


12-1-2005

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Recommended Citation

Alisa L. Geller, *In the Aftermath of the Terri Schiavo Case: Resolving End-of-Life Disputes Through Alternative Dispute Resolution*, 6 Pepp. Disp. Resol. L.J. Iss. 1 (2005)

Available at: <https://digitalcommons.pepperdine.edu/drlj/vol6/iss1/2>

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In the Aftermath of the Terri Schiavo Case: Resolving End-of-Life Disputes Through Alternative Dispute Resolution

Alisa L. Geller¹

Imagine yourself the proud parent of an adult daughter. You have spent many years nurturing your precious child so that she may excel in the world. Just as all of your dreams for her are coming true, the news no parent wants to hear was delivered. Your daughter lost control of her car, the vehicle overturned and she was found lying face down in a ditch.² You gasped. You expected the worst. A tragic end to a life yet lived. Then, the good news was delivered. You breathed a sigh of relief. You learned she survived. She was in a coma, but nonetheless, she survived.

Although she remained in a coma for three weeks, her condition eventually progressed to an unconscious state where she was able to orally ingest nutrition.³ In order to further recovery, a gastrostomy feeding and hydration tube was implanted by surgeons.⁴ Despite hopes for a recovery, these rehabilitative efforts proved unavailing and she currently remains in a persistent vegetative state.⁵

1. Alisa L. Geller graduated from California Western School of Law in December 2005. Prior to pursuing a Juris Doctorate, Ms. Geller graduated from Rutgers University in New Jersey. Much gratitude is extended to Christopher Sun, Lead Articles Editor, and the staff of the Pepperdine Dispute Resolution Law Journal for guidance provided in connection with this work. Additionally, the unending support and encouragement of Phyllis and Toby Geller, Jeremy Geller and Katey Cohen are acknowledged and deeply appreciated. Lastly, this article is dedicated to the memory of Terri Schiavo whose life and death has had and will continue to have a profound impact upon society.

2. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). This statement of the case paraphrases the Court's summary. *Id.* at 266-67. This introduction was inspired by Amy Zelaya, *Cruzan v. Director, Missouri Department of Health*, 14 J. CONTEMP. LEGAL ISSUES 313 (2004).

3. *See Cruzan*, 497 U.S. at 266.

4. *Id.*

5. *Id.* "'Persistent vegetative state' is a diagnostic term of art developed by the American Academy of Neurology: The vegetative state is a clinical condition of complete unawareness of the

Now the good news of her survival seems bittersweet. An end-of-life decision, for your daughter, your flesh and blood, is now in your hands. What should be done? Who should decide?

I. INTRODUCTION

This article will discuss the complicated and emotional choice family members are faced with regarding end-of-life decisions for an incompetent relative in the absence of a living will. Since the decision to sustain or terminate the life of a loved one is a personal judgment, conflict will often arise. Most parties turn to formal litigation for resolution. However this paper will show the courts have a split opinion as to how the law dictates the appropriate ruling on these cases.⁶ Litigation of these matters is an option but is not optimal since emotions are factored out of the decision. Alternative dispute resolution (ADR) may be a better option since it encourages a candid discussion of emotions, perceptions, interests, goals, and values.⁷ A “multi-modal” format of ADR is proposed to resolve emotional barriers so a satisfactory resolution may be reached.⁸ This article also proposes that should a decision not be achieved through ADR, litigation remains available.⁹ However it is the hope that by reducing the emotional conflict through ADR, any litigation that occurs in the aftermath will be significantly shorter and less bitter. This seeks to serve an important purpose, maintaining an intact family unit which an incompetent patient will one day leave behind.

self and the environment . . . with either complete or partial preservation of the hypothalamic and brain-stem autonomic functions. O. Carter Snead, *Dynamic Complementarity: Terri's Law and Separation of Powers Principles in the End-of-Life Context*, 57 FLA. L. REV. 53, 56 (2005).

6. See generally, I. Glenn Cohen, *Negotiating Death: ADR and End of Life Decision-Making*, 9 HARV. NEGOT. L. REV. 253 (2004) (discussing how alternative dispute resolution can improve on the resolution of end-of-life treatment disputes).

7. See Charity Scott, *Mediating Life and Death*, DISP. RESOL. MAG., Fall 2004, at 23 (book review).

8. See I. Glenn Cohen, *Negotiating in the Shadow of Death*, DISP. RESOL. MAG., Fall 2004, at 12, 13 [hereinafter *Shadow of Death*].

