbitration Ass'n, *Qualification Criteria for Admittance to the AAA National Roster of Arbitrators and Mediators*, http://www.adr.org/si.asp?id=4223 (last visited Sept. 15, 2007); Fed. Mediation and Conciliation Serv., *supra* note 49.

[51] BENNETT, *supra* note 36, at 80, 99–100, 109, 178; Cole & Blankley, *supra* note 35, at 318; RUBEN, *supra* note 35, at 143–44, 185–87.

[52] MOORE, *supra* note 23, at 48–49. *But cf. id.*, *supra* note 23, at 51–52 (recognizing that vested interest mediation, in which the mediator has procedural and substantive interests in the outcome and advocates for the mediator's own interests, fits uneasily within his definition of mediation).

activities or role of the mediator along continuums which he combines into a four-quadrant grid.[53] The later continuum's extremes are strategies and techniques that facilitate the parties' negotiation and those that evaluate matters important to the mediation.[54] Facilitative activities allow the parties to communicate with and understand one another while evaluative activities intend to direct some or all of the outcomes of the mediation. According to Riskin, evaluative mediators use techniques, also representing a continuum, including assessing the strengths and weaknesses of each side, predicting the outcomes, proposing agreement, or urging or pushing the parties to accept settlement. He did not, however, address what differentiates mediation from, for example, non-binding arbitration.[55]

Riskin's proposal generated significant debate within the mediation community.[56] Some authors, such as Lela P. Love, contend that evaluative mediation is not mediation as it is properly understood. Practices she considers evaluation include giving advice, making assessments, and stating opinions.[57] Evaluative processes include litigation, "rent-a-judge" arbitration, early neutral evaluation, and summary jury trial. She characterizes arbitration as "a private, voluntary dispute resolution process in which the parties to a dispute agree in writing to submit the dispute for resolution to a third-party neutral chosen pursuant to the agreement of the parties."[58] She emphasizes

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[53] Riskin, *supra* note 25, at 25. *See also* Leonard L. Riskin, *Mediator Orientations, Strategies and Techniques*, 12 ALTERNATIVES TO THE HIGH COST OF LITIG. 111, 111 (1994).

[54] Riskin, *supra* note 25, at 17, 23–24. *But cf.* Riskin, *supra* note 32, at 11–20, 30–33 (arguing that evaluation and facilitation are not alternatives or opposites. Many mediators use both approaches, often in tandem. Emphasizing the centrality of party self-determination, Riskin contends evaluation can foster, impair, or both foster and impair self-determination. He recognizes that not all of the techniques he previously labeled evaluation, particularly urging or pushing parties to accept settlement, belonged together. He suggests replacing the language of evaluative and facillative with directive and elicitive.).

[55] Riskin, *supra* note 25, at 40. *But cf.* MOORE, *supra* note 23, at 55–56 (recognizing mediators exercise varying degrees of directiveness or control relative to substantive issues, the problem solving process, and the management of relationships. Moore does not address when a high degree of directiveness violates the mediator's role, but only contends that the process needs to be adapted to the needs of the parties.).

[56] *See also* Riskin, *supra* note 32, at 4 n.5; Kimberlee K. Kovach & Lela P. Love, *Mapping Mediation: The Risks of Riskin's Grid*, 3 HARV. NEGOT. L. REV. 71, 72 n.4 (1998).

[57] Lela P. Love, *The Top Ten Reasons Why Mediators Should Not Evaluate*, 24 FLA. ST. U. L. REV. 937, 938 (1996–97).

[58] *Id.* at 943 n.33; Kovach & Love, *supra* note 56, at 90.

that these processes are adversarial.[59] She contrasts this with mediation, which she sees as collaborative[60] or as reorienting parties toward one another.[61] The contrast between adversarial and collaborative processes correlates with differences in the neutral's role. In adversarial processes the neutral applies rules to facts and offers an opinion[62] and in a collaborative process the neutral facilitates the parties' evaluation and decisionmaking.[63] Love characterizes "evaluation" activities, such as challenging proposals that might derail the negotiation or that seem unrealistic, as part of the mediator's facilitative role.[64] As she understands it, their aim in mediation is, however, to empower the parties.[65]

The debate over facilitative and evaluative mediation suggests the distinction between collaborative and adjudicative processes as an alternative framing of the issue of decisionmaking authority. The debate also suggests the difficulty in characterizing mediators' individual actions relative to these distinctions.

Public, authoritative third-party decisionmaking includes both judicial and legislative decisions. These processes differ from mediation and

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[59] Love & Kovach, *supra* note 32, at 306. *See also* Jeffrey R. Seul, *Litigation as a Dispute Resolution Alternative*, *in* THE HANDBOOK OF DISPUTE RESOLUTION 347–48 (Michael L. Moffitt & Robert C. Bordone eds., 2005).

[60] Love, *supra* note 57, at 940; Kovach & Love, *supra* note 56, at 92–93.

[61] *Id.* at 92, 94. *See also* Gatter, *supra* note 22, at 1106; Jeffrey W. Stempel, *The Inevitability of the Eclectic: Liberating ADR from Ideology*, 2000 J. DISP. RESOL. 247, 274; MEGAN ELIZABETH TELFORD, MED-ARB: A VIABLE DISPUTE RESOLUTION ALTERNATIVE 2 (2000).

[62] Kovach & Love, *supra* note 56, at 73.

[63] *Id.* at 74, 89. *See also* David C. Elliott, *Med/Arb: Fraught with Danger or Ripe with Opportunity?*, 34 ALBERTA L. REV. 163, 179 (1995).

[64] Kovach & Love, *supra* note 56, at 79.

[65] *Id.* at 95. *But cf.* Waldman, *supra* note 30 (identifying three models of mediation based on their relationship to existing social and legal norms: norm-generating, norm-educating, and norm-advocating mediation. In the norm-generating model the parties negotiate without recourse to extrinsic norms. *Id.* at 708, 718. In the norm-educating model the mediator informs the parties regarding social and legal norms to provide them a baseline framework, but does not insist on their implementation. *Id.* at 730. And, in the norm-advocating model the mediator insists on their incorporation. *Id.* at 745. She does not, however, clearly distinguish mediation from arbitration. She simply states, "To some, norm-advocating mediation is a contradiction in terms. Yet, its growing use is undeniable." *Id.* at 753; *see also id.* at 755–56. Several of Waldman's examples of norm-advocating mediation are in fact hybrid processes that incorporate consultation, mediation, and arbitration or incorporate experts into the mediation process itself. *Id.* at 748–50.).

arbitration because they are public.[66] Litigation differs from mediation and arbitration because the plaintiff can compel the defendant's participation.[67] Like arbitration, the decisionmaker, a judge or jury, is impartial and neutral. The decisionmaker, however, is usually required to make a decision congruent with legislation and legal precedent. The outcome, once appeals are completed, is binding and enforceable.[68] Courts can award three types of relief in civil cases: money damages, equitable relief, and declaratory relief. Courts, however, cannot compel unwilling parties to apologize or express regret.[69]

Litigation is a more formal process than either mediation or arbitration. The process begins when the plaintiff files a complaint with the court and serves it on the defendant.[70] Courts only entertain disputes that can be expressed in terms of legal rights or liabilities.[71] The defendant must then either answer the complaint or seek to have the lawsuit dismissed.[72] If the lawsuit proceeds, pretrial activity may include gathering evidence, identifying witnesses, and developing legal theories and trail strategies.[73] The gathering of evidence, called "discovery," is highly formalized.[74] The trial itself involves opening statements, presentation of each side's case accompanied by cross-examination, and closing statements.[75] Only relevant information admissible under rules of evidence can be introduced at trial.[76] The fact-finder renders a decision, which is potentially subject to appeal.[77]

As ADR has developed, mixed or hybrid approaches have also been proposed including early neutral evaluation and mediation-arbitration (med-arb). In early neutral evaluation, the third-party evaluates each side's case and the probable court outcome and then facilitates settlement discussions. It

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[66] MOORE, *supra* note 23, at 10.

[67] Seul, *supra* note 59, at 338, 346.

[68] MOORE, *supra* note 23, at 10. *See also* Mnookin, *supra* note 2, at 249–50.

[69] Seul, *supra* note 59, at 343–44. Equitable relief, such as requiring a seller to complete a real estate transaction, can be granted when money would not provide adequate compensation. *Id.* Declaratory relief is a pronouncement by the court, such as the meaning of a contract provision, in a contested matter. *Id.*

[70] *Id.* at 338.

[71] *Id.* at 340.

[72] *Id.* at 338.

[73] Seul, *supra* note 59, at 338–39.

[74] *Id.* at 341.

[75] *Id.* at 339.

[76] *Id.* at 341.

