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Jacqueline N. Font-Guzmán*

Abstract

In this article I discuss how World Café Dialogues can be used to unveil structural and cultural violence that drive the behaviors that maintain end-of-life care inequalities, especially among minorities, in acute healthcare hospitals. Conflict practitioners are rarely included in conversations of end-of-life care inequalities and when included it is to “solve a problem” through bioethics mediation or provide training in cross-cultural competence. I argue that conflict practitioners need to broaden their approach to conflict and use their skills to surface unequal power structures and implicit beliefs that maintain the unjust *status quo* in end-of-life care disparities.

Introduction

“You ache with the need to convince yourself that you do exist in the real world, that you’re part of all sound and anguish, and you strike out with your fists, you curse and you swear to make them recognize you. And, alas, it’s seldom successful!”
(Ellison, 1995, p. 4)

In May 2006, I co-facilitated with two colleagues (Debra Gerardi and Rob Robson) a World Café Dialogue in San Francisco, USA (hereinafter, Patient Safety World Café). We welcomed approximately fifty people from North, Central, and South America to share their experiences, wisdom, and knowledge on how to improve patient safety and raise awareness about the devastating impact of medical errors. The participants of the Patient Safety World Café fell in one of the following categories: victims of a medical error as a patient or family member, clinicians who had partaken in a chain of events that led to a medical error, and/or patient advocates. The result of many of the medical errors discussed in the Patient Safety World Café had resulted in someone’s death. This event was sponsored by the World Health Organization (WHO) and the Pan American Health Organization (PAHO).

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The Patient Safety World Café participants were welcomed into a room with background music, snacks, round tables, and tablecloths. At the tables there were colored markers, different color post-it notes, and flip chart paper for participants to write notes summarizing the main points in the discussion and/or doodle. There were three rounds of conversations driven by questions, previously drafted, and every twenty minutes or so, music alerted the participants that it was time to relocate to another table with a newly formed group and share their ideas. The three questions that served as discussion starters in each successive round were: What is important to our group? What does the group need in order to be energized and feel engaged in these efforts? What conversations could create ripples and create new possibilities for engagement? After finalizing all three rounds, the facilitators led a group discussion to share as a group the patterns and themes that had emerged. Contrary to brainstorming, where the main goal is usually to generate solutions or strategies to solve a problem, through these questions our aim was to foster deep listening, enable a diverse group of people to connect with each other, and tap into their inner wisdom. A graphic artist captured the narratives that emerged in the conversations.

Within minutes, strangers were actively engaged in powerful conversations. They were sharing their intimate experiences, frustrations, fears, hopes, values, expectations, and feelings about death, dying, and living. These conversations not only served as a communication tool, they were creating experiences. You could feel the intensity of the synergy in the room. As I will further discuss in this article, the taboo topics of dying, medical errors, and the structural and cultural violence that surrounds dying patients, were unveiled. Contrary to ethics consultation which focuses on the care of an individual patient, these conversations addressed broader systemic challenges.

This article is an invitation to conflict practitioners to use dialogue processes, specifically World Café, to unveil unequal power structures during end-of-life care that allow for disparate treatment of minorities and to confront oppressive structures that prevent their end-of-life needs and wishes to be honored. This invitation is consistent with Mayer's (2004) call to have engagement professionals question normative assumptions of the field in order to deal more effectively with diversity and challenge hierarchical structures that favor the dominant culture. I argue that through dialogue processes, conflict practitioners can pose a challenge to oppressive power structures by educating those with power about the mutual benefit of altering relationships so that they can lead using "power with" and not "power over." Conflict practitioners need to expand their role in healthcare beyond the scope of

mediation, negotiation, and cross-cultural training (hereinafter, CCT) as a way to engage with end-of-life conflict.

I have chosen end-of-life care because it is a stage in which cultural beliefs, from patients and providers, are more palpable and prone to clash (Krakauer, Crenner & Fox, 2002). In addition, throughout the dying process, structural and cultural violence become ubiquitous. Moreover, death is a universal phenomenon and how we die is intrinsically related to how we live. I also focus the discussion on clinician/physician's role in end-of-life care to narrow the scope of this article. I begin by discussing end-of-life care disparities. I then discuss structural and cultural violence in end-of-life care and how it is institutionalized in ways that sustain end-of-life care disparity. I conclude by showing how CCT training has been ineffective in addressing disparate end-of-life care and that conflict engagement practitioners have the necessary skills to facilitate structural interventions in acute healthcare facilities that may rearrange power structures and lessen unequal end-of-life care.

