



“Dying is an art, like everything else.” ~Sylvia Plath

THE FINAL NEGOTIATION

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INTRODUCTION

We negotiate everyday. Roommates will negotiate a clean-up schedule. An employee will negotiate a pay raise with his boss. Negotiation is a part of everyday life and is a skill that is mastered throughout a lifetime by both lawyers and non-lawyers. The avenues in which parties come to an agreement differ according to age, experience, and personality. For example, a powerful criminal defense attorney may be a more hardball negotiator and adopt competitive bargaining tactics when she negotiates a plea deal for her client with the prosecutor because she has an ethical obligation to be a zealous advocate for her client.¹ On the other hand, a mother who wishes to maintain an ongoing and loving relationship with her daughter may negotiate more collaboratively when she strategizes how long her daughter can watch television.

For the most part, in a negotiation, individuals will not decide whether or not one will live or die.² When most people negotiate, they attempt to solve their problems amongst themselves instead of having a court make a decision. The ideal result is to resolve the dispute in a way where each party's interests are satisfied. This favorable result is not always achieved.

Most people fail to recognize the grim circumstances that will inevitably affect every family: Death. Death is certain for everyone. For the well prepared, the family will have a mutually agreed upon direction of where to go and what to do after a loved one dies. Other families may have taken the extra step by creating an advanced directive or living will that explains what to do in a situation where the donor is in a vegetative state.³ You and your family must be prepared for the situations where you may fall comatose. If you have not created an advanced directive, disputes will ensue about what to do next. As a comatose individual without any cognitive functions, you cannot make

¹ See Model Rules of Professional Conduct §1.3, 2008 edition, American Bar Association Center for Professional Responsibility.

² Extreme examples of incidents where negotiations may in fact decide whether or not one will die include: hostage negotiations, or cases where the consequences could hold maximum life-sentences or the death penalty.

³ “**Advanced directives** are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on. A **living will** tells how you feel about care intended to sustain life. You can accept or refuse medical care. There are many issues to address, including the use of dialysis and breathing machines, if you want to be resuscitated if breathing or heartbeat stops, tube feeding, organ or tissue donation.”

See: “Living Wills and Advance Directives for Medical Decisions.” Available at: <<http://www.nlm.nih.gov/medlineplus/advanceddirectives.html>>, last visited, January 17, 2011.

any of these decisions.⁴ It is as if you are a silent hostage in your own body. This situation can occur with both the elderly and the young adult.

The majority of individuals do not create advanced directives or living trusts. It would cut down on litigation and save family strife if individuals created these legal documents. According to Dr. Raymond Shields, the lead internist at The Mayo Clinic, “most patients do not have an advanced directive, although patients are asked about an advanced directive each time they arrive at the clinic for a procedure or a new outpatient appointment.”⁵ Some attorneys recommend their clients compose an advanced directive. Timothy Lappen, a successful Estate Planning attorney in Los Angeles advises his clients of all ages to compose a detailed advanced directive.⁶ Mr. Lappen discussed an example of advising a religious client on how to create a living will that directs the doctor to proceed with the least intrusive measures during treatment and what kind of blood product to accept in lieu of a blood transfusion.⁷

Recent legislation in Estate Law has greatly influenced families’ decisions in whether to terminate or maintain life-sustaining treatment for their comatose family member. On December 17, 2010, President Barack Obama signed into law the “Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010” (“TRA 2010”).⁸ This law affects the Estates of 2010 decedents.⁹ The way the law is constructed may breed grounds for elderly abuse and pre-mature death for the elderly in a comatose state. Further analysis of this phenomenon will be discussed later.

Roadmap

This paper will explore how Americans negotiate end-of-life disputes. In particular, it will discuss the need for an effective approach to negotiation as a means of resolving end-of-life disputes compared to litigation. Collaborative negotiation is the preferred way to resolve end-of-life disputes because it provides for a more respectful environment to discuss the different interests of the disputing parties, allows for a quicker

⁴ Some physicians may argue that some comatose individuals can see or hear. For purposes of this paper, please assume that comatose individuals do not have command of their sensory organs.

⁵ Dr. Raymond Shields, *Personal Telephone Interview*, January 9, 2011.