9. See Cohen, *supra* note 6, at 329.

II. HISTORICAL PRECEDENT FOR END-OF-LIFE DECISIONS

Litigation is an adversarial process designed to uncover facts and determine conclusions based strictly on the law.¹⁰ End-of-life decision cases do not easily adhere to the rigidity of the court system, since issues of death and dying are complex, emotional and require value judgments which courts are unwilling to make. The complicated nature of these cases cause a split in the courts' opinions regarding end-of-life decisions. Therefore, end-of-life decisions and the American law vacillate between two extremes.¹¹ As exhibited in numerous court decisions, courts' waiver between the recognition of patient autonomy and self-determination on the one hand, and court over-involvement on the other.¹²

A. *The Courts Permit Patient Autonomy and Self-Determination*

Allowing patient autonomy and self-determination stem from the courts' desire to not interfere with the dying.¹³ By abstaining from the decision-making process the courts exhibit hesitation to apply legal principles to such a highly personalized and emotional decision.¹⁴ The first case in which the United States Supreme Court recognized patient autonomy and self-determination was *Roe v. Wade*.¹⁵ A chain reaction of cases followed which sought judicial recognition of the right to die and the right to refuse treatment.¹⁶ In the case of *In re Karen Quinlan*,¹⁷ the New Jersey Supreme

10. See Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329 (1999).

11. See *Negotiating in the Shadow of Death*, *supra* note 8, at 12.

12. See *id.*

13. See *id.*

14. See Hafemeister, *supra* note 10.

15. See *Roe v. Wade*, 410 U.S. 113 (1973). *Roe v. Wade* was decided by the United States Supreme Court in 1973. See *id.* The Court held that the Texas criminal abortion statutes prohibiting abortions at any stage of pregnancy except to save the life of the mother were unconstitutional. See *id.* at 166. The Court held that abortion should be regulated according to the attending doctor's assessment and the maternal health. See *id.* at 165. Despite these slight restrictions, this decision defended a woman's right to privacy and autonomy regarding her reproductive choices. See *id.* at 153-54.

16. See generally *Shadow of Death*, *supra* note 8, at 12.

17. See *In re Karen Quinlan*, 355 A.2d 647 (1976). In 1975, Karen Quinlan fell into an irreversible coma and Quinlan's parents asked the court to allow them to disconnect the respirator that was sustaining her life. See *id.* at 651. Contrary to her parents' wishes, the medical doctor was opposed to complying with the request for termination. See *id.* The doctor was guided in his

Court used a hands-off approach by deferring the decision to family members for a patient in a persistent vegetative state and recognizing the right to terminate methods used to artificially prolong life.¹⁸

B. *The Court Maintains Control Through Over-Involvement*

A classic example of over-involvement is established in the United States Supreme Court decision, *Cruzan v. Director, Missouri Department of Health*, which reflected the Court's attempt to impose legal opinion in end-of-life disputes.¹⁹ The Court's decision in *Cruzan* upheld a Missouri statute prohibiting the withdrawal of treatment for an incompetent patient unless there was clear and convincing evidence that it was what the patient would have wanted.²⁰ The Court relied heavily on evidentiary standards for evaluating facts in a neutral manner.²¹ This shows a strong preference for formal adjudication thereby maintaining the view point that the Court is the best arena to settle an incompetent patient's disputes.²²

C. *On the Road to ADR*

The litigation route promises a high degree of uncertainty since end-of-life decisions are determined through attempts to apply legal principles to facts in a neutral manner.²³ Developing a legally-based and consistent precedent will be very difficult as indicated by the varying opinions of whether to allow or deny the right to die. Additionally, the formal litigation approach is problematic in the context of making end-of-life decisions because, "feelings are at the heart of what's going on" and courts fail to recognize the underlying emotions which will likely yield unsatisfying outcomes.²⁴ Therefore, resolving end-of-life disputes through litigation is an option but is not optimal.

decision by the Hippocratic Oath, which states that a doctor should only adopt treatment for the benefit of the patient. PETER G. FILENE, *IN THE ARMS OF OTHERS* 20 (1998).

18. See *In re Karen Quinlan*, 355 A.2d 647 (1976).

19. See *Cruzan*, 497 U.S. at 261; See also *Shadow of Death*, *supra* note 8, at 12.

20. See *Cruzan*, 497 U.S. at 282.

21. See *id.*

22. See Cohen, *supra* note 6, at 266.

23. See *id.* at 283.

24. *Id.* at 299-300.

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D. Implementing a Model of ADR in End-of-Life Decisions

ADR accomplishes the resolution of differences outside of a courtroom setting through methods which include negotiation and mediation. The ADR framework encourages the expression of emotions and engenders an atmosphere where the parties feel heard and acknowledged.²⁵ Utilizing any single approach to address an end-of-life decision which is rife with conflict, complexity, and emotion may not alone resolve the dispute.²⁶ However, it is suggested that if a “multi-modal” form of ADR is employed, at the very least, diffusion of the emotional issues will occur and the likelihood of success is increased.²⁷

Prior to setting forth the “multi-modal” form of ADR, it is vital to discuss the objections and reservations of critics to the implementation of the ADR-based model in the end-of-life decision making process. Additionally, the benefits of an ADR model over formal litigation will be analyzed.