[77] *Id.* at 338–44.

combines non-binding arbitration and mediation.[78] In med-arb the parties submit the dispute to a mediator who has the authority to determine a binding settlement of any unresolved issues.[79] A number of variations exist within the general framework of med-arb.[80] While a single individual typically serves both the roles of mediator and arbitrator,[81] different individuals may play these roles, either sequentially or concurrently.[82] Another variation is in terms of process. Mediation may occur after the arbitration but before the decision is announced.[83] Particular issues include when to shift from mediation to arbitration and who has the authority to make this decision.[84]

Proponents of med-arb contend that knowing unresolved issues will be arbitrated provides an incentive to mediate.[85] Critics of hybrid approaches contend that knowing the mediator may eventually arbitrate modifies the parties' behavior during the mediation phase.[86] Parties may be unwilling to disclose information that they fear will disfavor them if mediation fails. They may also frame their participation in terms of the potential arbitration, seeking to put themselves in the best, and their opponents in the worst, light.[87] Alternatively, they may disclose information that may harm them later.[88]

In addition, there is the concern that private contact with the parties will compromise the neutral's adjudicative role.[89] While mediators may caucus with the parties, arbitrators are typically prohibited from unilateral ex parte

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[78] Kovach & Love, *supra* note 56, at 73 n.9.

[79] Barry C. Bartel, Note, *Med-Arb as a Distinct Method of Dispute Resolution: History, Analysis, and Potential*, 27 WILLAMETTE L. REV. 661, 644–45 (1991); Karen L. Henry, Note, *Med-Arb: An Alternative to Interest Arbitration in the Resolution of Contract Negotiation Disputes*, 3 OHIO ST. J. ON DISP. RESOL. 385, 386 (1988).

[80] Elliott, *supra* note 63, at 175–79; TELFORD, *supra* note 61, at 2, 14–15.

[81] Bartel, *supra* note 79, at 665–66.

[82] Elliott, *supra* note 63, at 175, 178.

[83] Bartel, *supra* note 79, at 668.

[84] *Id.* at 683–84.

[85] Henry, *supra* note 79, at 386, 390; TELFORD, *supra* note 61, at 3.

[86] *E.g.*, Kovach & Love, *supra* note 56, at 99 ("If the neutral assumes an evaluative role or orientation, the parties' focus during the process shifts towards influencing the neutral decisionmaker and away from crafting outcomes for themselves."). *See also* TELFORD, supra note 61, at 4.

[87] Kovach & Love, *supra* note 56, at 102.

[88] Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545, 1597 (1984).

[89] Bartel, *supra* note 79, at 679, 685–88; Henry, *supra* note 79, at 396–97; TELFORD, *supra* note 61, at 4.

contacts.[90] There is a concern that neutrals cannot disregard information that they learn in caucus, which one party may consider confidential, or which the other party may be unaware of and has not had the opportunity to confront.[91] Supporters of med-arb contend that the situation is not fundamentally different from judges who must decide on the admissibility of evidence. They argue this is one of the competencies of the neutral.[92]

Dispute resolution processes exist along a continuum without a single discriminating feature. Differentiating features include whether a third party is involved, who has decisionmaking authority, and what the nature of the process is. For example, the process may be cooperative or adversarial. Some of these features, particularly the distinctions between facilitation and evaluation or cooperative and adversarial, are not dichotomous. The presence of multiple differentiating features and the gradations within some of the individual features makes distinguishing processes difficult. Expert knowledge is also viewed differently, as a hindrance or as beneficial, in each of these processes. This complexity increases when processes are combined into various hybrids.

II. ADVANTAGES/DISADVANTAGES

In broad terms, each of these methods of dispute resolution has its strengths and weaknesses, and may be more or less appropriate for certain types of conflicts.[93] Some typologies focus on types of cases or subject matter of the dispute: labor, family, environmental, or commercial. Jeffrey W. Stempel, for example, asserts that facilitative mediation is more appropriate for family law matters (matters where parties have had a significant past relationship, a current relationship, or future interactions) and evaluative mediation in commercial matters (where there is no prior or subsequent relationship and getting along is instrumental to optimal

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[90] *See supra* notes 30, 46–47 and accompanying text.

[91] TELFORD, *supra* note 61, at 4.

[92] *Id.* at 5, 10–11.

[93] *Compare* Frank E.A. Sander & Stephen B. Goldberg, *Fitting the Forum to the Fuss: A User–Friendly Guide to Selecting an ADR Procedure*, 10 NEGOTIATION J. 49 (1994), *with* Love & Kovac, *supra* note 32, at 300–01 ("The suggestion to prescribe permissible or desirable mediator activities by dispute or case type seems both unnecessary and counterproductive. Assuming, *arguendo*, that there may be a certain case type which will be benefited most by evaluative services, then that case type will logically choose neutral evaluators or arbitrators—or mediators who provide a mixed process. However, experience indicates that mediation offers its unique benefits across all case types.").

monetary compromise).[94] Typologies are more appropriately focused on the parties' goals or objectives. (See Table 2.) Once such goals are defined, relevant elements in the dispute situation or context can then be identified.[95] It is important to recognize, however, that the disputants' goals may differ from public goals.[96]

	Mediation	Arbitration	Litigation
Efficiency	X	X	
Relationships	X	X	
Party Self-Determination	X		
Justice	X	X	X
Vindication			X
Precedent			X
Determinative Outcome		X	X

Table 2: Advantages of Dispute Resolution Processes

Mediation has a number of benefits compared to other dispute resolution processes. It potentially produces integrative outcomes that better satisfy parties' needs. [97] A secondary benefit of this satisfaction is greater compliance with agreements.[98] Mediation is also more rapid, and less costly—both economically and emotionally.[99] Kovach and Love summarize mediation's benefits as "high level of party satisfaction with the process; outcomes tailored to the unique characteristics and interests of the particular

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[94] Stempel, *supra* note 61, at 250–51, 285–90. One might argue instead that evaluation is beneficial in cases when one's best alternative to a negotiated agreement is conditioned by external standards such as tort claims.

[95] Robert A. Baruch Bush, *Defining Quality in Dispute Resolution: Taxonomies and Anti–Taxonomies of Quality Arguments*, 66 DENV. U. L. REV. 335, 346 (1988–89).

[96] Sander & Goldberg, *supra* note 93, at 60–61.

[97] Kovach, *supra* note 27, at 305; Milne, Folberg, & Salem, *supra* note 26, at 8; Frank E.A. Sander & Lakasz Rozdeiczer, *Matching Cases and Dispute Resolution Procedures: Detailed Analysis Leading to a Mediation-Centered Approach*, 11 HARV. NEGOT. L. REV. 1, 12–14 (2006).

[98] Kovach, *supra* note 27, at 305; Craig A. McEwen & Richard J. Maiman, *Small Claims Mediation in Maine: An Empirical Assessment*, 33 ME. L. REV. 237, 261 (1981); Milne, Folberg, & Salem, *supra* note 26, at 8.

[99] Kovach, *supra* note 27, at 305; Sander & Goldberg, *supra* note 93, at 52–53.

participants; and impressive levels of party compliance with self-created outcomes."[100]

Proponents of specific mediation methods differ in their characterization of mediation's benefits. Robert A. Baruch Bush and Joseph P. Folger, for example, argue that mediation is uniquely capable of generating empowerment and recognition.[101] They characterize empowerment as the restoration to individuals of a sense of their value and strength and their own capacity to make decisions and handle life's problems[102] and recognition as the evocation in individuals of acknowledgment, understanding, or empathy for the situation and the views of the other.[103] These changes are seen to result in changes in the quality of social interaction and society. Settlement is not a primary goal, but a secondary effect. Folger and Bush argue that conflict transformation is the most important benefit of mediation because it is the most valuable of the possible benefits and mediation has the special ability to achieve it.[104]

Arbitration, it is argued, provides the determinative outcome of a judicial process with increased flexibility and efficiency.[105] Steven C. Bennett lists a number of reasons parties may choose to arbitrate: privacy, choice of decisionmaker, flexible rules, reduced cost and time to decision, recovery of costs, business-like atmosphere, finality and enforcement, and neutral forum.[106] The ability to choose the decisionmaker is particularly advantageous when specialized knowledge is sought.[107]

Proponents of mediation and arbitration both claim that it contributes to relationships, but characterize this contribution in different ways. Advocates of mediation assert that it is capable of addressing relationship issues even if this means dissolving the relationship.[108] While some proponents of arbitration advocate its use in conflicts where there is no necessity of a

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[100] Kovach & Love, *supra* note 56, at 98.

[101] *See* BUSH & FOLGER, *supra* note 23, at 8–9 (identifying other accounts of mediation, each with its own conception of benefit: reducing court congestions and providing "higher-quality" justice, organizing people and communities to obtain fairer treatment, and covertly achieving social control and oppression).

[102] *Id.* at 22.

[103] *Id.* at 13–14, 18.

[104] *Id.* at 35.