Health Disparities and the Dying Patient

The manner in which dying patients continue to be invisible in many acute healthcare settings in the United States and are victims of healthcare inequalities is unconscionable. The dying patients in acute healthcare settings are either “minimized” or “swept beyond view into palliative care” because they do not fall within the norm of saving lives (Chapple, 2010, p. 27). Palliative care aims at alleviating pain and relieving symptoms. Since many physicians/clinicians see palliative care as inconsistent with saving lives, they have the misconception that this type of care should only take place once all rescuing attempts have been exhausted (Chapple, 2010). As I will illustrate in this article, worse than being a dying patient, is being a dying patient who is perceived by medical personnel as belonging to a “different” culture, race, or ethnicity. Evidence points to the fact that minority patients are not benefiting from the efforts that have been undertaken to improve end-of life care (Krakauer, et al., 2002). These “different” dying patients become unintelligible. In Butler's (2004) words, you are unintelligible

when the laws of culture and of language find you to be an impossibility [you have no] access to the human, [you] find that your language is hollow, that no recognition is forthcoming because the norms by which recognition takes place are not in your favor. (p.30)

There is bountiful empirical evidence that African Americans and other racial and ethnic minorities receive lower quality of healthcare than whites, even when taking into

account factors such as insurance status, age, income, and illness severity (Institute of Medicine of the National Academies (IOMNA), 2002; American Medical Association, 2009). This unequal treatment is also present in end-of-life care (Welch, Teno, & Mor, 2005). Many dying patients are subjected to unnecessary pain as a result of caregivers' lack of knowledge of available pharmacological interventions and ignorance as to other available palliative care (Institute of Medicine (IOM), 1997; Krakauer et al., 2002). Furthermore, cultural biases and fears about death are a contributing factor in healthcare professionals avoiding dying patients and their families (IOM, 1997). Additionally, minority patients' responses to physicians' biases and their own biases may result in higher levels of mistrust towards clinicians and healthcare institutions when compared with white patients (Dovidio & Fiske, 2012).

In an attempt to improve the communication skills of physicians with dying patients across cultures and reducing health care inequalities, cultural competence programs have flourished throughout the United States. Medical schools and residency programs in the United States are required to include in their curriculum CCT and education in end-of-life care (Chun, Yamada, Huh, Hew, & Tasaka, 2010; Sulmasy, Cimino, He, & Frishman, 2008; Graves, Like, Kelly, & Hohensee, 2007). Although research indicates that CCT has the potential for improving cross-cultural communication between physicians and patients, evidence linking minority healthcare disparities with lack of cultural competence is, at the most, meager (Stone, 2008; Yamada & Breckke, 2008).

Herein I argue that dying patients, in particular minorities, in acute care facilities are victims of larger social forces (e.g., poverty, racism, and discrimination) who are either ignored or marginalized during their last days. I maintain that in order to address healthcare inequalities in end-of-life care, it is imperative to address the power structures that allow for health disparities to take place (Farmer, 2010; Farmer, Nizeye, Stulac, & Keshavjee, 2006). Blaming physicians' lack of cultural competence for health disparities is at best, a cop-out strategy. Playing the blaming game provides a false sense of action and ignores the root causes of unequal distributions of power within the health care system. In many healthcare CCTs, culture has been reduced to a utilitarian variable, "a kind of quasi-analytical category used to explain variation in behavior" (Stephenson, 2001, p. 4). Minorities continue to suffer painful deaths in acute hospitals and their end-of-life care preferences are ignored because they are dying, immigrants, poor, non-white, and victims of racism; it is not because physicians lack cultural competency.

Structural Violence and Cultural Violence in End-of-Life Care

Minority patients dying in acute care facilities are rendered invisible and at best, are a marginalized group within the healthcare system who are victims of structural violence. Structural violence is a process by which social or institutional structures (e.g., legal, religious, political, economical) perpetuate unequal power distributions that prevent certain groups from fulfilling basic needs such as survival, wellbeing, identity, and freedom (Galtung, 1990). This type of violence is structural because it is ingrained in the political and economic systems that form our social world; violent because it is preventable and it injures members of the society, usually those that are more distressed or destitute (Farmer et al., 2006). The “underdogs” can be so disadvantaged in this relationship that they can die or be in a “permanent state of misery” (Galtung, 1990, p 293).