⁶ Timothy Lappen, partner at Jeffers Mangel, Mitchell and Butler, Los Angeles. *Personal interview*, January 13, 2011.

⁷ *Id.*

⁸ See “The New TRA 2010 Law,” available at: <<http://www.jeffjoneslaw.com/site/index.php/news/68-president-signs-2010-tax-law>>. last visited January 19, 2011.

⁹ *Id.*

resolution, and the decision will remain confidential. The research will explain 1.) The specific techniques negotiators should use to address the emotional and financial needs of the family members and personal representatives, 2.) The professional obligations of the physician, and 3.) The interests of the comatose individual, the voiceless individual whose life depends on the decision reached in negotiation. The paper will also discuss the conflicting bioethical, legal, and social obstacles to negotiating end-of-life disputes. The research will conclude with an exploration of the prospects of the area of negotiating end-of-life disputes and recommend a plan for negotiating end-of-life disputes.

Litigating End-of-Life Disputes

It is the New Year and you have made a resolution to lose weight. A friend of yours who has recently lost several pounds suggests you do a trial diet. One week into the diet, you fall into a coma. Although you had composed a will, you failed to compose an advanced directive.

The neurologist informs your immediate family that you are comatose and most likely will remain brain-dead for the rest of your life. Since you have neither formally nor informally stated what you would like to do in this situation, your family must decide whether to terminate or to maintain the life-sustaining treatment. On the one hand, your spouse has religious convictions that do not support artificial treatment. Your spouse also believes that you would not want the rest of your days to be in a hospital with a feeding tube inserted into your body. Alternatively, your parents want to keep you alive just in case there is a chance you come out of your coma. Since your family disagrees on what to do, they hire attorneys to battle your case in court. Following three years of taxing litigation, exorbitant attorney fees, and grueling appeals, the Court rules to terminate the life-support. The next day, your feeding tube is removed and you die five days later.

This case is far from unusual. This fact pattern is strikingly similar to the well-known Terri Schiavo case.¹⁰ There are many legal and moral issues within this case, and the matter will be discussed later in the paper. The following analysis will focus on the post-*Schiavo* increasing disapproval of the Court interfering in end-of-life decisions and the need for an alternative dispute resolution, specifically negotiation.

¹⁰ *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378 (M.D. Fla. 2005).

a.) *Cons of Litigating End-of-Life Disputes*

In American Hospitals, end-of-life disputes continue to increase. While the *HIPPA* Privacy Act prohibits hospitals from revealing the number of disputed cases, studies estimate that these disputes occur frequently.¹¹ Typically, the hospital staff sends the disputes to a Hospital Ethics Committee [“Committee”], an advisory panel that includes “doctors, nurses, social workers, an attorney, a chaplain, a medical ethics professional, and a member of the community.”¹² The University Hospital Medical Executive Board selects members to be placed on the Committee.¹³ “Upon request, the Committee evaluates ethical or moral questions that may rise at some stage in a patient’s care.”¹⁴ Dr. Shields states that the Clinic has an “Ethics Consultation Service that is available 24/7.”¹⁵ If the Committee cannot resolve the dispute, litigation, although not the preferred option, is the next step.¹⁶ Some may argue that the decision to end one’s life is a personal decision, one that should not be decided by a Court who has no relational, financial, or emotional interest in the outcome.

There are some advantages to litigating end-of-life disputes. If parties do not seek out alternative ways to resolve the dispute, the decision is usually left with the most dominant family member, and the decision could be very one-sided. The same could be argued about litigation since the wealthier side of the family could afford to hire the best attorneys and pay to drag the case out with appeals. However, litigation at least leaves the final decision to someone other than the family member, and each party does have the opportunity to tell his or her side to the Judge. While litigation is an avenue for parties who cannot decide whether or not to terminate or sustain life-support for a patient, there are pitfalls to litigating end-of-life disputes. Lawsuits are expensive and time-consuming. In end-of-life disputes, the patient has a short time left to live and any extension in the legal proceedings is a “de facto acceptance” of choosing death over life.¹⁷

Emotion is at the heart of an end-of-life dispute and litigation does not address the

¹¹ *Id.*

¹² Dr. Raymond Shields, *supra* note 5.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Cohen, Glenn, “Negotiating Death: ADR and End of Life Decision-Making,” *Harvard Negotiation Law Review*, Vol. 9, No. 253, 2004, at 15.