[105] Henry, *supra* note 79, at 389; Kovach & Love, *supra* note 56, at 90; MOORE, *supra* note 23, at 9.

[106] BENNETT, *supra* note 36, at 6–8.

[107] *Id.* at 6; RUBEN, *supra* note 35, at 11.

[108] MOORE, supra note 23, at 15; *See also* Stempel, *supra* note 61, at 285–90.

continued relationship,[109] others emphasize arbitration's contribution to maintaining relationships. Bennett notes that arbitration functions in the labor context as a means to provide a swift resolution as an alternative to a strike or litigation in a continuing relationship.[110] These characterizations differ in terms of whether the conflict is constitutive of or secondary to the parities' identities or relationship.

Critics of ADR have articulated related benefits of adjudication: the production of just outcomes, protection of weaker parties, and the articulation of societal values or precedent.[111] Some critics of ADR emphasize the distinction between agreement and justice.[112] Owen Fiss, for example, argues:

> Their [public officials'] job is not to maximize the ends of private parties, nor simply to secure the peace, but to explicate and give force to the values embodied in authoritative texts such as the Constitution and statutes: to interpret those values and to bring reality in accord with them.[113]

The issue of obtaining justice through the courts is sometimes framed in terms of seeking vindication.[114]

In the same way that mediators and arbitrators talk about relationships in different ways, advocates of ADR and litigation mean different things by justice. The justice available in litigation is the justice as articulated in the law and accomplished by the legal system. Other conceptions of justice exist and courts are constrained in the type of relief they can grant.[115] Mediation focuses on justice as defined by the parties.[116]

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[109] *See* John W. Cooley, *Arbitration vs. Mediation—Explaining the Differences*, 69 JUDICATURE 263, 264 (1985–86).

[110] BENNETT, *supra* note 36, at 154; *See also* Cole & Blankley, *supra* note 35, at 324–25.

[111] *See also* Seul, *supra* note 59, at 352–53; RUBEN, *supra* note 35, at 14.

[112] Hoffmann, *supra* note 22, at 825.

[113] Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073, 1085 (1984) (identifying additional problems with settlement including the difficulty of generating authoritative consent because parties are organizations or social groups rather than individuals and the inability to provide a foundation for continued judicial supervision). *See also* Harry T. Edwards, *Alternative Dispute Resolution: Panacea or Anathema?*, 99 HARV. L. REV. 668, 676–79 (1986).

[114] *E.g.*, Grillo, *supra* note 88, at 1561; Sander & Goldberg, *supra* note 93, at 51–53.

[115] Seul, *supra* note 59, at 341–44.

[116] *E.g.*, MOORE, *supra* note 23, at 18; Waldman, *supra* note 30, at 718–19.

Another concern is that informal forums disadvantage weaker parties including racial or ethnic minorities and women. Based on an analysis of the social science literature on the causes of and strategies for reducing prejudice, Richard Delgado and his co-authors argue that the expression of prejudice is context-dependent and informality tends to increase its expression. In contrast to ADR, "modern rules of procedure and evidence contain numerous provisions that are intended to reduce prejudice in the trial system by defining the scope of the action, formalizing the presentation of evidence, and reducing strategic options for litigants and counsel."[117] Delgado and his co-authors argue that court adjudication, therefore, is more appropriate for cases involving parties of unequal power and status, cases that have a broad societal dimension, and possibly issues touching on sensitive or intimate areas of life.[118] Similarly, Trina Grillo agues that mandatory mediation further disempowers socially disadvantaged groups, particularly women.[119] She contends that women tend to have a more relational sense of self.[120] Mandatory divorce mediation requires direct engagement, usually without a lawyer present.[121] In this context, Grillo contends, women may act to maintain their connection to their spouse or children at the expense of putting their own needs forward.[122] Grillo concludes mandatory divorce mediation represents a threat to women.[123] Proponents of mediation identify strategies to balance power but acknowledge that they may not always be effective and the mediation may in some situations need to be terminated.[124]

As a rule-governed activity, courts interpret and establish precedent. Even though arbitrators may issue decisions which articulate reasons, such awards do not establish precedent.[125] Precedent may be important for establishing rights or legal endowments.[126] Settlement may stifle the

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[117] Richard Delgado, Chris Dunn, Pamela Brown, Helena Lee, & David Hubbert, *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359, 1374.

[118] *Id.* at 1402–04; *See also* Grillo, *supra* note 88, at 1588–90.

[119] *Id.* at 1549–50.

[120] *Id.* at 1601.

[121] *Id.* at 1579.

[122] *Id.* at 1604.

[123] *Id.* at 1601.

[124] *E.g.*, Joan B. Kelly, *Power Imbalance in Divorce and Interpersonal Mediation: Assessment and Intervention*, 13 MEDIATION Q. 85 (1995).

[125] RUBEN, *supra* note 35, at 14.

[126] Seul, *supra* note 59, at 349–50.

development of law in "disfavored" areas such as civil rights or family law.[127] Other uses of precedent include deterring similar claims in the future[128] or preventing recurring violations.[129] Litigation may therefore be an appropriate process for disputants who are seeking "justice," are disempowered, or value the establishment of precedent.

Hybrid processes, according to their proponents, are capable of combining the benefits of the constituent methods. For example, med-arb, it is argued, combines the informality of mediation and its ability to address underlying interests with arbitration's guarantee of a final resolution.[130] Efficiency, in particular, is strongly emphasized.[131] Thomas J. Brewer and Lawrence R. Mills, for example, contend: "Combined med-arb proceedings can offer parties important dispute resolution advantages, such as: [t]he parties can obtain a certain resolution of their dispute within a reasonable time, [and t]he resolution can often be achieved at a reduced cost and with improved overall efficiency."[132] In the labor field, authors disagree regarding what types of disputes med-arb is most appropriate for.[133]

The ADR literature as a whole emphasizes parties' awareness of and voluntary participation in the various dispute resolution processes.[134] For example, Love argues: "Mediators are not foreclosed from engaging in some other process or helping parties design a mixed process. Whatever the service being provided, however, it should be requested by the parties and accurately labeled."[135] In the succeeding parts of this article, I recognize that participants in ethics consultation may value the potential goals differently. While advocating for the use of mediation, I recognize that others, emphasizing determinative outcomes or efficiency, may choose a hybrid process. I, nonetheless, contend that proponents of hybrid processes do not

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[127] Edwards, *supra* note 113, at 679; *See also* Fiss, *supra* note 113, at 1085.

[128] Seul, *supra* note 59, at 352–53.

[129] Sander & Goldberg, *supra* note 93, at 60.

[130] Bartel, *supra* note 79, at 665.

[131] *See* Elliott, *supra* note 63, at 164; Milne, Folberg, & Salem, *supra* note 26, at 11; TELFORD, *supra* note 61, at 2.

[132] Brewer & Mills, *supra* note 46, at 34 (listing more control over the process than "pure" arbitration and greater finality than "pure" mediation as advantages of med-arb).

[133] *Compare* Bartel, *supra* note 79, at 678, *and* Henry, *supra* note 79, at 396, *with* TELFORD, *supra* note 61, at 6, 9.

[134] *See* Gerald F. Phillips, *Same-Neutral Med-Arb: What Does the Future Hold?*, DISP. RESOL. J., May–July 2005, at 24, 26–27; Sander & Goldberg, *supra* note 93, at 49–50; Seul, *supra* note 59, at 352; Stempel, *supra* note 61, at 269, 284; Riskin, *supra* note 25, at 13–14.

[135] Love, *supra* note 57, at 948.

take adequate account of the due process protections incorporated into arbitration or the issues articulated in the ADR literature regarding the combination of the roles of mediator and arbitrator.

III. ADR AND ETHICS CONSULTATION

Ethics committees and consultation developed as an explicit alternative to litigation.[136] Courts, with the exception of those in Massachusetts, have tended to view themselves as less-than-ideal decisionmakers. The New Jersey Supreme Court, for example, emphasized the need for expertise and efficiency in its decision to withdraw life sustaining treatment. It stated, "[w]e consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."[137]

In contrast, the Massachusetts Supreme Court emphasized justice:

> Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and not to be entrusted to any other group purporting to represent the 'morality and conscience of our society,' no matter how highly motivated or impressively constituted.[138]

As we have seen, the prioritization of different goals leads to the selection of different dispute resolution processes.

The President's Commission identified the need for a review of decisions to forego life-sustaining treatment and, while acknowledging beneficial aspects of the judicial process, argued that initial recourse should be to ethics committees.[139] Commendable aspects of judicial process, according to the Commission's report, include public proceedings, principled decisionmaking,

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[136] *See* Paris & Reardon, *supra* note 17, at 112–16.

[137] *In re* Quinlan, 355 A.2d 647, 669 (N.J. 1976). *See generally* Robin Fretwell Wilson, *Hospital Ethics Committees as the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 N.C. L. REV. 353, 359–60, 368–69 (1997–98).