In the healthcare and legal systems, insurance companies, hospitals, and schools of medicine there are plentiful evidence of structural violence that are sources of healthcare disparities for minorities and interfere with providing adequate care to the dying patient (IOM, 1997; IOMNA, 2002). Examples include economic barriers due to inadequate healthcare insurance, social barriers that prevent equal access to care in comparison to whites, and underrepresentation of minority clinicians in medicine (Krakauer et al., 2002). These barriers have a direct impact on patients’ wellbeing and survival (Moseley & Kershaw, 2012). Several studies have shown that some physicians perceive black patients as less intelligent, less cooperative, less likely to comply with treatment plans, and more likely to engage in destructive behavior such as drug abuse when compared to white patients (Ryn & Burke, 2000; Sabin, Nosek, Greenwald, & Rivara, 2009; Weng & Korte, 2012). Physicians that hold these beliefs may be less likely to recommend certain treatments to blacks because they see it as “wasteful” (IOM, 1997, p. 173). These racial biases that lead to discrimination are often present at a subconscious level and are more prevalent when communicating with patients and families that are perceived to be from a different culture or race (Surbone, 2010, citing Sabin et al., 2009).

Many of these disparities are traced to historic patterns of segregation and discrimination that were legalized in the past and unfortunately continue to have a negative impact today (IOMNA, 2002). Segregation, oppression, and violence against blacks were institutionalized as a result, in part, of the American elite and the judicial system defining who is black by the one-drop rule (Davis, 2002). Anyone who had a “single drop of black blood” was considered black by definition and consequently inferior (Davis, 2002, p. 5). This

social construct was institutionalized with the help of legislation and judicial decisions such as *Plessy v. Ferguson* (1896) 163 US 537. This judicial decision endorsed segregation by taking judicial notice, “that a negro or black is any person with any black ancestry” and it was acceptable to be separate but equal (Davis, 2002, p. 8).

One of the many impacts of segregation in the United States is that there is a legacy of underrepresentation of minority healthcare providers (Welch et al., 2005; Merchant & Omary, 2010). Decisions such as *Plessy v. Ferguson* (1896) 163 US 537 and Jim Crow laws (U.S. laws that allowed for racial segregation prior to 1965) accentuated racial divides which resulted in the exclusion of minority physicians from medical education which historically has been largely limited to white, male, and upper class individuals (IOMNA, 2002). Throughout the 20th century, only 12% of North American physicians come from a working class background (Wear, 2003, p. 553). The mean income of the parents of medical students who enrolled in all the Association of American Medical Colleges for year 2000 was \$101,319 and the mean education level for fathers was a graduate degree and for mothers a college degree (Wear, 2003, p. 553, citing Association of American Medical Colleges, 2000). This tendency of medical students to come from a family in which both parents are highly educated and have a high socioeconomic background continued between 1992 and 2008 and is most noticeable among white students (Grbic, Garrison, & Jolly, 2010). In 2011 the percentage of minority students matriculated in medical schools (e.g., Asian (20.1%), Hispanic (8.5%), black (6.1%), and Native American, Alaskan, Hawaiian, and other Pacific Islander (0.1%)) continues to be extremely low when compared to white students (57.5%) (Association of American Medical Colleges, 2012, p.27).

Beyond the legal and medical ideology, the scientific community has also been instrumental in legitimizing and perpetuating discrimination towards minority groups by promoting theories such as eugenics that were used to wrongly justify the inferiority of minority groups (e.g., African Americans, poor, mentally retarded) (IOMNA, 2002). To this day, many blacks distrust medical institutions and white physicians as a result of a collective memory of oppression that springs from abuses such as the Tuskegee experiments by which black patients were untreated for syphilis decades after there was a cure in order to see the effects of the disease (Bloche, 2001; Welch et al., 2005).

