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# Mediation and Advocacy

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## Mediation and Advocacy

Autumn Fiester

One of the concerns about patient advocacy raised by Rasmussen (2012) is that it can be understood as a type of “side-taking.” Although she merely gestures towards the questionable moral status of taking sides in an ethics consult (page #), I have argued that side-taking in an ethics dispute is morally problematic because it hierarchizes one party’s values over others’ without the moral authority or legitimacy to do so (Fiester 2011). Patient-advocacy is vulnerable to this same charge because it is an attempt to advance the interests of the patient, granting the patient’s interests a priority that trumps other parties’ interests. As Rasmussen acknowledges, our values-pluralism makes that choice a morally spurious one (note 23). Patient-advocacy, therefore, should be morally proscribed.

But the motivation behind patient-advocacy is a morally laudable one: when patient-advocacy comes into question, it reveals a clear need of the patient to have her voice amplified and her interests better articulated. The need for patient-advocacy arises when the patient’s priorities are not getting proper recognition or consideration. And since this means that someone in the consult is being injured or harmed, allowing that harm is itself a moral wrong. Thus, the impetus to advocate comes from an important moral obligation on the part of the consultant to protect the patient from that harm. How are we to balance the moral prohibition of side-taking with the moral obligation to protect individuals from harm?

The cause of this ethical dilemma turns out to be the way the problem has been framed. When Rasmussen defines the problem as: “Should an ethics consultant ever advocate for the patient?,” she obscures the real, root problem that generates this impulse to advocate. The

problem with her frame is that it implies that the kind of vulnerability at issue here is one that only patients can have. We only ever talk about “patient advocacy,” rather than “surrogate advocacy,” or “nurse advocacy,” or even “physician advocacy.” And there are reasons for this: it is often the case that patients are in the most powerless position in an ethics dispute – but not always. So the problem at the root of Rasmussen’s discussion is more accurately named by the question: “Does the patient in this case need help protecting his or her interests and/or values?” In the cases she describes, the answer is a resounding “yes.” But that kind of need is not limited to patients in an ethics consult: being voiceless, powerless, marginalized, silenced, dominated are potential vulnerabilities or liabilities of *anyone* engaged in a dispute – of any kind, but certainly in an ethics-dispute. Some families members can be marginalized by other family members or someone on the treating team; sometimes members of the treating team find their moral concerns dismissed or deemed irrelevant with the consequence of serious moral distress; sometimes patients silence their family members who express concerns about care-decisions that will directly impact those very family members; sometimes one member of the provider team will be dominated by others in a kind of tyranny of the majority. In summary, then, the problem that generates a need for advocacy is that the voice or interest of a stakeholder in a dispute has failed to be heard or articulated, but patient-advocacy only worries about the marginalization of one category of stakeholder rather than all of them.

The solution to the problem of stakeholders being marginalized in an ethics consult is mediation. When ethics consultation is done as mediation, the mediator is responsible for protecting everyone’s interests and is obligated and accountable for ensuring that no one is marginalized or voiceless. Rasmussen considers mediation but muses that when consultation is done as mediation, advocacy would violate the mediator’s obligation to be “neutral” (page #).

Although she rightly points out that taking a mediation approach to clinical ethics consultation precludes *patient-advocacy*, she is confused about the reasoning behind that prohibition.

Mediation does not rule out patient-advocacy because it undermines neutrality, but because mediation demands *universal* advocacy for all of the stakeholders' interests, not just the patient's. One of the mediator's critical functions is to safeguard the interests of all individuals involved in the ethics consult, which amounts to advocacy for any and all marginalized voices and positions in the conversation – from whatever source.

Mediator-neutrality is often misunderstood. The mediator is not neutral about *how* the process is conducted, but neutral about *what resolution* the parties agree to within the constraints of law, as Nancy Dubler and Carol Liebman carefully point out (Dubler and Liebman 2011). In fact, the mediator is an absolute partisan when it comes to the process, taking a very hard line: all voices must be heard, no one may be silenced, every interest important to the stakeholders involved must be articulated. There is no neutrality on those points. Mediation is a carefully monitored dialogue intended to help the stakeholders find a shared resolution that brings the cherished values and interests of those involved into clear focus. If one person – patient, mother, father, child, nurse, physician, etc. – has no conversational space to articulate those values, the mediator has failed to protect all of the parties at the table. Because the mediator does not take a stand on which moral positions are legitimate and what outcome is best, the mediator is *neutral*. But the flipside of that mediator neutrality is universal advocacy. If the mediator's stance is that no stakeholder's values should be aided in trumping any others – hence she is neutral – then her stance is also that all stakeholders' values must be part of the conversation – hence her universal advocacy. Without universal advocacy, the mediator's neutrality is, indeed, compromised, because she has hierarchized one set of interests or values over others. Mediation, therefore,

embraces a kind of constant and revolving advocacy, protecting any parties struggling to have their voices heard. But that also means not singling out any category of disputant – e.g., “patients” – as those worthy of, or *de facto* in need of, that type of support or protection.

But what about when the patient has *no* voice at all – either because the patient is too young to be granted full status as a decision-maker or because the patient lacks full cognitive capacity, as in Rasmussen’s two cases? When a patient’s voice is absent, fuzzy, faint, or has no standing (as in the case of a minor), the patient deserves a *true* patient advocate, someone who can articulate the patient’s values and wishes without any reservations or caveats or conflicts of interest. With that voice genuinely represented, the CEC can then effectively mediate the discussion, protecting *all* interests, so that the parties can come to a shared resolution.

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