[138] Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 435 (Mass. 1977). *See generally* Fentiman, *supra* note 22, at 829–33; Yeun, *supra* note 9, at 600–04.

[139] PRESIDENT'S COMMISSION, *supra* note 11, at 153–70.

impartial decisionmakers, and an adversarial process.[140] The Commission also identified a number of reasons, including some of these same attributes, against judicial involvement:

> [J]udicial review in such cases is costly in terms of time and expense; it can disrupt the process of providing care for the patient, since medical decisionmaking is evolutionary rather than static; it can create unnecessary strains in the relationship between the surrogate decisionmakers and others, such as the health care providers, who may be forced into the role of formal adversaries in the litigation; and it exposes ordinarily quite private matters to the scrutiny of the courtroom and sometimes even to the glare of the public communications media.[141]

The Commission concluded that the detriments of routine court review outweighed the benefits.[142] This conclusion was supported, in the Commission's view, by the fact that courts typically did not have enough information to determine whether the course of action was correct and simply deferred to the treating physician.[143] While acknowledging concerns and unresolved issues with ethics committees,[144] the Commission tentatively recommended their use.[145] The report cited a number of benefits: rapid review, sensitive decisionmaking, and informal and private procedures.[146] The Commission nonetheless envisioned the need for judicial review in unusual cases.[147]

The need for, and the court's possession of, medical or ethical expertise has been a significant issue in this debate. For example, the D.C. Court of Appeals asserted:

> We observe . . . that it would be far better if judges were not called to patients' bedsides and required to make quick decisions on issues of life and

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[140] *Id.* at 159.

[141] *Id.* at 159. *See also* Bernard Lo, Fenella Rouse, & Laurie Dornbrand, *Family Decision Making on Trial: Who Decides for Incompetent Patients?*, 322 N. ENG. J. MED. 1228, 1231 (1990); Robert Steinbrook & Bernard Lo, *Artificial Feeding—Solid Ground, Not a Slippery Slope*, 318 N. ENG. J. MED. 286, 289 (1988).

[142] PRESIDENT'S COMMISSION, *supra* note 11, at 160.

[143] *Id.*

[144] *Id.* at 165–68 (identifying unresolved issues including unintentionally increasing the number and type of cases reviewed and who should serve on the committees).

[145] *Id.* at 168–69.

[146] *Id.*

[147] *See Id.* at 164, 167. *See generally* Diane E. Hoffmann, *Regulating Ethics Committees in Health Care Institutions—Is it Time?*, 50 MD. L. REV. 746, 781–84 (1991).

> death. Because judgment in such a case involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment—through legislation or otherwise—of another tribunal to make these decisions, with limited opportunity for judicial review.[148]

In contrast, Robin Fretwell Wilson argues that courts make decisions in other areas requiring technical expertise, such as technology.[149] She also identifies tools the court may utilize to evaluate technical information, including expert testimony, special masters, amicus curiae briefs, and Court Guidelines.[150] These mechanisms, however, tend to increase expertise at the expense of efficiency. Regarding ethical expertise, Wilson contends that judges possess some of these skills by virtue of their training, and that these skills are not within the sole providence of ethicists.[151] She also emphasizes that many members of ethics committees possess no formal ethics training.[152] If one emphasizes the role of expertise, Wilson is correct to note the importance of training and qualifications.

The President's Commission report helped to catalyze the formation of ethics committees as the preliminary level of review.[153] The approaches to ethics consultation which subsequently developed represent, from the prospective of the ADR literature, a hybrid process.[154] The ADR literature helps to identify problematic features of such processes, such as the use of caucuses, which ethics consultants do not adequately recognize.[155]

The American Society for Bioethics and Humanities' (ASBH's) *Core Competencies for Health Care Ethics Consultation* is the authoritative statement on this topic.[156] It identifies ethics facilitation as the most

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[148] *In re* A.C., 573 A.2d 1235, 1237 n.2 (D.C. 1990).

[149] Wilson, *supra* note 137, at 372.

[150] *Id.* at 372–74, 375–76.

[151] *Id.* at 374–75.

[152] *Id.* at 384–86.

[153] *See supra* notes 14–18 and accompanying text.

[154] *Cf.* Gatter, *supra* note 22, at 1095, 1118, 1130–31.

[155] *See infra* notes 177–81, 197–208 and accompanying text.

[156] ASBH, *supra* note 10, at 1 (describing the study's initiation by the Society for Health and Human Values (SHHV) and the Society for Bioethics Consultation (SBC)). The report was reviewed and adopted by ASBH after it was formed by the merger of SHHV, SBC, and American Association of Bioethics. ASBH is the primary professional organization in bioethics and medical humanities with approximately 1,500 members. *See* Board of Directors of the American Society of Bioethics and Humanities to President George W. Bush, Aug. 2, 2004, http://www.asbh.org/about/action/Bush_ethics_and_detainees.pdf.).

appropriate approach to ethics consultation in our society.[157] The report emphasizes the increasing plurality of values in American society.[158] Ethics facilitation is characterized as an alternative to the extremes of the authoritarian and pure facilitation approaches.[159]

The report criticizes the authoritarian and pure facilitation approaches using a casuistic mode of argumentation; it supports its claims by the presentation of exemplary cases. The *Core Competencies* identifies the defining characteristic of the authoritarian approach as "its emphasis on consultants as the primary moral decisionmakers at the expense of the appropriate moral decisionmakers."[160] This can occur either in terms of process or outcome. An inappropriate outcome is illustrated by a consultant who recommends a competent, well-informed, adult Jehovah's Witness be transfused against his wishes because the consultant argues the patient's religious beliefs are false.[161] Erroneous process is exemplified in the report by a consultant who recommends that a futile treatment be discontinued without discussing the situation with the patient and family.[162] On the other hand, the inadequacies of the pure facilitation approach are also illustrated by a case— the patient's family and health care team agree to override a valid advance directive.[163] The authors appear to favor ethics facilitation as a means of achieving justice while acknowledging pluralism.

The ethics facilitation approach overcomes these shortcomings, according to the report's authors.[164] In contrast to authoritarian and pure facilitation approaches, the ethics facilitation approach identifies and analyzes the nature of the value uncertainty and facilitates the building of consensus. The identification and analysis of the value uncertainty includes identifying the range of morally acceptable options.[165] The report recommends that consultants be aware of how their own personal moral views influence their work. This influence, the report argues, should be made transparent, and consultants should not usurp decisionmaking authority or impose their values.[166]

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[157] ASBH, *supra* note 10, at 4–5.

[158] *Id.* at 4.

[159] *Id.* at 5.

[160] *Id.*

[161] *Id.* at 5–6.

[162] *Id.* at 6.

[163] ASBH, *supra* note 10, at 6.

[164] *Id.* at 5.

[165] *Id.* at 6.

[166] *Id.* at 7.

The report identifies the skills, knowledge, and character traits required to perform clinical ethics consultation.[167] Three categories of skills are identified—ethical assessment, process, and interpersonal skills—and basic and advanced skills in each category are distinguished.[168] The report differentiates the level of skill which every team or committee member needs and the skills an individual consultant, or at least one group member, must possess.[169] Process skills, for example, include the ability to engage in creative problem solving.[170]

The ethics facilitation model can best be characterized as a hybrid approach. Identification and analysis of the nature of the value uncertainty appears to require the consultant in some circumstances to make decisions for the parties[171] as an arbitrator would. This does not appear to simply be a means of reality testing, nor is the consultant recommended to withdraw from the process. Facilitating the building of consensus is consistent with mediation. The report explicitly states: "Formal training in specific techniques such as mediation, conflict resolution, or facilitation is one way to obtain advanced interpersonal and process skills."[172]

The document, however, is unclear regarding the scope of consultant authority. It relies on the distinction between personal moral values and societal values and law and emphasizes that consultants should not impose their own values.[173] The report, however, does not identify criteria for distinguishing public values from private.[174] The authors also fail to address situations in which parties may disagree with societal values, for example, seeking physician-assisted suicide or denying the validity of neurological criteria for death.

What degree or type of societal consensus is sufficient to constrain individuals' decisionmaking? The characterization of the futility example, as a shortcoming in process rather than outcome, is notable in this regard.

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[167] *Id.* at 11–23.

[168] *Id.* at 12–16.

[169] ASBH, *supra* note 10, at 15.

[170] *Id.* at 14.

[171] *Compare id.* at 6–7, *with id.* at 8.

[172] *Id.* at 16. *Cf. id.* at 16 ("Other ways of obtaining these skills include supervised clinical practicums, mentoring processes (apprenticeships with effective modeling), or fellowship programs that emphasize developing process and interpersonal skills in ethics consultation.").

[173] ASBH, *supra* note 10, at 5–7.