emotional needs of the parties since the court system is designed to make decisions based on facts and on the law.¹⁸ Emotions are combined of sadness about the patient's predicament, anger over conflicted solutions to the situation, confusion about whose decision is best, and pressure to make a decision quickly. The patient's last moments depend on the final decision and are often at the heart of these kinds of disputes. The parties may be clouded in their ability to think rationally. When the courts make decisions in end-of-life disputes, "family privacy and patient autonomy are undermined."¹⁹ The nature of the patient's illness and the strife between the families become public record. The adversarial court proceedings can stir more flame to the already fiery family situation.

Instead, collaborative negotiation is a proper alternative in an end-of-life dispute when time is of the essence. The set-up of negotiation allows parties to make more of the ground rules and is less formal than litigation.²⁰ Also, decisions are made much quicker compared to litigation. The Joint National Commission on ADR in Health Care recommends, "ADR proceedings occur within a reasonable time, and without undue delay."²¹ Specifically, the provisions suggest, "recommended time frames for resolving disputes: acute emergencies—24 hours; emergencies—72 hours; non-emergencies—60 days."²² These procedural guidelines suggest a quick resolution for the end-of-life disputes.

Collaborative negotiation is the preferred method of resolving end-of-life disputes since the process allows for a "candid discussion of emotions, perceptions, interests, goals and values."²³ The structure of negotiation allows individuals to bargain and compromise:

When a dispute emerges and negotiations begin, the two parties start at a distance from one another, in disagreement, opposition, and conflict, with disparate ideas and expectations about an acceptable outcome. Through the process of negotiation the parties gradually may be able to come together into coordination and collusion and, in the end, to some agreement

¹⁸ *Id.* at 1.

¹⁹ Canter, Joanna, "Nonjudicial Alternatives for Resolving End-of-life Decisions For Minors," 43 *Fam. Ct. Rev.* 527, July 2005, at 10.

²⁰ Geller, Alisa L., "In the Aftermath of the Terri Schiavo Case: Resolving End-of-Life Disputes Through Alternative Dispute Resolution." 6 *Pepp. Disp. Resol. L.J.* 62, 2006, at 4

²¹ *Id.*, at 4.

²² *Id.*, at 4.

²³ Geller, *supra* note 18, at 1.

between them.²⁴

The results of the negotiation remain confidential and the parties do not have to disclose any details to the public. Negotiation allows disputing parties to participate in collaborative bargaining and to focus on their respective interests instead of legal positions.²⁵

b.) Laws Affecting End-of-Life Disputes

With the influx of end-of-life disputes, one must be reminded of the patient's Constitutional right to life. The 14th Amendment of the United State's Constitution provides that, "No State shall deprive any person of life without due process of law."²⁶ For persons on life-support, Congress has further established rights of incapacitated²⁷ individuals. Chapter 89 of Title XXVII of the United States Code §1453 provides "Protection of Rights of Incapacitated Persons."²⁸ This act allows the patient or personal representative of the patient to, within "30 days following exhaustion of all available State remedies, remove any claim or cause of action the State has implemented," including withdrawing treatment or nutrition."²⁹ The Code empowers patients and their personal representatives to overrule the Court's decision to determinate life-support.³⁰

While Congress has enacted some bills that support patient autonomy, other Laws have authorized the hospitals or doctors to make the decision without penalty of criminal or civil sanctions. In 1999, the Texas legislature passed the "Texas Advanced Directives Act."³¹ Much debate has occurred over §166.046(e) of the Code. This Section permits a doctor or medical facility to terminate life-support "ten days after giving written notice if the continuation of life-sustaining treatment is considered inappropriate by the treating medical team."³² The Code essentially immunizes doctors and hospitals from wrongful death suits provided certain procedures are followed, including:

- 1.) Family must be given written information concerning hospital policy

²⁴ Wiggins, Charles B. and L. Randolph Lowry. Negotiation and Settlement Advocacy: A Book of Readings: A Second Edition, West: St. Paul, MN, 2005, at 4.

²⁵ Sybbis, Sheaa, "Mediation in the Health Care System: Creative Problem Solving," at 6.

²⁶ 14th Amendment of the United States Constitution.

