2019 Kinsman Bioethics Conference

Raising Voices:
The Ethics of Dialogue and Communication in Health Care

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<th>PLenary Session</th>
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<td>Techniques for Effective Dialogue in Challenging Ethics Consultations</td>
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<td><strong>Speaker</strong></td>
<td>Autumn Fiester, Ph.D.</td>
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<tr>
<td><strong>Date</strong></td>
<td>Thursday, April 11, 2019</td>
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<td><strong>Time</strong></td>
<td>1:05 – 2:40 PM</td>
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<td><strong>Location</strong></td>
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**PLenary Session Speaker**

Dr. Autumn Fiester is Associate Chair for Education & Training in the Division of Medical Ethics at the Perelman School of Medicine at the University of Pennsylvania. She is the Director of the Penn Program in Clinical Conflict Management, which promotes conflict resolution training for formal clinical ethics consultations and ethics conflicts at the bedside. Dr. Fiester is a consultant for the Hospital of the University of Pennsylvania Ethics Service, and she conducts workshops in conflict management around the country.
Techniques for Effective Dialogue in Challenging Ethics Consultations

• Barriers to Effective Dialogue
• Skills for Effective Dialogue


John Roberts is a 73-year-old man who presented to the hospital with respiratory distress. He required intubation and mechanical ventilation upon arrival. Subsequently, he underwent a battery of tests that diagnosed metastatic lung cancer. His hospitalization has been complicated by pneumothorax, venous thromboembolism, cardiac arrhythmias, anemia, pneumonia, and severe malnutrition. He has undergone multiple procedures including a tracheostomy and feeding tube placement. One month into his course of treatment, he has persistent respiratory failure and remains ventilator dependent. Additionally, he has now developed acute renal failure that requires renal replacement therapy to sustain life. He is otherwise hemodynamically stable. His wife has medical power of attorney. During previous conversations, his wife has stated a strong desire to continue aggressive therapy and indicated that her best understanding of the patient's wishes would be to continue with aggressive therapy indefinitely. Now she is insisting on dialysis. The medical team feels that hemodialysis will not alter the patient's prognosis. He has metastatic cancer and is too unstable to safely receive even palliative chemotherapy. His life expectancy is weeks, and while withholding this life-sustaining treatment could hasten his demise, it will not change the outcome of certain death, as a direct result of complications from his lung cancer. Therefore, the medical team is refusing the dialysis. An ethics consult is called.

**OBJECTIVE:**
To learn approaches that can detract from & enhance effective facilitation of a dialogue between stakeholders in an ethics conflict

Example: A conversation between Mrs. Roberts and members of the clinical team...
Techniques for Effective Dialogue in Challenging Clinical Encounters

- Barriers to Effective Dialogue
- Skills for Effective Dialogue

Barriers to Effective Dialogue

1. Failing to Recognize the Peril of Ground Rules
2. Falling for the Decorum Bias
3. Allowing the conversation to focus on Positions vs. Interests
4. Succumbing to the Lure of Stock Characters
5. Defending the Enemy
6. Establishing “Behavior Contracts”
7. Rushing up the “Ladder of Inference”
Barrier #1 to Effective Dialogue

Failing to Recognize the
- Peril of Ground Rules

Peril of Ground Rules
- Imagine that both Mrs. Roberts & Dr. Richards are prone to interruptions, insults, sarcasm, & foul language
- Tempting to set out rules for allowable behavior & to demand compliance

DON'T DO IT!
(in my humble opinion...)

Barrier #1 to Effective Dialogue

Peril of Ground Rules

WHY NOT?!?!

- Because they don’t work &
- Because they harm your standing as a facilitator

Peril of Ground Rules

- Ground Rules don’t work
  - Believing that a set of prescribed rules ("No Interrupting," "No Swearing," "No Yelling") will prevent bad conversational behavior is like believing that abstinence rules will prevent premarital sex
  - They only work for people who were not going to break the rules in the first place
Barrier #1 to Effective Dialogue

Peril of Ground Rules

- Ground Rules harm your credibility as a facilitator & undermine trust
  - Say someone raises a voice or uses a swear word:
    - If you call the person out, you’ve shamed the person, lost trust, & made the person into the “bad guy”
    - If you don’t call the person out, you have shown that your Ground Rules were just hot air and you look ineffective

Barrier #2 to Effective Dialogue

- Falling for the Decorum Bias
Barrier #2 to Effective Dialogue

**Decorum Bias**

- The belief that Polite Language/Good Manners = Good Character
- & Foul Language/Impolite Behavior = Bad Character

But nasty, demeaning, insulting things can be said with polite language:
Barrier #2 to Effective Dialogue

Decorum Bias

- “One has got all the goodness, and the other all the appearance of it.”