Structural violence, in turn, is justified or legitimized by cultural violence to the extent that it becomes ubiquitous and yet, simultaneously, invisible (Farmer et al., 2006; Galtung, 1990). Cultural violence “makes direct and structural violence look, even feel right,

or at least not wrong” (Galtung, 1990, p. 291). Cultural violence is a mental process that operates by changing the moral value of an act from wrong to right or acceptable (Galtung, 1990). For example, black and other minority patients are usually administered less pain medication when compared to white patients (Krakauer et al., 2002; Pletcher, Kertesz, Kohn, & Gonzales, 2008). The question has been posed as to whether there is an unconscious belief that blacks have less sensitivity to pain, which was one of the many alleged features that justified the medical community to perform unconscionable experiments on them (Krakauer et al., 2002). This would make it “right” or “acceptable” to withhold pain medication. Another way in which cultural violence operates is by blurring reality so that a violent and/or unjust act becomes invisible or not so violent (Galtung, 1990). For example, providing futile healthcare or unwanted extraordinary measures to a patient that is dying has become an invisible violent act; alternatively, it is not seen as overly violent. Biotechnology has turned into an ideology and physicians feel *compelled* to exercise power over the patient and sustain life, in spite of the patient’s wish (Brodwin, 2000). Technology becomes a social imperative and is seen as necessary and not as a contingency; “what is contingent [...] is regarded as natural” (Brodwin, 2000, p. 214).

Cultural violence also takes place through language. Medical students learn how to communicate in very formalized, unambiguous, and precise terms with the purpose of selecting from the patient’s narrative “only the ‘important negatives’ that might cast doubt on a diagnosis, and not to mention a positive symptom or finding without following its implications further” (Sinclair, 1997, p. 213). In end-of-life conversations, the focus continues to be on specific interventions rather than long term implications (e.g., “Do you want an insulin drip?”) (Lamas & Rosenbaum, 2012, p. 1656). Although some medical schools are beginning to address this issue, medical students continue to focus on the problem at hand and thinking in terms of “what ifs?” is not encouraged (Dokken & Ahmann, 2006, p.175). The focus is on the present. For example, oncologists “deliberately ‘blur the horizon of the future’ and create for patients an experience of immediacy or living for the moment” (Johnson, Cook, Giacomini, & Willms, 2000, p. 281; Lamas & Rosenbaum, 2012). The mother of a premature baby who died in a pediatric intensive care unit describes the impact of the doctor’s discourse on her in the following way: For the most part in the critical care setting,

thinking tends to be short-term. We were never, and I say truly never, given enough information or enough of an opening to discuss a long term view of

Abby's situation. No clinician had the courage to give us a "what ifs?"[...] the approach impedes the notion of thinking about the longer-term consequences in any aspects of planning 'whether planning is going home or planning is starting to confront that your child might die. (Dokken & Ahmann. 2006, p. 175)

Acquiring scientific language, "although unsuited to dealing with internal mental events," (Sinclair, 1997, p. 321) is seen as a necessary evil that allows physicians to be objective and emotionally detached so that they can make proper clinical judgments (Robichaud, 2003; Sinclair, 1997). Patients that are categorized as "incurable" are not worth taking care of (Becker, Geer, Hughes, & Strauss, 1977, pp. 316-317; Chapple, 2010). Physicians learn to limit their conversations with patients and families to "technical matters" (Anspach & Beeson, 2001, p.122; Lamus & Rosenbaum, 2012). Recent studies have shown that in spite of incorporating end-of-life care into the medical school "formal curriculum," the "hidden curriculum" (including the trainee's observations and what they are taught in their medical rounds) is to be emotionally detached and depersonalize the patient during their end-of-life care (Billings, Engelberg, Curtis, Block, & Sullivan, 2010).

Structural and cultural violence are enabled and sustained by erasing and distorting the historical memory thereby allowing hegemonic accounts of "what happened and why" (Farmer, 2010, pp. 354-357). Therefore, it is not possible to have an honest dialogue about drug addiction among blacks without having a conversation about slavery, segregation, and discrimination in the United States (Farmer et al., 2006). As I will discuss later on, World Café is an appropriate process to facilitate authentic conversations about end-of-life that stimulate new ways of thinking and explore possibilities without ignoring the broader historic and current context in which healthcare disparities take place.

Cross-cultural Competency Training (CCT)

Culture has been extensively discussed in the academic literature across different disciplines and an in-depth discussion is beyond the scope of this article. However, since cultural differences are constantly (mis)used as "causes" of health disparity, I will provide a brief contextual discussion. When it comes to culture most scholars in the health care and conflict studies disciplines would agree that it is a set of behaviors, values, and customs that are common to a group of people and that they use to make meaning of the world they live in (e.g., Gregg & Saha, 2006; Mayer, 2012). Culture is about sense making. In his seminal work, Geertz (1973) describes culture as "webs of significance" that man has spun himself

“and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning” (p.5).