[174] *Cf.* Edwards, *supra* note 113, at 671–72.

Futility, as the report acknowledges, is a controversial concept.[175] The consultant's recommendation may be authoritarian not only in process but also in outcome because, although the concept of futility has support in the literature, it is not universally held or legally enforceable except in Texas.[176] The report lacks a developed conception of consensus that would justify the consultant's authoritative decisionmaking for the parties.

The document contains a brief description of the consultation process which touches on a number of due process issues. The report contends access to ethics consultation should be open to patients, families, and surrogates and notes disagreement regarding which health care providers or others may request consultation.[177] It contends that patients, or their surrogates, and the attending physician must be notified of consultation requests. The report, however, limits notification of patient to "situations where their participation in decisionmaking is ethically required," and permits consultations to proceed, in some cases, in spite of the patient's refusal to participate.[178] The report advocates that institutions develop policies regarding the degree and type of documentation, but does not make specific recommendations beyond communicating the results of consultations requiring patient involvement to the patient.[179] These processes offer significantly weaker protections for patient participation than arbitration would.[180] Additional issues identified in the ADR literature, such as the use of caucuses, [181] are not addressed.

Nancy N. Dubler and Carol Liebman explicitly propose incorporating mediation into bioethics consultation in a process they term "bioethics mediation."[182] They claim: "Whereas mediation has been proposed as one perspective for training professionals and conducting a consultation, we would like to suggest that it is the best theoretical framework in which to

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[175] ASBH, *supra* note 10, at 6. *See* Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. MED. 3 (1995).

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

[177] ASBH, *supra* note 10, at 9.

[178] *Id.*

[179] *Id.* at 10.

[180] *See supra* notes 44–48 and accompanying text.

[181] *See supra* notes 89–91 and accompanying text.

[182] *See* NANCY N. DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS (United Hospital Fund of New York 2004). *See also* DUBLER & MARCUS, *supra* note 22.

embed these tasks[.]"[183] They characterize bioethics mediation as a multistage process which includes: assessment and preparation, beginning the mediation, presenting and refining the medical facts, gathering information, problem solving, resolution, and follow-up.[184]

Specific to their proposal is an emphasis on establishing the medical facts.[185] This emphasis is congruent with the authors' understanding of a common source of conflict—inadequate communication. The authors contend that differing opinions among the care team are often communicated to patients or their surrogates. These mixed messages often lead to confusion and produce conflict.[186] Establishing the medical facts eliminates these mixed messages. It involves, in the authors' view, speaking with individual team members and facilitating a meeting with the care team prior to the mediation session.[187]

During the mediation session itself, the mediator may hold further caucuses. Reasons for caucusing include "to obtain confidential information."[188] Mediators' skills include summarizing, reframing, and reality testing.[189] For example, the bioethics mediator may reality-test by

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[183] DUBLER & LIEBMAN, *supra* note 182, at 1, 8. Other related claims appear to restrict mediation to a component of ethics consultation rather than a comprehensive methodology. *See, e.g.*, *id.* at xiii ("We are suggesting, in this book, that although there might be other ways to acquire these [interpersonal and process] skills, by far the most effective and efficient way is to study the body of knowledge, skills, and techniques represented by the field of mediation.").

[184] *Id.* at 45.

[185] *Id.* at 27–28.

[186] *Id.* at xiv, 50. *See also* R. Førde & I. H. Vandvik, *Clinical Ethics, Information, and Communication: Review of 31 Cases from a Clinical Ethics Committee*, 31 J. MED. ETHICS 73, 74 (2005) (reporting that issues related to information or communication were an explicit problem in 3 of 31 cases brought to a clinical ethics committee, and an implicit problem in 22 of 31 cases); John A. McClung, Russell S. Kamer, Margaret DeLuca, & Harlan J. Barber, *Evaluation of a Medical Ethics Consultation Service: Opinions of Patients and Health Care Providers*, 100 AM. J. MED. 456, 459 (1996) (reporting that 13% of physicians, 20% of nurses, and 59% of family members reported a lack of communication as a problem in a situation resulting in an ethics consult). A more robust conflict map would include a variety of types of conflicts including value, relationship, data, interest, and structural conflicts. Data conflicts may involve misinformation but can also involve different assessment procedures. Such conflicts might be addressed through the use of third-party experts. *See* MOORE, *supra* note 23, at 64–65.

[187] DUBLER & LIEBMAN, *supra* note 182, at 29, 50–53.

[188] *Id.* at 94–95.

[189] *See id.* at 85–97.

asking what will happen if the issue is not resolved, or how the other party is likely to respond.[190]

While the authors emphasize mediation, I contend that bioethics mediation is more accurately characterized as a hybrid process because the neutral may make decisions for the principal parties. Dubler and Liebman assert that one of the fundamental goals of bioethics mediation is to maximize the likelihood that the resolution will fall within clearly accepted ethical principles, legal stipulations, and moral rules.[191] They claim: "Sometimes in bioethics mediation the mediator will need to step out of the role of mediator and into the role of consultant. This role switch is most likely to happen if the process is leading to an ethically unsupportable outcome."[192] They then characterize consultation as a "directed, substantive process."[193] Although some of the authors' language suggests the mediator educates the parties,[194] the authors' main emphasis is that the mediator constrains the outcome.[195] This role is congruent with the role of the arbitrator.[196]

Dubler and Liebman acknowledge, but do not adequately address, this issue. In a footnote, the authors acknowledge that med-arb:

> [I]s controversial (and disfavored by the authors) because the knowledge that the neutral mediator may ultimately pass judgment on what he or she has heard is likely to affect what the participants say to the mediator and how they say it and also affect the type of information the mediator elicits and to which he or she attends.[197]

The authors fail, however, to differentiate bioethics mediation from med-arb or identify how they mitigate the adverse effects on party participation.

The characterization of bioethics mediation as a hybrid process is also supported by Dubler and Liebman's cases. For example, "A Dying Patient and the Issue of Scarce Resources: Alex Barlow's Case," involves a nineteen-year-old who is dying as the result of a brain tumor, sepsis, and a chronic

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[190] *Id.* at 95.

[191] *Id.* at 10–11. *See also id.* at 24–25, 77.

[192] DUBLER & LIEBMAN, *supra* note 182 at 13. *See also id.* at 50 n.4.

[193] *Id.* at 14.

[194] *Id.* at 13.

[195] *See id.* at 46. *See also* Waldman, *supra* note 30, at 754 (characterizing bioethics mediation as norm-advocating rather than norm-educating mediation).

[196] *See supra* notes 35–51 and accompanying text.

[197] DUBLER & LIEBMAN, *supra* note 182, at 13 n.4.

lung infection and who is being treated with platelets that are in short supply.[198] The mediator takes a number of direct actions including requesting a palliative care consult.[199] The mediator also describes her role to the patient's sister as placing constraints on the possible decisions.[200] She identifies three systems for distributing scare resources and states that the hospital utilizes the third system, most likely to benefit, and, therefore, the patient will be denied platelets.[201] This represents decisionmaking rather than education. The patient might be eligible for platelets under the first or second systems, queuing or lottery,[202] but the mediator does not justify why these options are excluded. Like the *Core Competencies*, the authors do not present criteria to identify when there is sufficient consensus to legitimate the consultant constraining the outcome.

A number of considerations appear to contribute to the author's preference for a hybrid process. The dominant concern appears to be preventing the parties from colluding in an immoral agreement.[203] The authors do not, however, present evidence that this is a frequent occurrence that the initial dispute resolution process needs to be designed to prevent. Other features of the process might, in fact, limit the occurrence of unconscionable outcomes. For example, the presence of multiple parties, including some, such as doctors and nurses, who have received training in medical ethics,[204] may significantly reduce immoral agreements.

Dubler and Liebman also emphasize the need for a determinative outcome and efficiency. The authors state, "[d]eciding not to reach a resolution is not an option."[205] This claim is bolstered by their further

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[198] *Id.* at 15–19. *See also id.* at 3–5 (describing the mediator, rather than the care team, conveying the patient's imminent demise to the patient's wife).

[199] *Id.* at 16.

[200] *Id.* at 17.

[201] *Id.*

[202] *Cf.* JOHN F. KILNER, WHO LIVES? WHO DIES?: ETHICAL CRITERIA IN PATIENT SELECTION (Yale University Press 1990).

[203] DUBLER & LIEBMAN, *supra* note 182, at 13.

[204] Training in medical ethics is an accreditation requirement of medical schools and residency programs. *See* Liaison Committee on Medical Education, Function and Structure of a Medical School, *Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree* 3 (2007), *available at* http://www.lcme.org/functions2007jun.pdf; Accreditation Council for Graduate Medical Education, *Institutional Requirements* 10 (2003), *available at* http://www.acgme.org/acWebsite/irc/irc_IRCpr703.pdf. Ethics education is also a function of ethics committees. *See supra* note 11 and accompanying text.