— Elizabeth Bennet, talking about the taciturn Mr. Darcy & the charming Mr. Wickham, Pride & Prejudice
Barrier #2 to Effective Dialogue

**Decorum Bias**

- Try to look past the tone, volume & form of what people say in stressful, crisis situations

Barrier #3 to Effective Dialogue

- Allowing the conversation to fixate on the stakeholders’ *positions* instead of their *interests*
Barrier #3 to Effective Dialogue

Mediators distinguish between:

- POSITIONS
  - Stated claims, stance one is taking on an issue or situation

- INTERESTS
  - Normative Content: underlying motivations, needs, concerns, values, “skin in the game,” what’s at stake
Mediators distinguish between:

**POSITIONS**
- Are often diametrically opposed in a values conflict
- Rarely allow compromise
- But can be anchored by many different Interests

**INTERESTS**
- Are “human,” not “partisan”
- Can be overlapping, even if Positions aren’t
- Can be game-changing (re: perceptions, possibilities )

Fry & Usher, Harvard Negotiation Project, authors of *Getting to Yes*:

“Since the parties’ problem appears to be a conflict of positions, and since their goal is to agree on a position, they naturally tend to think and talk about positions - and in the process often reach an impasse.”
Barrier #3 to Effective Dialogue

- Do not allow the conversation to fixate on the stakeholders’ positions instead of their interests.
- Dig for the underlying concerns of the parties and focus the dialogue on those concerns.

John Roberts is a 73-year-old man who presented to the hospital with respiratory distress. He required intubation and mechanical ventilation upon arrival. Subsequently, he underwent a battery of tests that diagnosed metastatic lung cancer. His hospitalization has been complicated by pneumothorax, venous thromboembolism, cardiac arrhythmias, anemia, pneumonia, and severe malnutrition. He has undergone multiple procedures including a tracheostomy and feeding tube placement. One month into his course of treatment, he has persistent respiratory failure and remains ventilator dependent. Additionally, he has now developed acute renal failure that requires renal replacement therapy to sustain life. He is otherwise hemodynamically stable. His wife has medical power of attorney. During previous conversations, his wife has stated a strong desire to continue aggressive therapy and indicated that her best understanding of the patient’s wishes would be to continue with aggressive therapy indefinitely. Now she is insisting on dialysis. The medical team feels that hemodialysis will not alter the patient’s prognosis. He has metastatic cancer and is too unstable to safely receive even palliative chemotherapy. His life expectancy is weeks, and while withholding this life-sustaining treatment could hasten his demise, it will not change the outcome of certain death, as a direct result of complications from his lung cancer. Therefore, the medical team is refusing the dialysis. An ethics consult is called.
Searching for interests...

Mrs. Roberts/Dr. Richards:
- “is worried about…”
- “has a need for…”
- “is concerned about…”
- “values…”

Barrier #3 to Effective Dialogue

Mrs. Roberts:

POSITION:
“My husband must receive dialysis”

INTERESTS?

Barrier #3 to Effective Dialogue

Dr. Richards:

**POSITION:**
“We will *not* begin dialysis on Mr. Roberts”

**INTERESTS**
?

Seven Maxims of Mediation

1. “Difficult” people should be viewed as a syndrome, not a species
2. Anger is a reactive emotion, so the key is finding its source
3. It takes mere seconds to escalate or deescalate a brewing conflict
4. Calling someone out for bad behavior will inevitably make matters worse
5. Exercising neutrality ups the odds of successful conflict resolution
6. **UNCOVER INTERESTS:** Focusing the dialogue on stakeholders’ interests starts to build trust, makes opponents sympathetic to each other, discovers common ground, & opens up new possibilities
7. A sincere expression of consolation can go a long way in defusing a tense interaction (“I am so sorry that…”)

Fiester, A. “What Mediators Can Teach Physicians about Managing ‘Difficult’ Patients,” American Journal of Medicine
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Barrier #4 to Effective Dialogue

Succumbing to the

Lure of Stock Characters

Lure of Stock Characters
- A stock character is a stereotypical, fictional character in a work of art such as a novel, play, or film, whom audiences recognize from frequent recurrences in a particular literary tradition. Stock characters are archetypal characters distinguished by their flatness.
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Barrier #4 to Effective Dialogue

Succumbing to the
Lure of Stock Characters
Barrier #4 to Effective Dialogue

Stock Characters in Medicine
- The Unfeeling Doctor
- The Adult Child Who Just Wants the Welfare Check
- The Religious Fanatic
- The Drug-Seeker
- The Frequent-Flyer
- Personality Disorder

Are there others?!!
Barrier #4 to Effective Dialogue

- **Lure of Stock Characters**
  - Real human beings are always 3 dimensional (they always have profound concerns, distinct perspectives, core values, unique histories).
  - Labels are fictions; they mask who people are, rather than illuminate it.
  - Categorizing a person as a stock character undermines your ability to discover their interests.