²⁷ 'Incapacitated:' "individual who is not capable of making cognitive decisions about withdrawing nutrition or medical treatment under applicable law." (*Webster's Dictionary, 2008*).

²⁸ Chapter 89 of Title XXVIII of United States Code §1453: Protection of Rights of Incapacitated Persons.

²⁹ *Id.*

³⁰ *Id.*

³¹ Texas Statutes Health & Safety Code, Chapter 166. ADVANCED DIRECTIVES §166.046.

³² *Id.*

on the ethics consultation process.

- 2.) The family must be given 48 hours' notice and be invited to participate in the ethics consultation process. Family members may consult their own medical specialists and legal advisors if they wish.
- 3.) The ethics consultation process must provide a written report to the family of the findings of the ethics review process.
- 4.) If the ethics committee cannot resolve dispute, the committee must attempt to arrange transfer to another provider physician and institution who are willing to give the treatment requested by the family and refused by the current treatment team.
- 5.) If after 10 days, no such provider can be found, the hospital may withdraw therapy.
- 6.) The party who disagrees with the decision could appeal to the relevant state court and request the judge to grant an extension of the time before treatment is withdrawn. The extension is to be granted only if the judge determines that there is a reasonable likelihood of finding a willing provider of the disputed treatment if more time is granted.
- 7.) If either the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil or criminal prosecution.³³

This code is applicable in Texas only. The provisions protect families where hospitals insist on terminating life-support.³⁴ There are some advantages to the Texas Advanced Directive Act. For one, it encourages a quick resolution to the end-of-life dispute and it encourages family members and their attorneys to collaborate with the ethics consultation.³⁵ Also, the act does not discriminate between poor and wealthy families.³⁶ Further, "if the ethics committee fails to return with a resolution, the Law mandates that the committee transfer the patient to another hospital that will carry out the treatment plan that the family had demanded."³⁷ The disadvantage is that the time-pressure of ten days may not be enough time for committee to find another hospital to maintain life support.³⁸

c.) Courts Cases

Courts struggle to uphold patient autonomy and the court's inherent authority to decide these cases.³⁹ *Roe v. Wade*⁴⁰ was the premier case to concede patient autonomy when the Court advocated a woman's right to choose. After *Roe*, many cases followed and sought a constitutional "right to die and the right to refuse treatment."⁴¹ In the decision of *In re Karen Quinlan*,⁴² the Court refused to issue an injunction to sustain life-

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ Sybbis, Sheaa, *supra* note 25, at 2.

⁴⁰ See *Roe v. Wade*, 410 U.S. 113 (1973)

⁴¹ *Id.*, at 2.

⁴² See *In Re Karen Quinlan*, 355 A.2d 647 (1976).

sustaining treatment.⁴³ The court left that decision with the family.⁴⁴

After famous baseball star Ted Williams died of heart disease, the family fought over what to do with his body. Some wanted to preserve his body through cryogenics.⁴⁵ Other siblings wanted to cremate him.⁴⁶ Reports state that the consent form for cryonic suspension did not have Williams' signature.⁴⁷ An investigation claims that the only evidence that Ted Williams wished to have his body preserved through cryogenics was from a "scrap paper stained with motor oil and dated Nov. 2, 2000."⁴⁸ The document allegedly includes the signatures of the children of Ted Williams and discusses "their desire to be put in Bio-Stasis after we die in the chance of the three of them might be together in the future."⁴⁹ Since his death, Courts have questioned the authenticity of the signature of the documents.⁵⁰ Today, his severed head remains preserved through cryogenics, and the rest of his body is preserved separately in a Cryonics lab in Arizona.⁵¹

Litigation ensued because the parties disputed over what Ted Williams intended to have done with his body after he died. The whole public knows about the grim details of this case, not only because Ted Williams was a famous baseball player, but also because the dispute has become public record through litigation. Perhaps if the parties had sought Alternative Dispute Resolution such as negotiation, the confidentiality of the preservation process would have been upheld.

d.) Defining the Patient's Intent

A key issue in negotiating end-of-life disputes includes defining the patient's intent. If parties could identify this information, then disagreements about what to do with a patient's body would decrease. Recent Court decisions have endeavored to define

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ Cryogenics: the practice or technique of deep-freezing the bodies of those who have died of an incurable disease in the hope of a future cure. *Source:* Webster's Dictionary, 2008 edition.