IV. OBJECTIONS AND RESERVATIONS REGARDING THE USE OF ADR IN THE END-OF-LIFE DECISION-MAKING PROCESS

A. Is the Use of ADR Appropriate in the Context of End-of-Life Decisions?

Critics maintain reservations as to when, if ever, the use of ADR is appropriate in the context of end-of-life decision-making. This contention is backed by the question of whether end-of-life decisions are amenable to compromise, since the only possible solutions appear to be in extreme opposition: sustaining or terminating life.²⁸ Critics are unable to understand how a resolution may be reached when there are only two obvious options. It is the rigidity of critics’ viewpoints which stifles the exploration of the creative solutions that an ADR-based model seeks to achieve.

Supporters of the ADR-based model acknowledge that extremely divergent views are “often fueled by different perceptions of the medical facts, the prognosis, different interpretations of patient behavior, and

25. See *id.* at 300.

26. See Bryan A. Liang, *Understanding and Applying Alternative Dispute Resolution Methods in Modern Medical Conflicts*, 19 J. LEGAL MED. 397, 412 (1998).

27. See *Shadow of Death*, *supra* note 8, at 13.

28. See Cohen, *supra* note 6, at 271.

different personal value[s].”²⁹ ADR embraces openly sharing perceptions, and the willingness to listen to the interests, goals, and values of the opposition. Additionally, parties who choose to attempt resolution through ADR must enter voluntarily and with good faith intentions.³⁰ To rebut the critics’ concern, it is the combination of these factors which promises to facilitate compromise between these seemingly opposite viewpoints.

B. *Is Due Process Threatened Through the Use of ADR?*

Critics also maintain that “ADR in this context poses significant risks . . . because an ADR model strips away due process protection [and] it threatens to bully patients [or a patient’s decision maker] into forfeiting their rights in a way the adjudicatory model may not.”³¹ In end-of-life decisions it is not uncommon for a lay person, representing an incompetent patient, to enter into a dispute with experts from a hospital.³² Critics worry that the hospital healthcare professionals have a lot of authority and may unduly influence a lay person’s decision to either sustain or terminate life.³³

Supporters of the use of ADR propose that the threat of undermining due process can be eliminated through suggested safeguards set forth by the Joint National Commission on Health Care Alternative Dispute Resolution.³⁴ The principles established by this Commission require a fundamentally fair process and access to information regarding the ADR program.³⁵ There must also be a knowing and voluntary agreement to use ADR for resolution.³⁶ The party who administers the ADR program must be neutral, competent and qualified.³⁷ The Commission also sets forth the right to representation by an attorney or spokesperson.³⁸ These parameters require neutrality and regulation to ensure a fair process and seek to protect parties choosing to use ADR.³⁹ Additionally, allowing the representation of

29. Nancy Neveloff Dubler, *Heroic Care Case: When Difficult Decisions About Care are Near, Mediation Can Help Bridge the Communications Gap*, DISP. RESOL. MAG., Spring 1999 at 7.

30. See Roderick B. Matthews, *New Protocols Seek to Assure Consumers a Fair Process in the Resolution of Disputes in the Health Care Industry*, DISP. RESOL. MAG., Spring 1999, at 14, 15.

31. Cohen, *supra* note 6, at 309.

32. See THOMAS L. HAFEMEISTER & PAULA L. HANNAFORD, RESOLVING DISPUTES OVER LIFE-SUSTAINING TREATMENT: A HEALTH CARE PROVIDER’S GUIDE 21-26 (National Center for State Courts 1996).

33. *See id.*

34. *See* Matthews, *supra* note 30, at 15.

35. *See id.*

36. *See id.*

37. *See id.*

38. *See id.*

39. *See* Matthews, *supra* note 30, at 15.

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an attorney during ADR eliminates critics' concern that parties will be coerced into decisions.⁴⁰

C. *Is ADR Appropriate When There is a Conflicting Medical Diagnosis?*

ADR is most typically used as a means to resolve an end-of-life dispute when there is a consensus as to the diagnosis among health care providers and the dispute to be resolved exists between the family and the health care providers.⁴¹ The dispute that fuels these cases is the difference in level of knowledge and expertise between the family and the physicians.⁴² Therefore, physicians and family members often struggle to "reconcile differing visions, conflicting values and changing expectations as they make difficult and complex choices about . . . how aggressively to treat seriously ill patients."⁴³ ADR can successfully facilitate a discussion addressing these physician-patient differences and achieve a mutually satisfactory resolution.

However, using an ADR-based model may not always be appropriate when an end-of-life dispute involves a conflicting medical diagnosis between medical professionals. Varying explanations exist as to why a conflicting medical diagnosis may exist. First, a dispute may arise over the meaning of monitored patient data.⁴⁴ Second, these disputes may involve a "differential diagnosis" . . . [which] implies the possibility of multiple explanations for certain conditions."⁴⁵ In both of these scenarios, where a conflicting medical diagnosis has been identified, resolution can be achieved if the medical professionals meet as colleagues to discuss and resolve these differences or medical discrepancies.⁴⁶ A conflicting medical diagnosis may

40. *See id.*

41. Nancy Neveloff Dubler & Carol B. Liebman, *Bioethics: Mediating Conflict in the Hospital Environment*, 59 DISP. RESOL. J. 32, 33 (2003).