In the context of end-of-life care, culture shapes the manner in which patients, doctors, family members and those who participate in the decision-making process make sense of and experience death, life, and illness. Herein, I am adopting Kleinman’s (1988) definition of illness as opposed to disease: illness is how the sick person and those who comprise their social network experience and make sense of their symptoms; disease is the situation as seen through the lens of the physician and the biomedical model (e.g., hypertension, panic attack).

In healthcare, cultural competence is defined as “the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds; aspects of diversity include, but go beyond, race, ethnicity, gender, sexual orientation, and country of origin” (Betancourt & Green, 2010, p. 583). After examining the definition of culture, it is perplexing that CCT has focused on categories, such as race and ethnicity, to increase cultural competence and reduce health care inequalities. It raises the question, if culture is about making sense and finding meaning, why is the focus of CCT on boilerplate categories? How do these trainings reduce healthcare inequalities for the dying patient?

Since the late 1970s many universities began to offer as part of their medical education CCT to teach students about the health beliefs and practices of ethnic populations; examples include the University of California at Davis and the Harvard Medical School (Good, James, Good, & Becker, 2002). However, these trainings rarely focus on the socialization of physicians or how it may contribute to the institutionalization of racism in the practice of medicine (Good et al., 2002). Cross-cultural competency trainings in medicine usually focus on attitudes, knowledge, and skills (IOMNA, 2002). The main focus in attitude training is to increase provider awareness on how patient’s social and cultural background impacts health care decisions (IOMNA, 2002). This approach encourages self-reflection, which includes understanding one’s culture and biases (IOMNA, 2002). However, these trainings usually are not effective in addressing the implicit biases that physicians hold. For example, a recent study found that physicians show implicit (i.e., non-conscious beliefs not apparent to the individual) reference for white Americans when compared to black Americans (Sabin et al., 2009). The second approach, usually referred to as an etic approach, is to focus on teaching providers the attitudes and beliefs of certain cultural groups (e.g.,

“patients of culture x believe...and behave...” (IOMNA, 2002, p. 206). The third approach is to focus on developing tools and skills that improve the providers’ communication skills and to apply an inductive framework that “focuses on the patient, rather than theory, as the starting point for discovery” (IOMNA, 2002, p. 206-207).

The increased interest in trying to improve physicians’ cultural competency has certainly raised awareness of the need to be culturally sensitive. However, there is still much room for improvement. For example, although I do not deny the potential heuristic value of taking an etic approach to CCT, one that privileges the outsider’s point of view and focuses on isolating specific component of cultural groups, it tends to oversimplify the human cultural matrix and encourage stereotypes (Morris, Leung, Ames, & Lickel, 1999). The focus on attempting to configure universal categories of cultural behavior has unintentionally ignored the synergistic interaction that takes place among different cultures and the fact that cultures are dynamic.

A recent literature review reflects that most studies measure cultural influence through racial or ethnic group membership that is “at best, a proxy for culture” (Kwack & Haley, 2005, p. 640). Furthermore, there is an inherent challenge in trying to reduce healthcare disparities by minimizing discrimination on the basis of race and ethnicity. That is, “in order to minimize discrimination on the basis of difference between people, differences must be systematically and authoritatively monitored, recorded and hence re-emphasized” (Banks, 1999, pp. 74-75). By subsuming race under culture, racism is redefined as a “cultural difference” which makes it easier to ignore racism, privilege, and power relations such as dominance/subordination (Beagan, 2003; Gregg & Saha, 2006). Framing CCT as learning how the “other” non-dominant group behaves and what their beliefs are has tendencies that may lead the learner to see them as inferior, exotic, or aberrant (Wear, 2003). This erroneously assumes that “normal” is an objective and color blind standard that does not reflect the cultural values of the dominant medical culture.

Taking an etic approach to culture allows for the hard questions to remain unanswered: What are the structural and systemic changes that need to take place so that dying patients are no longer oppressed and ignored? How does occupying a space of white privilege impact end-of-life care for minorities? How do we address in CCTs the unequal power relationships and structural forces that have been sustaining health care inequality in the United States for centuries?