[205] DUBLER & LIEBMAN, *supra* note 182, at 21. *See also id.* at 25.

assertion that "[t]ime is of the essence."[206] The authors clarify that there are default rules that apply if an agreement cannot be reached,[207] but the need for a resolution is nevertheless internalized to the bioethics mediation process. Dubler and Liebman also do not present evidence that the default rules cannot provide a determinative or efficient outcome.

The underlying issue may be better characterized as the perceived inadequacy of the default rules rather than the need for a determinative outcome or efficiency. The default rules typically require patients' (or their proxies', parents', or guardians') consent for administering new or withdrawing existing treatments. These rules typically preserve the status quo. Alterations in these default rules to promote determinative outcomes and efficiency would have significant implications for the relative power of patient and medical staff.[208]

In spite of their differences, the *Core Competencies* and *Bioethics Mediation* both represent hybrid approaches.[209] While the consultant attempts to facilitate agreement, the consultant may make decisions for the principal parties which delimit the range of acceptable outcomes. Neither proposal identifies criteria for which norms the consultant may legitimately enforce. Furthermore, neither adequately addresses the due process protections required by adjudication or acknowledges the potential limitations of hybrid processes.

IV. DUE PROCESS

While I argue that mediation is a more appropriate process for pediatric ethics consultation than arbitration or hybrid processes,[210] I recognize that others may evaluate the benefits and detriments of the available processes differently. Efficiency and a determinate outcome may be more highly valued by some, and used to justify hybrid models. My review of the ADR literature has shown that arbitration is a more formal process than mediation and advocates of hybrid process recognize the potential conflicts between the various third party roles and the way combining processes alters them.[211]

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[206] *Id.* at 21. *See also id.* at 27, 36.

[207] *Id.* at 25.

[208] *See generally* Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979).

[209] *See supra* notes 171–72, 191–202 and accompanying text.

[210] *See infra* notes 222–298 and accompanying text.

[211] *See supra* notes 44–48, 86–91 and accompanying text.

Proponents of approaches incorporating arbitration must, however, pay greater attention to due process protections.

Attention to due process was a more prominent concern in the earlier ethics consultation literature. Susan Wolf, for example, argues that although ethics committees should be advisory, they should offer procedural protections because of their potential influence and their full range of obligations.[212] By advisory, Wolf means that patients possess the binding decisional authority.[213] Committees may, nonetheless, be accorded or seek influence. Influence may be accorded to the committee's recommendations by patients, their surrogates, their caregivers, and possibly the courts. Patients may be constrained from seeking court intervention.[214] In addition, committees have sought to make treatment decisions and urged courts to defer to them.[215] Wolf argues that this influence engenders procedural due process obligations.[216]

Wolf outlines a number of protections. They include:

> [N]otice [including notice of the committee's existence and functions, of the procedures and procedural options, and of the intention to consider a case], an opportunity to be heard, a chance to confront those in opposition, receipt of a written determination and a statement of reasons, and an opportunity to challenge that determination.[217]

For example, she argues that, "[w]ithout notice, patients and their representatives have no way of challenging, correcting, participating in, or simply monitoring ethics committee consideration of the patient's case."[218] Participation decreases the likelihood of error regarding the medical facts, patient's views, and the ethical conclusions and increases the likelihood the committee will fulfill its obligations. Wolf also contends that committees

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[212] Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 831 (1991).

[213] *See id.* at 836.

[214] *Id.* at 833.

[215] *Id.* at 810.

[216] *Id.* at 833. *See also* Hoffmann, *supra* note 147, at 751 ("[T]he decisionmaking authority of ethics committees should be expanded to permit their use as an alternative to judicial decisionmaking only if the typical composition of ethics committees is fundamentally changed and numerous safeguards are implemented, including provisions for due process and the monitoring of committee deliberations and recommendations.").

[217] Wolf, *supra* note 212, at 831.

[218] *Id.* at 847.

have an obligation to periodically evaluate their procedures.[219] These protections are significantly greater than those articulated in the *Core Competencies*[220] or *Bioethics Mediation*.[221]

V. ETHICAL EXPERTISE AND THE BEST INTERESTS STANDARD

In cases of significant conflict in pediatrics, I argue that a single best outcome is unlikely due to the nature of both moral expertise and the best interests standard. This makes rule-governed activities such as arbitration inappropriate. While arbitration might be used in a hybrid process to delimit boundaries, this process will not necessarily produce a determinative outcome. Absent this benefit, the risks of deforming the communication process by combining mediation and arbitration are uncompensated. Part of the issue turns on the likelihood of an unconscionable agreement. Lacking published data, my experience is that such outcomes are unlikely and may be adequately addressed by the consultant terminating the process. In the absence of a mediated agreement, the default decisionmakers are the patient's parents or legal guardian. Their decisionmaking authority should only be overridden in cases of abuse or neglect. Evaluation of cases of potential abuse or neglect involves a narrower normative standard and could be performed by different neutral arbitration with appropriate due process protections. Results of this process could include referral to child protective services.

Adjudication is a rule-governed activity.[222] For ethics consultation to be analogous to adjudication, the consultant must be able to apply the applicable norms to the situation univocally. Diane E. Hoffman, for example, notes:

> [The norm-centered approach] assumes that the application of the legal and ethical principles articulated by ethics committees will lead to a clear, singular and 'right' answer. The assumption is especially suspect when the norms being applied are rather vague and subjective, or nonexistent. An example is the application of the best interest standard.[223]

While ethical expertise is possible, it is unreasonable to expect it to provide a single right answer, especially on subjects engendering significant

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[219] *Id.* at 851.

[220] *See supra* note 180 and accompanying text.

[221] *See supra* note 197 and accompanying text.

[222] *See supra* notes 39–40 and accompanying text.

[223] Hoffmann, *supra* note 22, at 871.

conflict. Furthermore, the best interests standard, as Hoffman notes, is too indeterminate to provide such guidance.

Bruce D. Weinstein provides a useful discussion of expertise and specifically moral expertise. He distinguishes two senses of expertise.[224] Expertise in the epistemological sense entails knowledge in or about a particular field.[225] Weinstein also describes this as the capability to offer strong justifications for a range of propositions in the field.[226] In contrast, expertise in the performative sense involves the ability to perform a demonstrable skill well.[227] These senses are conceptually and logically distinct in that experts in one sense need not be experts in the other sense. An expert juggler, for example, does not need to be able to explain how to juggle. [228] Weinstein recognizes issues in differentiating degrees of strength of justification for a proposition, and that such differentiation in relation to time, domain, and population.[229] He claims epistemic expertise only exists in domains which admit to objective truth.[230] In nontechnical fields, nonexperts may nonetheless hold justified beliefs.[231] Experts need not agree particularly when all relevant evidence is not available or there is disagreement about what evidence is relevant.[232] Experts also do not always have to be right.[233]

In a subsequent article, Weinstein argues that ethical expertise is possible.[234] Based on his distinction between epistemic and performative expertise and the epistemic subdomains of ethics, he argues it is possible to have epistemic expertise in descriptive ethics (the study of the moral beliefs of a particular culture, institution or religious tradition), metaethics (the study of the language and logic of moral arguments),[235] and normative ethics.[236]

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[224] Bruce D. Weinstein, *What is an Expert?*, 14 THEOR. MED. 57, 58 (1993). *See also* Francoise Baylis, *Persons with Moral Expertise and Moral Experts: Wherein Lies the Difference?*, *in* CLINICAL ETHICS: THEORY AND PRACTICE 89 (Barry Hoffmaster, Benjamin Freedman, & Gwen Fraser eds., 1989).

[225] Weinstein, *supra* note 224, at 58.

[226] *Id.* at 63.

[227] *Id.* at 58–62.

[228] *Id.* at 58.

[229] *Id.* at 70–71.

[230] *Id.* at 66–67.

[231] Weinstein, *supra* note 224, at 64.

[232] *Id.* at 69.

[233] *Id.* at 67–68.

[234] Bruce D. Weinstein, *The Possibility of Ethical Expertise*, 15 THEOR. MED. 61 (1994).

[235] *Id.* at 63–64.

[236] *Id.* at 67–70.

Performative expertise in living a good life is also possible.[237] Many authors contend that the form of ethical expertise relevant to philosophers or clinical ethicists is epistemological rather than performative.[238] Peter Singer, for example, states: "It is important to note . . . that this alleged expertise does not consist in the possession of special moral wisdom, or privileged insights into moral truth, but in understanding the nature of moral theories and the possible methods of moral argument."[239]

Weinstein argues that disagreement among experts in normative ethics does not preclude the possibility of expertise in this domain. [240] He argues moral prescriptions are capable of justification by appeal to moral rules, principles, and theories.[241] He cites Paul Ramsey and Richard McCormick's debate concerning nontherapeutic research on children as an example.[242] Both Ramsey and McCormick were experts because neither merely asserted their beliefs; both provided well-supported reasons and their conclusions of their arguments followed from the premises. Ramsey and McCormick nonetheless disagreed.[243] Ethical expertise consists of giving and analyzing reasons but need not result in agreement.