42. *See id.*

43. *Id.*

44. *See Using Mediation for Bioethical Dilemmas*, Alternatives to the High Cost of Litigation, Dec. 1995, at 159.

45. Scott, *supra* note 7, at 24.

46. The medical discussion would occur in a private caucus setting with only medical professionals and the neutral party present. *See Using Mediation for Bioethical Dilemmas*, *supra* note 44, at 159-60. This method of having an initial private caucus meeting among medical professionals was developed through the work at Montefiore Medical Center in Bronx, N.Y. *Id.* A main reason medical discussions should happen apart from other participants to the mediation is two-fold. *Id.* First medical professionals use technical jargon which is confusing for the lay person. *Id.* Second, medical professionals have a tendency to discuss a patient's diagnosis and prognosis in a brutally honest manner which would be inappropriate for the family involved in the dispute to

be overcome for purposes of ADR if all the medical opinions are directed to the same ultimate prognosis or outcome, whether it be life or death. They diverge only as to discrepancies involving the cause of the condition or other minor variables. The disagreements between medical professionals as to whether the patient has hope for life or no hope where death is imminent must be resolved in order to proceed successfully with an ADR-based model. This resolution must be achieved independent of intimidation and coercion and should also respect the integrity of the medical professionals involved.⁴⁷ If the conflicting medical diagnosis between medical professionals is not resolved, using an ADR-based model is inappropriate.

V. THE BENEFITS OF USING ADR OVER LITIGATION IN END-OF-LIFE DECISIONS

After examining the benefits of using a method of ADR in end-of-life decisions, resorting to formal litigation for resolution of these matters should occur only after all other methods are exhausted. First, the use of ADR could result in a quicker resolution.⁴⁸ Second, ADR allows for medical professionals to confer as to expert opinions. Third, ADR is able to consider and determine the resolution on the basis of value judgments which courts are reluctant to do.⁴⁹ Fourth, patient and family member autonomy is increased.⁵⁰ Lastly, ADR enables an emotional resolution by facilitating the grieving process.⁵¹

A. *The Use of ADR Expedites a Resolution*

Due to the time sensitive nature of end-of-life decisions, the resolution needs to be expedient.⁵² The importance of a timely resolution in the health care context influenced the Joint National Commission on Health Care and Alternative Dispute Resolution to establish protocol guidelines stating “ADR proceedings should occur within a reasonable time, and without undue delay.”⁵³ These protocol guidelines also include the following

hear. *Id.* Therefore, these initial meetings are important to discuss any conflict so that a relatively clear picture of the patient’s condition can be presented to the family. *Id.*

47. *See id.* at 159.

48. *See* Cohen, *supra* note 6, at 284.

49. *See id.* at 287.

50. *See id.* at 284 (stating that one of the benefits of ADR in the end-of-life decision-making process is the increase of patient autonomy).

51. *See id.* at 293-94.

52. *See id.* at 284.

53. Matthews, *supra* note 30, at 15.

recommended time frames for resolving disputes: “acute emergencies - 24 hours; emergencies - 72 hours; non-emergencies - 60 days.”⁵⁴ Additionally, ADR offers flexibility in the informality of the process.⁵⁵ This is advantageous in an emergency when time is of the essence, since a resolution can be reached quickly.⁵⁶ Contrary to this, litigation is a long and formal process.⁵⁷ An extreme drawback to litigation is the difficulty of exhausting legal options in the small timeframe allotted in emergency situations.⁵⁸ Especially in the context of end-of-life decisions, it is possible that while courts are contemplating whether to sustain or terminate life, the end-of-life decision becomes a moot point through natural means.⁵⁹

B. Medical Professionals Confer as Colleagues in an ADR Format

A formal adjudicatory proceeding is adversarial in nature. In this regard, both the plaintiff and defendant would consult medical professionals whose opinions support their perspective of the case.⁶⁰ Testimony bolstering their vantage point is elicited from the medical expert creating polarization between the plaintiff and the defendant.⁶¹ Therefore, in a formal adjudicatory proceeding, the medical experts consulted would not have had an opportunity to confer with each other because they become adversarial experts. ADR however would allow opportunities for the physicians to meet as colleagues to debate and analyze their findings with the purpose of reaching a medical consensus.⁶²

C. Value Laden Judgments are Permissible in an ADR Method

At the core of any end-of-life decision are personal values and emotions.⁶³ Decision makers turn to religion, sociological influences, ethical

54. *Id.*

55. *See* Cohen, *supra* note 6, at 284.