⁴⁶ "Would Freezing Ted Williams Really Work?" *Available at:* <<http://abcnews.go.com/US/story?id=91481&page=1>>, last visited, January 17, 2011.

⁴⁷ *Id.*

⁴⁸ "What happened to Ted? SI: Hall of Fame's Bizarre Post-Mortem defies Belief." *Available at:* <http://sportsillustrated.cnn.com/baseball/news/2003/08/12/williams_si/>, last visited: January 16, 2011.>

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

the patient's intent.⁵² The majority of these decisions favored terminating life-support over sustaining it.

The root of the problem lies with identifying the intent of a patient who did not compose an advanced directive. Without this documentation or any other evidence of the patient's intent, it is close to impossible to determine what the patient truly wants. Equitable arguments that favor life over death may work, but are not always the winning position.

It appears that litigation has caused more confusion and strife to resolving end-of-life disputes with failed attempts to define the intent of the patient. Alternative Dispute Resolution, specifically negotiation should be explored—a process that is less expensive and more private. Negotiation could provide a more affordable and collaborative avenue for resolving sensitive end-of-life disputes.⁵³

Negotiation Procedures in End-of-Life Disputes

End-of-Life disputes are particularly complex cases, ones that inexperienced negotiators may not be prepared for. Estate Laws are multi-faceted and change frequently. Statutory laws that give rights to physicians and hospitals vary statewide. Case law precedent is inconsistent in that it struggles to balance a patient's 14th amendment right to life and a right to die with the hospital's right to terminate support without incurring criminal or civil sanctions. Different religions and cultures influence the moral dilemmas individuals have about life-sustaining treatment. Emotions run high, and parties to the negotiation could be very hostile since the decision will determine whether or not their loved one will live or die. Thus, a negotiator of an end-of-life dispute must be particularly experienced in handling these kinds of cases in order to advocate for the party effectively.

Although not all negotiators are attorneys, having a legal background or at least experience as a negotiator would be very helpful since most states have different laws about hospital policies, and much of the rights inherent to patients are given in laws.

⁵² See *Cruzan*, 497 US 261 (1976) where the Court sustained a MO statute that "proscribed the withdrawal of treatment for a comatose patient except when there was clear and convincing evidence that the patient would have wanted to terminate that treatment." See also *In Re Matter of Claire Conroy*, 486 A.2d 1209 (N.J. 1985), where the Court decreed that, "mentally disabled individuals in a nursing home could, under proper conditions, end treatment even when they had a life expectancy of a year."

⁵³ Shelton, David M. "Keeping End-Of-Life Decisions Away from Courts After Thirty years of Failure: Bioethical Mediation as an Alternative for Resolving End-of-Life Disputes," at 20.

Furthermore, studies in bio-ethics and different religions and cultures would assist the negotiator in understanding a party's personal convictions behind a certain position of whether or not to accept life-support.

a.) Terminology in Negotiation:

Throughout this analysis, various terms will be used to explain the process of negotiation. Below is a chart of some commonly used terms in the area of negotiation.

BATNA	Best Alternative to a Negotiated Agreement. ⁵⁴ “It is the alternative action that will be taken should your proposed agreement with another party result in an unsatisfactory agreement or when an agreement fails to materialize. If the potential results of your current negotiation only offer a value that is less than your BATNA, there is no point in proceeding with the negotiation, and one should use their best available alternative option instead. Prior to the start of negotiations, each party should have ascertained their own individual BATNA.” ⁵⁵
ZOPA	Zone of Possible Agreement. This term is used throughout the bargaining process and discussed as prices or positions where parties are willing to agree on. ⁵⁶
RP	Reservation Price. ⁵⁷ “The reservation price is the least favorable point at which one will accept a negotiated agreement. For example, for a seller this means the least amount (minimum) or bottom line they would be prepared to accept, while for a buyer it would mean the most (maximum) or bottom line that they would be prepared to pay. It is also sometimes referred to as the ‘walk away’ point.” ⁵⁸
TFT	“Tit-for-Tat: typically includes communications that neither advanced nor hinder an agreement. It is a communication tactic that focuses on self-interest without conceding.” ⁵⁹
Position	“The official defined stance or standpoint that a negotiator will strongly defend. The interests of a negotiating party in the negotiation process usually determine the position. A position is often defined in the contract that a party puts forward or is proposing to their counterpart.” ⁶⁰
WATNA	Worst Alternative to a Negotiated Agreement. “Your WATNA represents several paths that you can follow if a resolution cannot be made.” ⁶¹
Concede / Concession	“Negotiation Concessions are also sometimes referred to as ‘Trade-Offs’ where one or more parties to a negotiation engage in conceding, yielding, or compromising on issues under negotiation and do so either willingly or unwillingly. Negotiation Concessions often include ‘log rolling’.” ⁶²
Position	“Why We Want Something.” ⁶³
Caucus	To break in between offers and concessions. This usually occurs when parties have reached an impasse. ⁶⁴