Many criticisms of claims to ethical expertise focus on whether ethics is objective knowledge. Giles R. Scofield for example, asserts: "Ultimately, the claims ethics consultants make simply cannot be proven because ethics is not like mathematics or the physical sciences."[244] Access to moral truths is not, however, necessary for moral expertise. There are other fields, such as architecture, economics, and genetic counseling, where expertise is

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[237] *Id.* at 70–71.

[238] *See* George J. Agich & Bethany J. Spielman, *Ethics Expert Testimony: Against the Skeptics*, 22 J. MED. PHIL. 381, 386–87 (1997).

[239] Peter Singer, *Ethics and Experts: How Do We Decide?*, HASTINGS CTR. REP., June 1982, at 9, 9.

[240] Weinstein, *supra* note 234, at 67. *See generally* Jan Crosthwaite, *Moral Expertise: A Problem in the Professional Ethics of Professional Ethicists*, 9 BIOETHICS 361 (1995). *But cf.* Christopher Cowley, *A New Rejection of Moral Expertise*, 8 MED. HEALTH CARE PHIL. 273 (2005).

[241] Weinstein, *supra* note 234, at 67.

[242] *Id.* at 67–70.

[243] *Id.* at 68.

[244] Giles R. Scofield, *Ethics Consultation: The Least Dangerous Profession?*, 2 CAMB. Q. HEALTHCARE ETHICS 417, 420 (1993). *See also* Ruth Shalit, *When We Were Philosopher Kings: The Rise of the Medical Ethicist*, 216 NEW REP., APR. 28, 1997, at 24 ("The problem with all this is basic. 'Clinical ethics' is not medicine, which is to say it is not science, which is to say it is to a very large degree whatever anyone wants it to be.").

recognized without objective knowledge. Rather than truth, practitioners in these fields provide knowledgeable answers along with good reasons.[245]

There are also moral arguments against ethical expertise. Moral expertise, critics argue, is inconsistent with liberal democracy and is dangerous.[246] Scofield argues:

> [T]o believe that someone possesses specialized knowledge in applied ethics presupposes that some individuals are legally regarded as knowing better than others what should, from an ethical perspective, be done in a given situation. The difficulty with this claim is that it is antithetical to the foundational beliefs of a pluralistic democracy.[247]

Scofield, therefore, limits the ethicist's role to educating others—teaching them how to approach and think about moral problems.[248] Equality in terms of moral agency, however, need not entail equality in terms of moral knowledge or decisionmaking skills.[249] The moral arguments against ethical expertise, therefore, do not necessarily deny the existence of such expertise but constrain how it is exercised. It should be used to facilitate others' moral development rather than constrain their decisionmaking.

Bernard Gert, Charles M. Culver, and K. Danner Clouser provide a more comprehensive moral theory which adds to the framework provided by Weinstein. Gert, Culver, and Clouser develop a comprehensive moral theory, which they call "common morality,"[250] which has several powerful explanatory features relevant to my consideration of ADR and ethics consultation. Their position accounts for the presence of generalized moral knowledge, while permitting a limited scope for moral expertise.[251] Gert,

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[245] *See* Baylis, *supra* note 224, at 90–91. *See also* Scot D. Yoder, *The Nature of Ethical Expertise*, HASTINGS CTR. REP., Nov.–Dec. 1998, at 11–15.

[246] *Id.* at 12.

[247] Giles R. Scofield, *Is the Medical Ethicist an "Expert"?*, 3 BIOETHICS BULL. 1, 9 (1994). *See also* Scofield, *supra* note 244, at 422 ("[T]he ultimate problem with the claims ethics consultants make is that they cannot be true in a pluralistic, democratic society founded on the belief that each person is the moral equal of every other.").

[248] Scofield, *supra* note 244, at 423–24. It is unclear, however, whether this role is compatible with prospective case consultation. *See also* Christian Lilje, *Ethics Consultation: A Dangerous, Antidemocratic Charlatanry?*, 2 CAMB. Q. HEALTHCARE ETHICS 438, 440 (1993).

[249] Donnie J. Self, *Is Ethics Consultation Dangerous?*, 2 CAMB. Q. HEALTHCARE ETHICS 442, 442 (1993).

[250] BERNARD GERT ET AL., BIOETHICS: A SYSTEMATIC APPROACH 21–23 (Oxford University Press, 2d ed. 2006).

[251] *See infra* notes 254–59 and accompanying text.

Culver, and Clouser also recognize unresolvable moral disagreement and identify its sources.[252] Finally, their distinction between moral rules and moral ideals can be used to legitimize a restricted adjudicatory function.[253]

Gert, Culver, and Clouser emphasize that there is widespread agreement on most moral matters.[254] This agreement is, however, in their view obscured by concentration on controversial moral issues.[255] They distinguish the moral system and moral theory. The moral system comes first and moral theory systematically describes and justifies it. Moral theory, according to the authors, does not create the moral system.[256] The authors analogize the moral system and moral theory to language and grammar.[257] Moral theory is firmly based on and tested by clear moral intuitions.[258] Individuals, therefore, have a significant degree of moral knowledge.[259]

Gert, Culver, and Clouser's moral theory distinguishes moral rules, moral ideals, and morally relevant features of situations, and identifies a two-step procedure for evaluating conflicts among rules or between rules and ideals.[260] Moral rules center on human vulnerability and require abstaining from unjustifiably causing harm to others. The authors argue that all rational persons want to avoid death, pain, disability, loss of freedom, and loss of pleasure unless they have an adequate reason not to.[261] The moral rules prohibit causing one of the harms (do not kill), or the kinds of actions that generally increase the amount of harm (do not deceive).[262] In the context of pediatric ethics consultation, this agreement provides the basis for enforcing norms against child abuse and neglect. The authors justify their focus on harm rather than benefit on several grounds: there is no agreement on what is the greatest good, avoiding harm is more important than gaining good, and focusing on the promotion of good encourages unjustified paternalism.[263] Moral ideals encourage people to prevent or relieve harm to others. Moral ideals, unlike moral rules, however, cannot not be followed all the time or

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[252] *See infra* notes 271–76 and accompanying text.

[253] *See infra* notes 260–70, 277–78 and accompanying text.

[254] GERT ET AL., *supra* note 250, at 21.

[255] *Id.* at 22.

[256] *Id.* at 5–6, 25–26.

[257] *Id.* at 24–25.

[258] *Id.* at 6.

[259] *Id.* at 3–4.

[260] GERT ET AL., *supra* note 250, at 10, 35–36.

[261] *Id.* at 28.

[262] *Id.* at 35–36.

[263] *Id.* at 11–14.

followed impartially toward everyone.[264] These rules and ideals are general but can be specified in terms of particular cultures[265] or professions.[266]

Determination of when it is justified to violate a moral rule is accomplished via a two-step procedure. For example, breaking a trivial promise to aid an injured person is morally acceptable.[267] The first step of the procedure is to describe the act in terms of the morally relevant features. Gert, Culver, and Clouser characterize possibly morally relevant features through a series of questions including: "What harms would be (a) avoided, (b) prevented, and (c) caused?"[268] The second step is determining which will produce less overall harm: everyone knowing the action will be interpreted as a violation of a moral rule, or everyone knowing it will not be interpreted as a violation of a moral rule.[269] Differing degrees of justification of the violation of a moral rule are possible depending on the existence and degree of disagreement regarding the amount of harm.[270]

Gert, Culver, and Clouser argue that a moral theory need not provide a unique right answer to every moral problem and provide an account of the sources of unresolvable moral disagreement.[271] The recognition of unresolvable moral disagreement is important in framing what can be accomplished within ethics consultation. Gert, Culver, and Clouser argue that there are four reasons for unresolvable moral disagreement:[272]

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[264] *Id.* at 43–44.

[265] *Id.*, at 78–82.

[266] GERT ET AL., *supra* note 250, at 88–92.

[267] *Id.* at 60.

[268] *Id.* at 39.

[269] *Id.* at 38–39, 83–86, 121–22.

[270] *Id.* at 42. *Compare id.* at 96 ("There is no moral expertise"), *with* GERT ET AL., *supra* note 250, at 96 ("No one should defer to an ethicist when a moral decision is called for. Nor should one allow an ethicist or 'moral expert' to overrule one's own moral intuitions or to inhibit one from participating in moral deliberations. Ordinary understanding of ethics is usually sufficient, as long as one knows and appreciates the facts, purposes, understandings, and relationships of the field with whose ethics she is dealing.").

[271] *Id.* at 3–5, 21–22.

