I. Why the Need For A Reconciling Process

A. Recent advances in science and medical technology have raised many complicated and profound medical, legal, ethical, and spiritual issues.

B. Changes in the roles of physicians and other healthcare professionals, along with an increasing emphasis on patients’ rights, have led to an increase in the number of conflicts within healthcare systems.

C. Changes in government regulations, managed care, and specialization have made it more difficult for healthcare professionals and patients to form trusting relationships.

D. These conflicts are largely based upon different perceptions, interests, values, and expectations, as well as a lack of good communication, between and among healthcare professionals, patients, and family members (Post, Blustein, and Dubler 2007, 13).

E. The three methods that healthcare systems have traditionally relied upon, i.e. litigation, ethics committee deliberations, and non-binding arbitration, do not address the major source of most bioethics conflicts, which is a lack of good communication between physicians and patients and family members (Stoller 2008, 2).

- The three traditional methods are not suitable for adequately addressing the “intensely personal” and “time sensitive issues” that underlie most bioethics concerns (Stoller 2008, 1)
- Exclusively relying upon those methods can have a damaging effect upon an ongoing physician-patient relationship (Stoller 2008, 2-4).

F. The above developments have illuminated the need to develop a more informed and inclusive way of addressing the complex issues and conflicts that arise everyday in modern healthcare. They have also illuminated the need to develop an innovative approach to clinical ethics, one guided by a framework that promotes compassionate, quality care.

G. The growing recognition of the important role that spiritual and emotional issues play in healing has also highlighted the need to rely upon an integrated holistic model of care that focuses on healing. It has also illuminated the need
to pursue a different way of handling the complex issues and conflicts that arise everyday in modern healthcare.

II. Biomedical (a/k/a Bioethics) Mediation - a unique form of healthcare mediation

A. Originally developed in 1978, by Nancy Dubler and Carol Liebman at Montefiore Medical Center in New York

B. A non-judgmental, confidential process designed to help quickly resolve issues and conflicts among and between the members of the healthcare team, between the healthcare team and the patient and/or the patient’s family members

C. Purpose is to help healthcare professionals, patients and family members to identify, understand, and resolve many different types of issues, including but not limited to:
   - disputes over diagnoses
   - over goals of treatment
   - over end-of-life issues (ex. withholding and withdrawing life support)
   - over organ donation
   - over allocation of scarce resources, and
   - over other major healthcare issues.

D. Differs from Arbitration or Adjudication
   - process can be formal or informal
   - impartial mediator helps parties focus on needs and values instead of rights and positions
   - participants have an opportunity to express feelings, thoughts, and concerns in a confidential, safe, environment
   - mediator helps parties explore their options and encourages them to be creative in seeking resolutions

E. Major Benefits of Using Biomedical Mediation
   - helps participants quickly address concerns that need immediate attention
   - facilitates communication among everyone involved in a case: allows all participants to feel “heard”
   - promotes a holistic understanding of the needs of the patient
   - encourages participants to focus on healing
   - promotes personal and professional growth
   - promotes development of attentive listening skills
   - promotes a more open way of relating
   - enables participants to identify, analyze, and resolve ethical issues, misunderstandings and conflicts, and
   - helps to create a healing environment throughout a healthcare system
III. Bioethics Mediation – Needs To Be Based Upon a Holistic Vision of Health Care

A. Focus on Healing – rather than solely on curing

- Healing – “the ability of a person to find solace, comfort, connection, meaning and purpose in the midst of suffering, disarray, and pain” (Puchalski and Ferrell 2010, 55).
- Healing occurs within an individual
- Healing is not something health care professionals can accomplish; can only help empower their patients to experience it
- Disease - a disturbance of vital relationships (including the internal physical relationships between body systems) that contribute to the unity and integrity of an individual (Puchalski et al. 2009, 890)
- Healing occurs in the context of trusting relationships, and reconciliation with the Source of Life, with the self, and with others is a basic human need.
- Clinical case examples

B. View Modern Healthcare System as More Than A Business Entity

- Health care system - a dynamic web of human relationships that includes administrators, physicians, nurses, social workers, case managers, therapists, chaplains, pharmacists, technicians, housekeepers, other members of the staff, volunteers, patients, and family members.
- Together these relationships constitute a healing community.
- Healing occurs when members of the health care team relate to patients, family members, and colleagues in a candid and respectful way – creates a climate of trust that permeates the whole community.
- Clinical case Examples

C. Importance of Healing Connections

- Health care consists of many unique encounters between patients and healthcare professionals.
- These ‘healing connections” or “moments of caring” are essential in helping a patient transcend an illness or injury, make clinical progress, and move towards wholeness (Hansen 2001, 1).
- Every modern health care system exists to promote these healing connections between everyone involved in patient care.
- As one professional nurse noted:

When a health care professional uses scientific processes from his education and experience and employs both the right and left brain, and includes himself, his being, his soul and spirit, he becomes a miraculous instrument of healing. It is during those moments that there exists an instant of
connectedness, when the mundane sciences are transcended and that moment becomes the safe and sacred place of healing. Not only does the Client experience the healing, but the beauty of the connection feeds the patient and the care provider. (Hansen 2001, 1).