Even more worrisome is the fact that most of the approaches to teach cultural competency ignore the relationship between cultural differences and inequities; by focusing on individual attitudes they ignore the source of inequality by keeping the “focus off structures, institutions, and governmental policies” (Wear, 2003, p. 551). In short, power differentials are ignored. As Kritek (2002) has pointed out “if you take the time to evaluate an uneven table, you can usually find what is missing—what dimensions of the conflict are being treated as if they simply did not exist” (p. 274). I posit that dialogue processes, such as World Café, are better equipped to unveil these unequal power structures. These invisible power structures become visible in World Cafés through deep listening and conversations about dying that take place among a diverse group of people (diversity in professional backgrounds and cultures). Once participants’ “blindfolds” are lifted they can name the injustices and address them. The structural inequities that lead to unequal treatment are so complex that they must be addressed through “deliberative and collaborative actions” from diverse sectors (Beadle, 2011, p. S17). The World Café is an excellent process for these deliberative and collaborative actions to take place.

Beyond Bioethics Mediation: World Café

When it comes to end-of-life conflict, conflict practitioners have limited their interventions, for the most part, to bioethics mediation. Bioethics mediation addresses conflicts that arise in a clinical healthcare context regarding the “proper” or “appropriate” plan regarding future goals of care (Bergman, 2013; Dubler, 2011). The main exponents and pioneers of bioethics mediation are Nancy N. Dubler and Carol B. Liebman (2004, 2011). Their model, which started in the 1990’s at Montefiore Medical Center in the Bronx, is based on a problem-solving mediation style and is framed within a principle-based approach or principlism.

A principled-based-approach to mediation visualizes principles as the essence of moral reasoning and has been the dominant discourse in Western bioethics for the last forty years (Beauchamp & Childress, 2001; McCarthy, 2003). In the context of bioethics mediation, “a principled resolution is a consensus that identifies a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts, and that facilitates a clear plan for future intervention” (Dubler & Liebman, 2004, p, 14). Within the bioethics mediation model as applied by Dubler and Liebman (2004) the four ethical principles are patient autonomy, beneficence, nonmaleficence, and distributive justice. Patient autonomy is the center of the decision

making process and what this means is that priority should be given the patient's values and wishes, and their choices must be supported (Dubler & Liebman, 2004). The principle of beneficence "underlies obligations to provide the best care for the patient and balance the risks or burdens of care against the benefits" (Dubler & Liebman, 2004, p. 37). Non-maleficence requires that the benefits of treatment outweigh the possible harm and the patient should not be harmed (Dubler & Liebman, 2004). Finally, distributive justice is defined as providing to each individual what is due or owed, "what is fair" (Dubler & Liebman, 2004, p. 37).

The role of a bioethics mediator is to remain neutral while equally empowering all of the participants to engage in problem-solving within the limits of the accepted dominant medical norm, as delineated by the four ethical principles listed above. Neutrality, in the context of bioethics mediation, is usually defined as not having a stake in the outcome and not favoring any side (Gibson, 1999; Marcus, Dorn, & McNulty, 2011), and not taking a stand as to the legitimacy of a moral position (Fiester, 2012). The mediator remains neutral as to the participants' final agreement, but is not neutral when it comes to how the process is managed; the mediator is an advocate of the process not the participants (Dubler & Liebman, 2011; Fiester, 2012).

I am not implying that bioethics mediators using a problem-solving methodology and principled-based approach are ignoring the end-of-life goals of minority patients and their cultural values by privileging the dominant medical culture. Dubler (2005) has argued, and I agree, that while bioethical analysis usually privileges the "dominant medical culture," the mediation process may deal better with addressing cultural differences than non-facilitated discussions (p. S24). The mediation setting provides a space in which the voices of disempowered groups can be amplified and diverse cultural values are honored (Dubler & Liebman, 2011). Nevertheless, there are serious limitations in the bioethics mediation model in terms of addressing structural and cultural violence. For example, during a bioethics mediation session, if agreement is not reached, the dominant medical, legal, and ethical culture will be imposed (Dubler & Liebman, 2011).