Barrier #5 to Effective Dialogue

- **Defending the Enemy**
Barrier #5 to Effective Dialogue

Defending the Enemy

- It is natural to want to defend & justify the actions, responses, performance of co-workers, the hospital, trainees, subordinates, but...

Imagine you felt that Nurse Tom Franklin was abrupt and indifferent to your ailing spouse. You raise this concern to the supervisor, requesting a different nurse. Her reply:

- e.g., “I have worked with Tom Franklin for 5 years and I have never witnessed him being anything but caring and compassionate. He is an exemplary nurse and you are lucky to have him.”
Barrier #5 to Effective Dialogue

- Defending the Enemy
  - Imagine you felt that Dr. Roberts trivialized your reasons for wanting to start dialysis. You believe he didn’t really listen to what you were trying to say. You raise this concern to another member of the ICU team, who responds:
  - e.g., “I am sure you misinterpreted what Dr. Roberts said. He would never be dismissive of a family’s concerns. He is always very supportive of families.”

- It is natural to want to defend & justify the actions, responses, performance of co-workers, the hospital, trainees, subordinates, but...
  - in a heated conflict, this will trap you in an unproductive “Us vs Them”
  - it can make parties believe it’s futile to try to work to solve the problem because they feel unheard
  - it can make parties become more strident, less willing to compromise, less willing to trust you
Barrier #6 to Effective Dialogue

Establishing

➢ "Behavior Contracts"
Establishing

➢ "Behavior Contracts"
   - Behavior Contracts come from primary & secondary school education:
     - "The behavior contract is a simple positive-reinforcement intervention that is widely used by teachers to change student behavior. The behavior contract spells out in detail the expectations of student and teacher (and sometimes parents) in carrying out the intervention plan…"
     --www.interventioncentral.org

➢ "Behavior Contracts"
   - Behavior Contracts come from primary & secondary school education
   - Since they are designed for children ages 5-17, they will be perceived as:
Barrier #6 to Effective Dialogue

Establishing

➢ ”Behavior Contracts”

Enough said.
Barrier #7 to Effective Dialogue

Rushing up the "Ladder of Inference"

- First coined by Chris Argyris
- Further developed by Peter Senge, *The Fifth Discipline: The Art and Practice of the Learning Organization*
- In a nutshell: “Jumping to conclusions”

"Ladder of Inference"

- We take in information about another person, filtered through our own interests, needs, perspectives & biases, and use it to draw conclusions about the individual that may be profoundly inaccurate
- We unintentionally select certain pieces of observed “data” about the individual, and then use that incomplete picture to reify an interpretation of that person that then structures how we treat him or her
Barrier #7 to Effective Dialogue

”Ladder of Inference”

- Example
"Ladder of Inference"

- I avoid her
- There is no point in having a dialogue with her when she's just going to say there is going to be a miracle
- Mrs. Roberts is demanding dialysis because she is hoping for a miracle
- Mrs. Roberts believes in miracles
- Mrs. Roberts is a devout Catholic
- Mrs. Roberts had rosary beads in her hands
- I see Mrs. Roberts

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<tr>
<td>Belief</td>
<td>There is no point in having a dialogue with her when she's just going to say there is going to be a miracle</td>
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<tr>
<td>Conclusion</td>
<td>Mrs. Roberts is demanding dialysis because she is hoping for a miracle</td>
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<tr>
<td>Assumption</td>
<td>Mrs. Roberts believes in miracles</td>
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<tr>
<td>Interpreted Reality</td>
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<td>Selected Reality</td>
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<tr>
<td>Reality</td>
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Barrier #7 to Effective Dialogue

”Ladder of Inference”

- I avoid her
- There is no point in having a dialogue with her when she’s just going to say there is going to be a miracle
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Where are the possible mistakes in inference?