56. *See id.* at 285. As Cohen states, a benefit of the flexibility of the ADR model raises concern about upholding Due Process. *Id.* *See also supra* Part IV.B.

57. *See* Cohen, *supra* note 6, at 284.

58. *See id.*

59. *See id.*

60. *See* FED. R. EVID. 702 (defining an expert to be anyone “qualified as an expert by knowledge, skill, experience, training or education.”).

61. *See* THOMAS A. MAUET, TRIAL TECHNIQUES 309 (6th ed. 2002).

62. *See Using Mediation for Bioethical Dilemmas, supra* note 44, at 159.

63. *See* Cohen, *supra* note 6, at 312.

beliefs, and medical opinions for guidance of whether to sustain or terminate the life of a family member.⁶⁴ Therefore, these decisions are highly personalized. ADR encourages discussion of a personal belief system and the emotions guiding the decision.⁶⁵ Additionally, decisions which encompass these underlying belief structures are permissible.⁶⁶ Since end-of-life decisions require personal value judgments based on emotions to be made, formal adjudication through the courts can not properly resolve these disputes. For the courts there is a need to maintain neutrality and base decisions on a legal application of neutral fact finding.⁶⁷ A resolution to not make value judgments in these cases is indicated by the courts' split opinion views as how to dictate ruling on these cases.⁶⁸

D. Patient and Family Member Autonomy is Increased

ADR encourages parties in the dispute to play an active role in the process.⁶⁹ In fact, the process relies on the vocalization of ideas, opinions, emotions, and values.⁷⁰ This solution is based on the input and compromise of the parties; therefore it is a highly customized process.⁷¹ Full involvement in the process increases the autonomy of the decision. This is unlike formal litigation where the outcome is decided by a judicial authority on the basis of application of law to neutral facts.⁷² Therefore, party involvement in the decision-making process does not exist in litigation.

E. Emotional Resolution is Possible Through Facilitation of the Grieving Process

ADR encourages the parties engaging in the process to identify and express the emotions they are experiencing.⁷³ This practice is especially relevant in the context of end-of-life decision-making where the parties certainly experience overwhelming emotions. "There are times when denying feelings serves a deeper psychological function: in the face of overwhelming anxiety, fear, loss, or trauma, removing yourself from your

64. See Scott, *supra* note 7, at 23.

65. See *id.* at 25.

66. See *e.g.*, *id.* at 24.

67. See Cohen, *supra* note 6, at 282-83.

68. See *Shadow of Death*, *supra* note 8, at 12.

69. See Scott, *supra* note 7, at 24.

70. See *id.* at 24.

71. See *id.*

72. See Cohen, *supra* note 6, at 261.

73. See Scott, *supra* note 7, at 24.

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feelings can help . . . in cop[ing] with daily life At the same time, the reality is that unacknowledged feelings are going to have an effect on communication.”⁷⁴ Once the emotional feelings have surfaced, ADR encourages sharing emotions in a nonjudgmental, supportive environment. This method promotes a party’s sense of feeling heard and acknowledged by not merely the opposition, but in some ADR methods, by a neutral third party as well.

Additionally, ADR facilitates an emotional catharsis, which is especially important when parties are suffering from anticipatory grief which strikes in advance of a severe loss.⁷⁵ The stages of anticipatory grief are identical to those of the post-loss grieving process.⁷⁶ Although grief is an individualized and personal process, the function of ADR may mimic the experience of speaking with a grief counselor, which is a recommended and routine treatment option.⁷⁷ Expressing feelings regarding the impending loss encourages the party to enter into a healthy grieving process.⁷⁸

VI. APPLICATION OF A “MULTI-MODAL” APPROACH TO RESOLVING END-OF-LIFE DECISION MAKING DISPUTES

Utilizing any individual ADR approach, such as negotiation or mediation, to address an end-of-life decision may prove ineffective to resolve the dispute. However, an effective “multi-modal” approach to use in the context of end-of-life decision making can be accomplished by combining and then modifying the general ADR principles.⁷⁹ This “multi-modal” approach increases the likelihood resolution will occur.

A. Negotiation

Negotiation is an informal, structured process used by disputants to reach agreement without the assistance of a third neutral party.⁸⁰ Since end-

74. Cohen, *supra* note 6, at 301.

75. See *Grief and Grieving*, WebMDHealth, http://my.webmd.com/hw/health_guide_atoz/aa128927.asp (last visited Sept. 27, 2005).

76. See *id.* The grieving process progresses through stages: (1) becoming aware of the loss; (2) feeling and expressing grief; (3) adjusting to the loss; and (4) acceptance. *Id.*

77. See *Grief Counseling*, WebMDHealth, http://my.webmd.com/hw/health_guide_atoz/aa129215.asp?navbar=aa128831 (last visited Aug. 30, 2004).