[272] *Id.* at 16, 59–60 (stating that disagreement about facts is the most common form of unresolvable moral disagreement and, therefore, omitting it from their list of the sources of moral disagreement because it is not denied or neglected). *But cf. id.* at 35 ("[O]ur experience on ethics committees and in doing ethics consultations has been that most actual moral disagreements are based on disagreements about the facts of the case, especially disagreements about prognoses.").

(1) Differences in the Rankings of the Harms (Evils) and Benefits (Goods): There is no objective ranking of harms and benefits that resolves all controversies. For example, in the debate over the legalization of physician-assisted suicide, individuals may legitimately disagree on how the relief of unwanted pain and suffering should be weighed against people dying earlier than they really want to.[273]

(2) Differences about Human Nature or the Nature of Human Societies: In the second step of evaluating the violation of a moral rule, individuals may disagree about what would happen if everyone were to know that certain kinds of violation of a moral rule were allowed. How frequently would laws making it easier to involuntarily commit individuals to psychiatric facilities be abused? Such views, the authors argue, may not be subject to empirical confirmation or disconfirmation.[274]

(3) Differences about the Interpretation of a Moral Rule: Individuals may disagree about whether discontinuing life-preserving treatment, such as artificial nutrition and hydration, counts as killing.[275]

(4) Differences about the Scope of Morality: There may not be any way to resolve disagreement about whether fetuses and higher mammals are fully protected, partially protected, or not protected at all.[276]

Disagreement does not, however, mean a lack of agreement on morally acceptable boundaries.[277] Such boundaries are established by universally accepted conceptions of harm. Note again the limited scope of such agreement. The authors also argue that recognition of legitimate disagreement can provide the precondition for individuals to "cooperate in trying to discover a compromise that comes closest to satisfying both of their positions."[278] This conclusion reinforces the appropriateness of mediative interventions in moral disagreements.

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[273] *Id.* at 55–57.

[274] *Id.* at 57–58.

[275] GERT ET AL., *supra* note 250, at 59.

[276] *Id.*

[277] *Id.* at 22.

[278] *Id.* at 105.

Claims of limited moral expertise, therefore, need not deny nonexperts' ethical knowledge. Nonexperts live in the moral system which is prior to moral theory. Ethical experts may be able to describe relevant moral rules and ideals and discuss possible justifications for the violations of moral rules. They can also identify reasons for unresolvable disagreement. They should not, however, be expected to provide a single best answer to a complex or controversial moral question. Consensus is likely to be restricted to actions that clearly cause harm, without possible justification. Given the broad range of possible actions, assisting in the development of consensus regarding a specific course of action is nonetheless a significant accomplishment.

While the nature of moral expertise makes adjudicative ethics consultation inappropriate, this problem is compounded in pediatrics by the indeterminacy of the best interests standard. My discussion of Gert, Culver, and Clouser's work should already suggest that this focus on the good is problematic.[279]

I now draw, in a similar way, on Robert H. Mnookin's analysis of child-custody adjudication to elaborate why the best interests standard is a problematic basis for third-party neutral decisionmaking in pediatrics. In this article, Mnookin develops two major themes: that "the determination of what is 'best' or 'least detrimental' for a particular child is usually indeterminate and speculative,"[280] and that "courts perform two very different functions in the resolution of custody disputes: private-dispute-settlement and child-protection."[281]

Mnookin argues that child custody disputes resolved under the best-interests-of-the-child standard differ from adjudication in a number of ways.[282] Child custody disputes apply person-oriented, not act-oriented, determination; they require individualized predictions of future events (including the effect of the outcome of the process on the parties), not determinations of past acts and facts; they accord limited relevance to precedent and scope of appellate review; and because the child is not a true participant, and, therefore, not all affected parties have a right to participate.[283] This reinforces the disanalogy between ethics consultation and adjudication.

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[279] *See supra* note 263 and accompanying text.

[280] Mnookin, *supra* note 2, at 229.

[281] *Id.*

[282] *Id.* at 250.

[283] *Id.* at 249–55.

Drawing on decision theory, Mnookin identifies several reasons why the best interest standard is indeterminate. [284] One is the difficulty of specifying possible outcomes. For example, in juvenile court proceedings, the judge may compare an existing family with an unknown alternative, because the judge may be unaware of the characteristics of the foster family.[285] A second is the inability to make confident predictions about the probability of the various outcomes. Mnookin argues that the behavioral sciences are unable to make the type of individualized predictions required by the best interest standard.[286] The third is the lack of societal consensus regarding what is "best." For example, what weight should be given to short-term versus long-term consequences? Should happiness, spiritual and religious training, economic productivity, warm interpersonal relations, disciple and self-sacrifice, stability and security, or intellectual stimulation be prioritized? If the appropriate normative standard is indeterminate, the third party's decisionmaking capacity should be significantly constrained.[287]

Mnookin contends that the indeterminate best-interests standard is problematic for both of the court's functions, but proposes different solutions in each case.[288] The child-protection function raises issues of the distribution of power between the family and the state.[289] Mnookin contends an indeterminate standard is inappropriate for the child-protection domain because it allocates too much responsibility to the state.[290] He proposes the following standard for decisions to remove children from their homes as more objective and determinative:

> A state may remove a child from parental custody without parental consent only if the state first proves: (a) there is an immediate and substantial danger to the child's health; and (b) there are no reasonable

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[284] *Id.* at 255–57. *But cf.* GERT ET AL., *supra* note 250, at 30–32 (criticizing instrumental accounts of rationality).

[285] *See* Mnookin, *supra* note 2, at 257–58.

[286] *Id.* at 258.

[287] *Id.* at 260–61.

[288] *Id.* at 268, 282.

[289] *Id.* at 265.

[290] *Id.* at 268–69. *See also* Mnookin, *supra* note 2, at 269–72 (articulating additional reasons, including indeterminate standards that invite judges' reliance on personal values).

> means acceptable to the parents by which the state can protect the child's health without removing the child from parental custody.[291]

In contrast, while identifying potential benefits of more determinative standards for the adjudication of private custody disputes, Mnookin argues that none is preferable to the best interest standard.[292] He, therefore, proposes negotiation and mediation as alternatives to adjudication. Judicial intervention in such agreements would be constrained by the child-protection standard .[293]

Similarly, the best interests standard does not permit ethics consultants or committees to function as arbitrators. The determinations that they must make under this standard are inconsistent with adjudication. In addition, the standard is indeterminate and prevents them from identifying or imposing a single best outcome. Disagreements would commonly be within the domain of private dispute settlement for which mediation is appropriate. One should, therefore, adopt processes that are most likely to contribute to the development of an agreement which is mutually acceptable to the parties. Incorporating adjudication into a hybrid process does not remediate this fundamental deficiency and has the potential of deforming the communication process and impeding the development of a mediated agreement.

Bioethics mediation so constructed has greatest affinity to family and divorce mediation. Like ethics consultants,[294] family and divorce mediators are required to have some specialized knowledge. In the case of divorce mediators, this includes knowledge of family law, child development, domestic abuse, and child abuse and neglect.[295] Within the boundaries of neutrality and party self-determination, the mediator may provide the parties information which the mediator is qualified to give.[296] Both the family and divorce mediator and the pediatric ethics consultant promote a frequently

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[291] *Id.* at 278. *But cf.* MILLER, *supra* note 1, at 118–45 (arguing for the concept of basic rather than best interests focusing on the primary goods of welfare, respect, and the right to an open future).

[292] Mnookin, *supra* note 2, at 282–87.

[293] *Id.* at 287–89.

[294] ASBH, *supra* note 10, at 16–21.

[295] *The Symposium on Standards of Practice, Model Standards of Practice for Family and Divorce Mediation* 2–3 [hereinafter *Symposium Standards*] (2000), *available at* http://www.afccnet.org/pdfs/modelstandards.pdf, *reprinted in* 39 FAM. CT. REV. 121 (2000).

[296] *Symposium Standards*, *supra* note 295, at 5.

absent child's interests.[297] Family and divorce mediators are instructed to suspend or terminate the mediation process if the parties are preparing to enter into an unconscionable agreement.[298]

This is not to suggest that mediation is a panacea. Mediation may fail, either in the absence of an agreement or as the result of the mediator's withdrawal. One might be concerned that the parent or guardian's proposed course of action constitutes abuse or neglect. Evaluating this contention would require a more adjudicatory process with a more restrictive standard of evaluation. Such a standard should be similar to Gert, Culver, and Clouser's focus on harm[299] or Mnookin's standard for decisions to remove a child from parental custody.[300] Given the potential consequences, due process protections are necessary, even if the neutral's recommendations are not binding.

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[297] *Id.* at 6–7.

[298] *Id.* at 9.

[299] *See supra* notes 261–63 and accompanying text.

[300] *See supra* note 291 and accompanying text.