⁵⁴ Professor Jasper Kim, Pepperdine University School of Law, Class Lecture, January 3, 2011.

⁵⁵ Available at: <<http://www.negotiations.com/definition/>>, last visited, January 21, 2011.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ Available at: <<http://www.negotiations.com/definition/reservation-price/>>, last visited, January 21, 2011.

⁶¹ Available at: <www.pn.harvard.edu/glossary/watna/>, last visited, January 21, 2011.

⁶² Available at: <<http://www.negotiations.com/definition/>>, last visited, January 21, 2011.

⁶³ Available at: <<http://www.negotiations.com/definition/>>, last visited, January 21, 2011.

⁶⁴ Professor Jasper Kim, Pepperdine University School of Law, Class Lecture, January 4, 2011.

Wiggins and Lowry define the negotiation process as “a communication process that people use to plan transactions and resolve conflict.”⁶⁵ Like litigation, the negotiation process is one of information gathering. To a great extent, the stages of negotiation control the information that is exchanged.⁶⁶ For example, in an end-of-life collaborative negotiation, the first piece of information given will most likely discuss the emotional side of the case: what the patient means to the family and how much they love him or her. This information will establish commonality between the two parties and create a friendlier atmosphere for collaborative negotiation. The last piece of information may include a recommendation as to why one should terminate or suspend life-sustaining treatment for this information is the crux of the disagreement and the one that will bring the most barriers to creating a resolution.

Negotiation is unlike litigation in that individuals are able to express all of their respective interests, not just factual ones that the court may deem relevant. Parties to an end-of-life negotiation have specific interests: 1.) Financial: heirs may be waiting for the patient to die so that they can receive their inheritance. Also, those who oppose sustaining life-support may be deterred by the financial costs of keeping the patient on life-support. Mr. Timothy Lappen, the Los Angeles Partner at Jeffers Mangel, Mitchell, and Butler, states that life-support treatment is very expensive and can cost from between \$6,000 to \$22,000 daily.⁶⁷ 2.) Moral: some parties may not believe in artificial sustenance of life. Some religions denounce blood transfusions, organ transplants, and other life-sustaining treatments.⁶⁸ 3.) Fiduciary: Doctors and Hospitals may have a policy that forbids them to keep a patient on life-support for an extended amount of time without a clear intent from the patient to remain on sustenance.⁶⁹ Furthermore, financial resources of the hospital may be depleted if the life-sustaining treatment is prolonged.

The premise of negotiation is to reach an agreement whereas in litigation, there is the winning party and the losing party. The best alternative to a negotiated agreement (BATNA) for parties in an end-of-life dispute is a matter of life or death. For example, a

⁶⁵ Wiggins, Charles B. and L. Randolph Lowry, *supra* note 42.

⁶⁶ *Id.*, at 6.

⁶⁷ Timothy Lappen, *supra* note 6.

⁶⁸ Jehovah's Witnesses to not accept life-sustaining treatments. See: “Highlights of the Beliefs of Jehovah's Witnesses.” Available at: <http://www.towerwatch.com/witnesses/beliefs/their_beliefs.htm>, last visited January 23, 2011.