78. *Id.*

79. See *Shadow of Death*, *supra* note 8, at 13.

80. See HAFEMEISTER & HANNAFORD, *supra* note 32, at 123.

of-life decisions are “highly charged, emotional situation[s],” both parties usually have “focused and inflexible (and perhaps unrealistic) goal[s]” posing a problem for resolution through negotiation.⁸¹ Since the traditional negotiation is conducted in the absence of a third neutral party, in an emotional end-of-life negotiation, little concession making would be expected.

Modification of the traditional “independent” negotiation has been achieved by allowing a “negotiation coach [to] observe initial real-life negotiations and [follow it with] encouragement and [] debriefing.”⁸² The use of a coach to critique intimate end-of-life negotiations is generally unsuccessful.⁸³ In a highly emotional and difficult situation, constructive criticism may be taken as offensive or alienating; and instead of promoting effective negotiation it may in fact be counterproductive.⁸⁴

Another more successful modification of negotiation is to train members of the healthcare hospital team in negotiation techniques to apply when presented with an end-of-life decision making issue.⁸⁵ Training sessions would include “presentation, demonstration, and discussion of appropriate techniques with simulation, exercises and feedback.”⁸⁶ This would enable the hospital team to improve their communication skills with an incompetent patient’s primary decision maker.⁸⁷ This is especially important because often the healthcare team has the first opportunity to discuss end-of-life decisions with the patient’s decision maker.⁸⁸ These early conversations permit resolution of misunderstandings before the situation escalates.⁸⁹ Should resolution not be achieved through negotiation, a modified form of traditional mediation should be attempted.

B. Mediation

Traditional mediation is also a voluntary process that uses an unbiased neutral party to assist disputing parties in reaching a mutually agreeable solution in good faith.⁹⁰ The neutral party, referred to as a mediator, must assist the parties to find a resolution that “honors their interests, goals and

81. Liang, *supra* note 26, at 414.

82. Cohen, *supra* note 6, at 320.

83. *See generally id.*

84. *Id.*

85. *See id.* at 319.

86. *Shadow of Death*, *supra* note 8, at 14.

87. *See HAFEMEISTER & HANNAFORD*, *supra* note 32, at 27-28.

88. *See id.* at 29.

89. *See id.* at 28-30.

90. *See BLACK’S LAW DICTIONARY* 42 (8th ed. 2004).

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values.⁹¹ Should this not be met, failure to resolve is permissible.⁹² Various mediation techniques such as summarizing, asking open-ended questions, acknowledging feelings, and holding private caucus meetings are powerful tools to spur communication and resolution.⁹³ Through the implementation of these techniques, concerns are discussed, emotions are vented, and perhaps highly-charged, emotional barriers which prevent resolution can be dissipated.⁹⁴

In the context of resolving end-of-life disputes, bioethics mediation is used.⁹⁵ Bioethics mediation is a blend of traditional mediation skills and ethical principles which optimally permits an option for resolution based on respect and consideration of the personalities, history, attitudes, feelings, and commitments of all involved.⁹⁶ It is the hope that through the bioethics mediation process, a balance between the patient's clinical realities and differing opinions on the end-of-life decision between family, friends, and care providers can be understood.⁹⁷

To help guide the bioethical mediation, a process which includes various stages has been outlined.⁹⁸ Most mediation will not adhere to a rigid structure, so these stages simply serve as guideposts which describe the process and demonstrate how it works.⁹⁹ Prior to commencing the mediation, a bioethics mediator will assess the situation and prepare for the mediation.¹⁰⁰ Assessing the situation entails meeting with all parties involved to gather information regarding the dispute and the relevant medical facts, establish the decision history of the case, and discuss potential treatment options.¹⁰¹ The medical facts and prognosis will be elicited from

91. Scott, *supra* note 7, at 25.

92. *See id.*

93. *See id.* at 25.

94. *See* Liang, *supra* note 26, at 413.

95. *See* Scott, *supra* note 7, at 23.

96. *See* Dubler & Liebman, *supra* note 41, at 34.

97. *See* Leslie H. Youssef, *The Art of Resolving Complex Health Care Disputes, Bioethics Mediation: A Guide to Shaping Shared Solutions*, 19 OHIO ST. J. ON DISP. RESOL. 1145, 1148 (2004).

98. *See id.*

99. *See generally id.*

100. *See id.*

101. *See Using Mediation for Bioethical Dilemmas, supra* note 44, at 159. Further explanation regarding the existence of a conflicting medical diagnosis is found above in Section IV.C.

treating medical doctors.¹⁰² In addition to participation by medical doctors, other interested parties, including family of the incompetent patient, will convene to mediate the dispute.¹⁰³ The mediation will incorporate discussion of the medical facts, ethical and legal principles, and the issues, interests, and feelings of the parties. Through this discussion, the mediator should be able to develop a working hypothesis to shift the discussion towards constructive problem solving.¹⁰⁴ Possible solutions should consider decision consequences in the context of parties' values, as well as considering the medical and legal realities.¹⁰⁵ A mediator must evaluate any agreement to ensure it is realistic and has been fully discussed and accepted by all parties.