I submit that conflict practitioners should take a more active role in addressing healthcare inequalities within healthcare institutions through other processes such as World Café conversations. In other words, what would happen if conflict practitioners move beyond their traditional "neutral" and problem-solving approaches? What if conflict practitioners were willing to use dialogue processes to raise awareness regarding unequal power structures

that negatively impacts end-of-life care within acute hospitals? “The problem-solving mindset can be adequate for technical problems. But it can be woefully inadequate for complex human systems where problems often arise from unquestioned assumptions and deeply habitual ways of acting” (Senge, Scharmer, Jaworski, & Flowers, 2005, pp. 51-52). Structural and cultural violence persist when erroneous assumptions remain unquestioned and become accepted ways of acting. Therefore, taking a problem-solving approach to surface and identify structural and cultural violence is ineffective in altering an unjust *status quo*.

Conflict practitioners can provide an important service by unveiling power structures that are an obstacle for patients to have their end-of-life wishes honored. This can happen through dialogue processes that raise awareness about the importance of discussing end-of-life goals of care, explore the social forces that operate in healthcare institutions that are oppressive to dying patients, and empower clinicians and patients to alter unequal social structures. Awareness of these social forces and the skills to change the power structures are very rarely taught to clinicians (Farmer, et al., 2006). However, there is some evidence that it is possible to address structural violence in healthcare, by way of structural interventions without the need of tackling more complex issues such as eliminating racism or a lack of national insurance (Farmer, et al., 2006). For example, a group of researchers and clinicians in Baltimore were able to reduce significantly the racial, gender, and socioeconomic disparities in HIV treatment within the group being studied by posing the following question: “what would happen if race and insurance status no longer determined who had access to standard of care?” (Farmer et al., 2006, p.1688). Exploring the answer to this question allowed clinicians to address issues of structural violence by first being able to “see” these injustices as they surface throughout the conversation and subsequently removing obvious economic barriers such as transportation costs, providing community-based care that allowed for better access, and educating the community to decrease stigma against patients with AIDS (Farmer et al., 2006).

The World Café is a conversational process that surfaces deeper assumptions and network patterns through which people can have intimate exchanges, discover shared meaning, engage in disciplined inquiries, cross-pollinate ideas, and think about what is possible (Brown & Isaacs, 2005; Brown, Homer, & Isaacs, 2007). The emphasis is on collective understanding and not problem-solving. In a World Café several small round tables that sit four to five participants are placed in a welcoming space and in each table they explore questions that matter to them (Brown et al., 2007). Questions are discussed in

iterative rounds of conversations, usually no more than three, with each round lasting between twenty to thirty minutes (Brown & Isaacs, 2005). After the first round of conversation, participants are invited to move to another table and share their ideas with the newly-formed group (Brown et al., 2007). Usually one participant stays at the table and serves as a “host” to the new group and shares with the new participants the highlights of the earlier conversation (Brown & Isaacs, 2005). After several rounds of conversations the whole group engages in mutual reflection and a conversation to identify patterns, discuss what they have discovered, and share ideas that are meaningful to them (Brown & Isaacs, 2005). The collective knowledge is made visible by writing or drawing the ideas that surfaced throughout the process (Brown & Isaacs, 2005). These ideas, as explained later on, may lead to action.

The World Café approach entails a dialogue process which is built on the assumption that people already possess the wisdom and creativity to engage challenges and also, the following seven core principles: 1) clarify purpose and parameters; 2) focus on questions that encourage collaborative participation; 3) encourage full participation; 4) cross-pollinate and connect diverse perspectives; 5) listen together for patterns, insights and deeper questions; 6) share collective knowledge; and 7) create a hospitable space (Tan & Brown, 2005).

World Café is a deceptively simple process (Prewitt, 2011). Its simplicity and lack of emphasis on problem-solving is what makes it such a powerful process in surfacing implicit beliefs and social forces such as those that perpetuate unequal treatment during end-of-life care. World Café theory and practice is partly informed by Bohm’s (1996) approach to dialogue (as cited in Prewitt, 2011). Bohm (1996) posits that in order to think in new ways, society’s tacit infrastructure (e.g., assumptions, attitudes and beliefs that are rigidly and unconsciously held) need to be unearthed and understood through a dialogic process that requires the suspension of assumptions and values (as cited in Nichol, 2003). Bringing these assumptions to light and reflecting upon them could reveal “blind spots” that allow participants of the dialogue process to achieve greater collective understanding and learning (Prewitt, 2011, p. 191, as cited in Atlee, 2009; Hansen, 2008). When participants act based on this collective understanding and learning one can see the tangible results of the World Café conversations (Brown, 2001).