- **Clinical Case Example**

D. Importance of Overcoming Barriers to Healing

- When healing connections are not made or are blocked, patients do not heal, even though they may experience a physical cure.
- When the lines of communication are down anywhere within a health care system, the entire system may be affected and need to heal.

E. Use of the Bioethics Mediation Process to Promote Healing Connections

- Provides opportunity to openly share feelings, thoughts, and ideas with colleagues and other members of the multidisciplinary team in a safe environment
- Promotes better understanding of a patient’s needs and of a patient’s medical condition
- Provides opportunity to identify and explore any underlying emotional or spiritual issues that may be affecting the healing process
- Provides an opportunity to apply clinical ethics in a way that respects the inherent dignity of every human being
- Provides an opportunity to explore options and work together to achieve resolution

IV. Need For Bioethics Mediation To Be Based Upon An Underlying Moral/Ethical Framework For Providing Compassionate Quality Care

A. Based upon a Spiritually-Integrated Model of Care

- Healing as a dynamic process involving body, mind, and spirit

Healing of the body pertains to issues that may have originated in or happened to one’s emotional state as well as one’s physical body. Only the rare illness in the practice of medicine does not have widespread influence on the person’s entire physical, spiritual, and emotional make-up. The goal of healing is wholeness, so that one who is physically ill, mentally stressed, or even spiritually weak can be made strong in mind, body and spirit. (Haynes and Kelly 2006, 120-121).
• Recognition that patients suffering from a major illness or injury have basic needs and often have the following deep spiritual needs:

   A need to make sense of the illness
   A need for purpose and meaning in the midst of illness
   A need for spiritual beliefs to be acknowledged, respected, and supported
   A need to transcend the illness and the self
   A need to feel in control and to give up control
   A need to feel connected and cared for
   A need to acknowledge and cope with the notion of dying and death
   A need to forgive and be forgiven
   A need to be thankful in the midst of illness, and
   A need for hope. (Koenig 2003, 20.

• Recognition that patients often experience spiritual struggles when experiencing a major illness or injury – importance of addressing spiritual distress

   Research study of 450 patients by Dr. Harold Koenig of Duke University – patients whose spiritual struggles were not addressed had “an increased risk of death, poor mental health, and low quality of life” (Koenig 2003, 2). Same study showed that unmet spiritual needs affected the length of the patients’ hospital stay and their need for long term care after they were discharged (Koenig 2003, 2).

B. Based Upon A Moral/Theological Framework Guided By The Vision of the Catholic Ethical and Religious Directives

• Emphasis on inherent sacredness of all human life
• Healthcare not limited to treating diseases or injuries
• Purpose of medical care is to promote health and relieve suffering
• Health care exists to promote healing relationships between health care professionals and patients based upon “mutual respect, trust, honesty, and appropriate confidentiality” (Ethical Directives 2010, 11).
• Health care systems need to encourage health care professionals to respond to suffering in a realistic and transforming way.

C. Moral Obligations of Health Care Professionals

• Recognition that “ethical issues are embedded in every clinical encounter between patients and caregivers because the care of patients always involves both technical and moral considerations” (Jonsen, Siegler, and Winslade 2010, 1).
• Health care professionals have moral obligations to provide competent, compassionate care to patients, to communicate honestly and openly, and to preserve confidentiality
D. Application of Four Main Principles of Bioethics to Clinical Cases
(Four Topic Chart in Jonsen, Siegler, and Winslade 2010, 8)

- The Principles of Beneficence and Nonmaleficence – Medical Indications:
- The Principle of Respect For Autonomy – Patient Preferences
- The Principles of Beneficence, Nonmaleficence, and Respect For Autonomy – Respect for Patient’s Life
- The Principles of Justice and Fairness – Contextual Features

E. Ethical Problems Can Emerge From What Appear to Be Noncontroversial Cases (Jonsen, Siegler, and Winslade 2010, 14) – Case Examples

IV. Qualifications of A Bioethics Mediator (Core Competencies for Ethics Consultation. 2006 Report of the American Society For Bioethics and Humanities Task Force)

A. Ethical Assessment Skills
B. Process Skills
C. Interpersonal Skills
D. Knowledge of Moral Reasoning and Ethical Theory
E. Knowledge of Common Bioethical Issues and Concepts
F. Spiritual and Emotional Preparation

V. Bioethical Mediation is a Fluid Process – can be formal or informal

A. Seven Interrelated Stages of Formal Bioethical Mediation - Case examples

- Assessment and Preparation
- Beginning the Mediation
- Eliciting the Medical Facts
- Gathering Information
- Problem Solving
- Resolution and Reconciliation
- Follow-Up

B. Benefits of using the process to address adverse outcomes and medical errors
C. Potential Future use of the process to address issues raised by genetic technology
VI. The Chaplain As A Vital Member of the Mediation Team

A. Opportunity to have a distinctive professional voice during the mediation process

B. Help to assess and attend to the spiritual and emotional needs and concerns of patients, family members, and staff

C. Opportunity to identify the spiritual and emotional strengths of patients and family members

D. Opportunity to help empower patients and/or family members who might be hesitant to speak up

E. Opportunity to remind colleagues that “questions of ultimate concern fill the healthcare endeavor” (McCurdy 2009, 22) and that suffering can be transformed

VII. Invitation to Participate in Case Scenario and Conclusion
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