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Barrier #7 to Effective Dialogue

”Ladder of Inference”

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Barrier #7 to Effective Dialogue

"Ladder of Inference"

Avoiding False Inferences:

- Working backwards:
  - Why did I draw that conclusion? Is the conclusion sound?
  - What am I assuming, and why? Are my assumptions valid?
  - What data have I chosen to use and why? Have I selected data rigorously?
  - What are the real facts that I should be using? Are there other facts I should consider?

https://www.mindtoos.com/pages/article/newTMC_91.htm

Barriers to Effective Dialogue

1. Failing to Recognize the Peril of Ground Rules
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Techniques for Effective Dialogue in Challenging Clinical Encounters

- Barriers to Effective Dialogue
- Skills for Effective Dialogue

Technique #1

Diagnostic Listening
- Distilling the core content of the speaker’s narrative &
- Restating it thematically back to speaker
Technique #1

Diagnostic Listening

- Distilling the core content of the speaker’s narrative &
- Restating it *thematically* back to speaker

Technique #1

Diagnostic Listening

- Used to capture the comprehensive set of concerns of the speaker
  - Establishes trust
  - Gathers the information needed to set the agenda for the dialogue
Technique #1

Diagnostic Listening

- In contrast to “sympathetic listening”
  - Goal is to allow the person “to vent” or to demonstrate empathy or concern
  - But not to offer an analytical framework for trouble-shooting the problem or conflict

Steps:
1. Listen analytically to the speaker's testimonial, trying to capture the essential themes, worries, complaints, perspective
2. Check your comprehension by restating the content back to the speaker
3. Ask for clarification if you have missed essential points, or misunderstood
Technique #1

Diagnostic Listening

→ Tip:

- Taking notes on what a speaker says not only demonstrates the importance of the speaker’s narrative, but lowers the risk that you will miss essential pieces that could matter significantly later in the dialogue.

- (If you sense discomfort, you could ask permission & dispose of the notes at the speaker’s request)

Technique #1

Diagnostic Listening: Example 1

- “In the 15 years, I’ve been a nurse, I have never seen behavior that is so atrocious. It’s appalling, the kind of things they say out in the hall in earshot of other patients – cursing, shouting at my staff. When the nurses go into the room, they crowd around the bed impeding our ability to care for Mrs. Jones. They complain about everything from the food to the way the IV is placed to the way we change the bed. My nurses should not have to take their verbal abuse.”
Technique #1

Diagnostic Listening: Example 2

- “My mother has been very consistent throughout the course of her ALS that she wants everything done. From the beginning, she said she would endure any procedure regardless of pain to get more time. I am honoring her wishes, and these doctors are painting me as a bad daughter, and a bad person. They wouldn’t want to live like this – it doesn’t matter. I hate the way they treat me, like I’m some religious fanatic. The constant guilt trip they lay on me. It has to stop.”

Technique #1

Diagnostic Listening

→ Working with a partner, let’s try the 2 examples in the packet...
Technique #2

Agenda-Setting

- Complex or heated conversations tend to meander, bouncing back and forth between topics/concerns
- Unproductive & causes Conversation-Fatigue

- Imperative that a focused agenda is created from a synthesis of concerns generated by Diagnostic Listening
- That agenda is confirmed with the stakeholders to test for accuracy & thoroughness
Technique #2

Agenda-Setting

- Steps:
  1. From the concerns generated by Diagnostic Listening, create a “laundry list” of issues from each stakeholder
  2. Organize into broad topics/themes for discussion
  3. Confirm accuracy & thoroughness with stakeholders

Technique #2

Agenda-Setting: Example 1

- “In the 15 years, I’ve been a nurse, I have never seen behavior that is so atrocious. It’s appalling, the kind of things they say out in the hall in earshot of other patients - cursing, shouting at my staff. When the nurses go into the room, they crowd around the bed impeding our ability to care for Mrs. Jones. They complain about everything from the food to the way the IV is placed to the way we change the bed. My nurses should not have to take their verbal abuse.”
Technique #2

Agenda-Setting: Example 1

- **Nursing Staff Agenda:**
  1. Family’s concerns about quality of patient care
  2. Difficulty caring for patient when family present in room
  3. Perception of verbal abuse of nurses by family
  4. Type, volume, content of conversations in public spaces

Technique #2

Agenda-Setting: Example 2

- “My mother has been very consistent throughout the course of her ALS that she wants everything done. From the beginning, she said she would endure any procedure regardless of pain to get more time. I am honoring her wishes, and these doctors are painting me as a bad daughter, and a bad person. *They* wouldn’t want to live like this – it doesn’t matter. I hate the way they treat me, like I’m some religious fanatic. The constant guilt trip they lay on me. It has to stop.”
Technique #2

Agenda-Setting: Example 2

- **Daughter’s Agenda:**
  1. Mother’s wishes as understood by daughter
  2. Values of the clinical staff vs. values of daughter/mother
  3. Perception of ill-treatment by clinical staff
  4. Care plan moving forward

Technique #2

Agenda Setting

→ Working with a partner, let’s try the 2 examples in the packet (first using Diagnostic Listening, then Agenda Setting)…