The role of mediation in advance care planning and end-of-life care

Craig Sinclair, Catherine Davidson, Kirsten Auret

Background

General practitioners (GPs) play a key role in advance care planning (ACP), but face a number of difficulties in implementing ACP in routine practice, including fear of disputes involving the patient’s family members. The interest-based negotiation approach employed by professional mediators may be a useful way of eliciting patients’ and their family members’ interests in ACP discussions, and establishing agreement and commitment to an advance care plan.

Objectives

This article introduces the key skill set of professional mediators, examines how this approach can be employed in general practice and presents an ‘interest mapping tool’ to assist the GP in managing ACP discussions.

Discussion

Interest-based negotiation differentiates between a person’s stated position and the interests underlying that position. By eliciting interests, the GP gains deeper insight into the factors driving patients’ and their family members’ preferences, and can identify shared interests as a basis for establishing agreement.

Mediation

Mediation is ‘a process in which participants, with the support of a mediator, identify issues, develop options, consider alternatives and make decisions about future actions and outcomes’.10

Mediation has received some attention in the health literature, though mostly as a means of resolving disagreements rather than a way of proactively eliciting values and goals and pre-empting conflict. The core of the mediation approach is interest-based negotiation, a key principle of which is differentiating between positions and interests.12 Interest-based negotiation proposes that beneath a person’s stated preference or position (eg ‘I don’t want to be resuscitated’) lie a number of interests that explain why a person holds that position (eg ‘I am suffering too much and no longer wish to live like this’).

Interests may be connected to a patient’s disease or practical situation, but are also motivated by deep human needs and emotions (eg fear, love).12 By eliciting interests, GPs can better understand the hidden factors driving patients’ and their families’ positions (Figure 1). Through this approach, the GP can model a collaborative approach to decision making, reduce the risk of miscommunication, and negotiate agreement and commitment to the ACP process.11 Additionally, we argue that by understanding the interests of other key people in a patient’s support network, patient autonomy can be promoted, and the ACP is more likely to be smoothly implemented.

A fundamental platform for interest-based negotiation is open disclosure by all parties of relevant interests that might inform decision making. Importantly, doctors also have other interests (eg professional, ethical, personal). Unlike a neutral mediator, for whom involvement is limited to the period of
negotiation, with no investment in any particular outcome, GPs will have ongoing relationships with patients and their family, and may be the doctor enacting decisions made in an advance care plan. The benefits of GPs sharing their own interests include strengthening the doctor–patient relationship, establishing a shared understanding of professional obligations, and minimising legal risk.

We illustrate these concepts through the case of Ellen (pseudonym), her GP and children. Ellen’s quoted material is drawn from a research interview (methods and ethical approvals described elsewhere). The perspectives of the GP and children are elaborated on the basis of the authors’ experience.

**Ellen**

Ellen is 83 years of age and lives alone in her family home. She has emphysema, requiring home oxygen, and is wheelchair-bound due to pain from arthritis. Ellen’s husband, Mick, is deceased. Ellen understands the seriousness of her emphysema and that it is incurable. She finds satisfaction in her life and strongly values her independence.

Four months ago, Ellen was hospitalised with pneumonia and required non-invasive ventilation and intensive chest physiotherapy. After discharge she saw her GP, whom she trusts:

> Well, we decided that because I have so many illnesses, that if I had a heart attack and I passed on, well they oughtn’t try to resuscitate me. Because I’d be coming back to a lot more pain and suffering. I definitely don’t want life support as far as I’m concerned. I could go tomorrow, so that’s why I made the decision not to be resuscitated, but at that stage, I didn’t discuss it with my family. I was in the doctor’s office, I talked it over with him. He said he’d make a note of it at this stage.