Participants of the initial small group conversations share their new ideas with other groups and this creates the possibility of large-scale institutional and societal change (Brown, 2001; Brown et al., 2007). For example, World Café dialogue may raise awareness of how the system operates and raise consciousness about the need for institutional change. At the

individual level patients and clinicians may modify their behavior if they “see” the connection between their behavior and health inequalities; at the community level, awareness may lead to groups organizing and pushing for changes in public policies that maintain oppressive structures (Benz, Espinosa, Welsh, & Fontes, 2011). Participants in World Café dialogues have described the process, not as “an activism *against* the authority structure but *for* the world we want” (Tan & Brown, 2005, p. 89). World Café conversations serve as a conduit to minimize the distance inherent in unequal power relationships and serves as a bridge between the past and the future (Tan & Brown, 2005).

Stepping away from a neutral stance and hosting World Café conversations through a critical theory framework could transform the taken-for-granted inequities that take place in end-of-life care. Hansen (2008) makes a compelling argument as to how conflict practitioners who wish to address social justice issues would benefit from incorporating into their practice an analysis of power and how to assist clients in overcoming structural and cultural violence. In the Patient Safety World Café, some of the unequal power relationships that participants identified as being important to them were the following: justice, equity, and addressing power imbalances; address political barriers such as corruption and fear of retaliation; the need for meaningful dialogue between patients and healthcare professionals; and challenge conventional authority in healthcare. By facilitating a discussion of these themes, participants shared their collective wisdom as to how to address these social justice concerns, and more importantly they began building networks and relationships.

Facilitating World Café conversations with physicians, healthcare clinicians, patients, family of patients, policy makers, and administrators could be valuable in unveiling end-of-life structural and cultural violence to the extent that it allows participants to: 1) discover and reframe unconscious biases; 2) share new meanings and knowledge through collective discoveries; 3) build relationships and networks; 4) develop attitudes that stimulate innovative thinking 5) engage in self-reflection; 6) cultivate collective intelligence; 7) identify and analyze the causes and effects of unequal distributions of power in healthcare; and 8) explore in-depth some of the key challenges and opportunities in end-of-life care. Brown and Isaacs (2005) invite us to see conversation *as* action because, based on their experiences with World Cafés, when participants are having conversations about issues that they care about they want to organize and take further action. In the Patient Safety World Café, one of the themes that emerged was, “transform pain and hurt into action.” Participants in the Patient Safety World Café drafted a joint statement pledging to fight medical errors and

developed strategies to advance their cause. Some of the strategies discussed were to identify power figures and organizations to share their statement with, identify media connections, create a listserv/clearing house, and connect with other organizations. Conversation, led to action.

Conclusion

In spite of the many initiatives that have been initiated in the last decades directed at eliminating end-of-life care inequalities; these disparities continue to be prevalent in healthcare institutions in the United States. Conflict practitioners have not fully inserted themselves, nor are they usually invited, to these conversations due, in part, to a narrow approach to conflict that hinders the capacity to step out of a position of neutrality and use their skills and processes to challenge the *status quo* and unequal power relationships. For the most part, conflict practitioners are partaking in end-of-life conflict as a third party “neutral” through bioethics mediation whose role is to remain impartial and try to assist people in reaching a mutually agreeable solution to their problem or serving as trainers in CCTs. These approaches have made some progress in raising awareness, improving clinicians’ attitudes towards minorities, and increasing cultural competence. However, they have been less successful in addressing cultural and structural violence, reducing healthcare disparities, or improving healthcare outcomes (Betancourt & Greene, 2010; Rabinovich-Einy, 2011).

Nearly a decade ago, Mayer (2004) invited conflict professionals to challenge their assumptions of neutrality and expand their role in helping people engage with conflict. Most recently, Hansen (2008) has also argued in favor of conflict practitioners taking “atypical” roles and serve as advocates, advisors, or any other role that allows marginalized individuals to challenge oppressive structures through constructive dialogue. These “atypical” roles, are more common among peacebuilding practitioners, but are less common among conflict practitioners. Being a third party neutral is still seen by conflict practitioners as a core part of their identity. Conflict practitioners continue to identify themselves by the role they have in a conflict as opposed to focusing on the purpose of the intervention (Mayer, 2012). As I have discussed in this article, hosting World Café conversations could be an excellent process for unveiling unequal power structures in end-of-life care. If conflict practitioners “let go” of their illusion of neutrality they could make significant contributions to reducing end-of-life care inequalities.

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