During the bioethical mediation process, many strategies employed in traditional mediation are used. However, there are a few significant differences. First, unlike traditional mediation, the bioethics mediator is usually employed by one of the parties, which imposes the risk of mediator bias or the perception of a conflict of interest.¹⁰⁶ Second, "time is of the essence" in these mediations and "deciding not to reach a resolution is not an option."¹⁰⁷ This is problematic because a decision may be coercive and not uphold the interest, goals and values of one of the parties. Despite these drawbacks a bioethics mediator, like a traditional mediator, "helps to identify all the parties and their interests, [and] develop a common understanding of the medical facts and options."¹⁰⁸ Once a common understanding of the medical facts is achieved, traditional mediation techniques should be applied which will encourage sharing and openness of perceptions, and the willingness to listen to the interests, goals, and values of the opposition. As stated above, the combination of these factors will reduce emotional barriers so a compromise may be reached.

102. While discussing the medical facts, it is important the mediator ensure that the participants without a medical background understand any technical jargon. See Youssef, *supra* note 97, at 1148.

103. *See id.*

104. *See id.*

105. *See* Cohen, *supra* note 6, at 324.

106. *See* Scott, *supra* note 7, at 24-25. "In 1992, the Joint Commission on Accreditation of Healthcare Organizations established a new standard that required all accredited institutions to have the capacity to address ethical issues in medical care practice." In compliance with this requirement, a healthcare facility will likely have a bioethics mediator as an employee of the staff. Dubler & Liebman, *supra* note 41, at 35.

107. Scott, *supra* note 7, at 25. Similar to the "Norm Advocating Model" of mediation which permits the mediator to withdraw from the mediation if the decision violates social norm, a bioethics mediator should be permitted to withdraw from a bioethics mediation if the agreed upon resolution is coerced. Ellen A. Waldman, *The Challenge of Certification: How to Ensure Mediator Competence While Preserving Diversity*, 30 U.S.F. L. REV. 723, 735 (1996).

108. *Shadow of Death*, *supra* note 8, at 14.

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VII. REALISTIC APPLICATION: WOULD A “MULTI-MODAL” APPROACH OF ADR HAVE ASSISTED IN THE CASE OF TERRI SCHIAVO?

A long, costly, destructive and bitter court battle involving one family’s controversy over an end-of-life decision was recently demonstrated in the highly publicized case of Terri Schiavo.¹⁰⁹ Schiavo has been in an unconscious state, which some doctors categorized as a persistent vegetative one, since 1990.¹¹⁰ In 1998, her husband, Michael Schiavo,¹¹¹ petitioned a Florida court to discontinue artificial life support, citing that since she was in a persistent vegetative state she would not have wanted extraordinary measures taken to sustain her life.¹¹² Schiavo’s parents, Mary and Robert Schindler, objected to the discontinuation since they believed their daughter’s diagnosis was incorrect. The parents referred to instances when Schiavo smiled or indicated eye movement as evidence of the incorrect diagnosis.¹¹³ The difference in opinion regarding the medical diagnosis has become a significant part of a vigorous legal dispute.¹¹⁴

In addition to disputing the medical diagnosis, the bitterness escalated when the Schindlers objected to Michael Schiavo remaining the guardian of their daughter.¹¹⁵ The Schindlers felt Michael Schiavo’s interests were not in alignment with their daughter’s wishes, although he adamantly disputed this allegation.¹¹⁶ Therefore, the question as to who has the best interests for Ms. Schiavo in mind became a crucial part of this right to die litigation.

Since 1998, when Michael Schiavo first petitioned the court to terminate Ms. Schiavo’s artificial life support, there have been seven years of litigation, ultimately culminating with Terri Schiavo’s death.¹¹⁷ In the

109. See *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378 (M.D. Fla. 2005).

110. See Snead, *supra* note 5, at 56.

111. The law often recognizes a pecking order based on next of kin in assigning decision making authority. Hafemeister, *supra* note 10.

112. See Snead, *supra* note 5, at 61. The New Jersey Supreme Court, *In the Matter of Claire Conroy*, rejected a common distinction between refusals of ordinary and extraordinary treatment. See *In the Matter of Claire Conroy*, 486 A.2d 1209, 1218 (1985). This inquiry usually termed “quality of life” is a subjective and value laden decision for the courts to make and not a decision that it easily defended on legal grounds. See Cohen, *supra* note 6, at 264.