Despite Ellen’s clear views, she is unwilling to formally document her preferences for fear of upsetting her family:

> When I did mention it, it didn’t go down well. My family isn’t very happy about it. It’s more my daughter is the one that’s upset, more than my son. So where it’ll finish up I have no idea. I don’t want to make my family miserable by making a decision [writing an advance healthcare directive]. She spoke of the ‘need to discuss things more’, but was uncertain as to what exactly was upsetting her children:

> I presume the thought of it – they just don’t want to face it if I die. They don’t want me to suffer either, but at the same time they think that if I was brought back that I may have several more years of good life. It’d really take a case of the doctor and all the family all getting together at one time and we’d discuss it, but my family’s going in so many directions.

**Ellen’s GP (Dr Jones)**

Dr Jones has cared for Ellen for years. He was also the GP for Mick prior to his death two years ago, and assisted him in making end-of-life decisions. This led to conflict with Ellen and Mick’s daughter...
steps one and two through teachings in difficult consultations (eg clinical practice guidelines and SPIKES method). Eliciting interests and identifying shared interests is a platform for discussion about the options, standards, alternatives and commitments that are part of negotiating agreement. 

Prior to eliciting interests, the GP should establish agreement about the goals of the discussion. Figure 2 shows a mapping tool that may assist in aligning participants around a goal, and charting positions and interests. Importantly, this tool illustrates how a number of participants share common interests despite having differing positions. Identification of these common interests can be used in discussions to establish agreement and commitment to ACP.

The GP might introduce the tool by emphasising the goals (eg ‘We’re here because we care deeply that Ellen receives the best possible care’) and take the opportunity to disclose his own interests (eg ‘As Ellen’s GP, I have some professional obligations that I’d like you to know about’). The complexity of a family-based discussion results in part from the additional positions and interests present around the table. The mapping tool is particularly useful in such situations, and could be promoted as a way of maintaining focus on the discussion goals, ensuring all participants are heard and understood. Filling in the mapping tool provides participants (including the GP) with the opportunity to reflect on their own interests and creates a point of visual focus during difficult moments in the discussion. This process can develop a sense of affiliation between the participants – a key factor in maintaining open communication and collaborative decision making. 

Working from areas of shared interest (eg desire to avoid repetition of conflict associated with Mick’s end-of-life care) provides a starting point for exploring options, understanding and alleviating specific concerns, and establishing agreement and commitment to the ACP.

### Conclusion

By eliciting the interests of key people involved in Ellen’s care, the GP can develop an approach to ACP that promotes patient autonomy while remaining family-centred. By disclosing relevant personal interests,

<table>
<thead>
<tr>
<th>Table 1. Components of an interest-based negotiation</th>
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<tbody>
<tr>
<td><strong>Relationship</strong></td>
</tr>
<tr>
<td>Who is connected to the patient?</td>
</tr>
<tr>
<td>What is the nature of these relationships?</td>
</tr>
<tr>
<td>Who has an interest in this decision?</td>
</tr>
<tr>
<td>Who needs to be here?</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td>Are there notes from any previous conversations?</td>
</tr>
<tr>
<td>What are the relevant medical facts?</td>
</tr>
<tr>
<td>What medical records are required?</td>
</tr>
<tr>
<td><strong>Interests</strong></td>
</tr>
<tr>
<td>What are the goals, needs, concerns and fears for all concerned?</td>
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<tr>
<td>Which of these interests are shared?</td>
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<tr>
<td><strong>Options</strong></td>
</tr>
<tr>
<td>What actions best serve the patient’s interests and autonomy?</td>
</tr>
<tr>
<td><strong>Standards</strong></td>
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<tr>
<td>What legal, ethical or professional standards impact on options and decisions?</td>
</tr>
<tr>
<td>What cultural or familial expectations impact on options and decisions?</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
</tr>
<tr>
<td>What other options are available?</td>
</tr>
<tr>
<td><strong>Commitments</strong></td>
</tr>
<tr>
<td>Can we agree and can we document the outcome?</td>
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The GP may also establish deeper trust with patients and their families, and increase the likelihood of an advance care plan being smoothly implemented when required. While this approach requires the GP to invest time, we suggest that such time is well spent in terms of averting future disputes. Selective use of this strategy, along with growing political momentum towards specific Medicare funding for ACP discussion, makes interest-based negotiation a feasible approach to ACP in general practice.

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References

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