113. See Snead, *supra* note 5, at 61.

114. See *id.*

115. See *id.* at 66.

116. See *id.* at 59-61.

117. Terri Schiavo died on March 31, 2005, “[thirteen] days after doctors removed the feeding tube” which sustained her life. *Terri Schiavo’s Life, Death Sparked National Debate*, <http://www.cnn.com/2005/US/03/31/obit.schiavo/> (Mar. 31, 2005) [hereinafter National Debate].

course of litigation, there have been “several trials, thirteen applications for appellate review, countless hearings on motions and petitions, three federal district court suits, several appellate court decisions, [petitions for review to the United States Supreme Court,] a state statute and executive order, . . . a gubernatorial stay” and the passage of federal legislation.¹¹⁸ It is clear that the court determination was not satisfactory to the Schindler party. As a result, litigation continued until the end of Terri Schiavo’s life.¹¹⁹

Unfortunately hindsight is twenty-twenty, and now the question arises as to whether using a form of ADR to clarify the facts of the case, the medical diagnosis, vent personal values, emotions, and opinions would have effectively diffused the situation. At this retrospective point, the application of a multi-modal form of ADR as applied to the case of Terri Schiavo is a hypothetical and speculative exercise. Therefore the true outcome and possible success of an ADR approach in the end-of-life dispute of Terri Schiavo will never be realized, but it should be discussed and applied to promote future use of ADR.

In this case, since emotions were very high, even with the guidance of a negotiation coach, resolution through a means of negotiation was very unlikely. It is then appropriate to enter bioethics mediation, a process generally reserved for difficult cases where extreme conflict exists.¹²⁰ A primary goal of the bioethics mediation is to achieve a common understanding of the medical facts and options.¹²¹ The medical facts and options were a primary source of debate between Michael Schiavo, the Schindler family, and the medical professionals.¹²² Generating a common consensus of the medical prognosis would have been difficult in this case, since the expert opinions of the medical professionals were in opposition.¹²³ However, in attempt to resolve these differences, at the onset of a bioethical mediation the medical professionals would have had private meeting(s) to discuss Terri Schiavo’s medical condition. Due to the diametrically opposed diagnostic opinions, in the case of Terri Schiavo, a common consensus would not have been achieved through mediation and an ADR-based model would not be utilized in this situation. However, if a common consensus as

118. Sy Moskowitz, *Still Part of the Clan: Representing Elders in the Family Law Practice*, 38 FAM. L.Q. 213, 230-31 (2004).

119. See generally *National Debate*, *supra* note 113.

120. Dubler & Liebman, *supra* note 41, at 37.

121. *Id.* at 36-37.

122. See generally *What Caused Terri Schiavo’s Condition?*, CNN, <http://www.cnn.com/2005/LAW/03/25/schiavo.qa/index.html> (Mar. 25, 2005).

123. Doctors that Michael Schiavo hired to evaluate Terri Schiavo’s condition believed she is in a persistent vegetative state where she cannot speak, think, or respond to verbal stimuli. Contrary to this, doctors hired by the Schindler family claimed that she is not in a vegetative state and would be able to improve with therapy. *Id.*

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to the medical facts could have been reached the mediation could have proceeded.

During the course of bioethics mediation, a bioethics mediator would have encouraged sharing and openness of perceptions, and the willingness to listen to the interests, goals, and values of the opposition.¹²⁴ In this case, each interested party to the mediation would have been invited to make a statement about the current situation.¹²⁵ These statements would probably have included passionate sentiments about a relationship with Terri Schiavo, medical facts, and personal value opinions regarding treatment options and consequences. This process would have allowed for an emotional catharsis, helping to foster understanding and diffuse the bitterness between Michael Schiavo and the Schindler family resulting in a satisfactory resolution and as a consequence the case might not have become a long legal battle.

If however after exhausting the methods of ADR, resolution had not been achieved, formal litigation remained an option. If litigation of this end-of-life decision remained necessary, hopefully by first using an ADR approach much of the emotional turmoil and bitterness would have been eliminated. This would then have left the court to address a truly difficult question regarding the right to die – What should be done? Who should decide?

VIII. CONCLUSION

May the need to decide whether to sustain or terminate the life of a loved one always remain a hypothetical question; however, if the decision is necessary and a dispute occurs, a solution that acknowledges the personal and emotional nature of the situation should be employed.¹²⁶ First, utilizing a “multi-modal” format of ADR, including modified negotiation or bioethics mediation is advised. These techniques encourage discussion of emotions, perceptions, interests, goals, and values, which facilitates a resolution. This allows the parties to experience an emotional catharsis which starts the healing process. Therefore, if a resolution is not achieved, the litigation which occurs in the aftermath will be less emotionally charged. Using ADR, the emotional turmoil caused by a right to die dispute can be dissipated. This is important since whether the decision made is to sustain or terminate

124. See Youssef, *supra* note 97, at 1151.

125. See *id.*

126. Zelaya, *supra* note 2.

life, death will eventually occur. It would not be the wishes of any incompetent patient for the decision regarding their life and death to be a destructive battle; therefore ADR can be instrumental in ensuring that vital familial relationships remain intact in the aftermath of an inevitable loss.