⁶⁹ Dr. Raymond Shields, *supra* note 5.

negotiator's BATNA who advocates for the party that wishes to sustain life-support is to keep the life-support on at least one more day, or to extend the treatment until a final agreement can be made. The worst alternative to a negotiated agreement (WATNA) would be that the life-support is terminated.

b.) Two Kinds of Negotiators: Competitive and Collaborative

Wiggins and Lowry define two types of negotiators: Competitive and Collaborative.⁷⁰ Competitive negotiation is similar to litigation in that the parties are generally adversarial and their primary goal is to maximize their self-interest.⁷¹ Competitive negotiators tend to be more positional and put their self-interests first over the other side's interest or position.⁷² The competitive negotiator plays hardball and rarely budes past a "fixed pie" ideal outcome.⁷³ A competitive negotiator of end-of-life disputes will often use TFT tactics just to build a block of self-interest and delay a decision. On the other hand, the cooperative negotiator focuses on a more integrative bargaining, where he identifies common interests and is willing to "expand the pie" of an ideal outcome.⁷⁴ With cooperative negotiation, a ZOPA is evident and there may be some flexibility in achieving a mutual agreement.

c.) Set-up of the Negotiation Table

Because of the sensitive nature of end-of-life disputes, collaborative negotiation would be the preferred method to resolve these disputes. Competitive negotiation mirrors much of the adversarial litigation scheme. The collaborative negotiator should focus on giving a respectful and flexible first offer. Due to the time-sensitive nature of end-of-life disputes, the end result can come out one way: either terminate or sustain life-sustaining treatment. There will be two sides to a negotiation table: A.) Terminate life support B.) Maintain life support. The reservation price of side A would want to have powerful and influential reasons for terminating life-sustaining treatment. The most powerful argument would be for financial reasons, specifically the costs of artificial sustenance. The RP, or bottom line for Side A would be to terminate life support whereas the RP for side B would be to maintain life-support even if for an extra day in order to accomplish

⁷⁰ Wiggins and Lowry, *supra* note 24.

⁷¹ *Id.*

⁷² *Id.*

⁷³ Professor Jasper Kim, Pepperdine University School of Law, Class Lecture, January 4, 2011.

⁷⁴ *Id.*

what they think would be the patient's and the family's best interest. If the child is a minor, the party may argue that if there is any chance of survival, they should hold out and not terminate the life-support.

Because the decision in a negotiated end-of-life dispute is a matter of life or death for the patient, great care should be taken in preparing opening offers and returning with a concession. When the negotiator makes her offer it should be reasonable, that way the other party should not be insulted to the point where he or she wants to end the negotiation. The negotiator should not concede too early since a premature concession fails to make a diligent effort to negotiate a mutually accepted agreement.

An example of a reasonable opening offer for a negotiator advocating for the party who wants to terminate life support would ask a question: 'please explain your position to maintain life-support when there is a 99% chance that the individual will not ever regain brain functions?' This party should be careful not to suggest termination yet, for this is the exact opposite of what the other party wants. Instead, the offer that is in the form of a question forces the other party to rationalize in a persuasive way, why the life-support should be sustained. The answer, if given, will help to identify the primary position of the party. Behind every position is an interest, and if the parties can identify a common interest, they can create a broader ZOPA.

Perhaps the interest in maintaining the life-support is a slim hope that the patient may survive. If that is the position, it is important for the negotiator to acknowledge the party's interest in the life of the patient and further clarify that both parties care deeply about the patient. The parties are both highly emotional, and although emotions are important feelings, they sometimes obscure the thinking processes at the negotiation table. When both parties identify a mutual understanding that both parties love the patient, the question of who loves the patient most will be squashed.

The negotiator for the party who wants to sustain the life-support should, instead of giving an offer, ask the question as to why the parties want to terminate life-support. Perhaps the interest is financial, since life-sustaining treatment is expensive.⁷⁵ Finances are a legitimate interest that must be respected. The party wishing to keep the life-

⁷⁵ Estate Planning attorney Tim Lappen estimates that the cost of life support per day can be anywhere between \$6,000 and \$22,000 per day.

support could offer to finance the treatment. This offer is respectful in that it addresses the party's interest in not spending excessive medical fees. It is also a collaborative effort to resolve the dispute because it offers to pick up a burden while at the same time kindly suggesting the other side to concede to the offer to maintain the life-support.

Offers should have reasonable explanations and should be respectful of the other party's interest and of the patient's life predicament. Thus offers that are merely tit-for-tat (TFT) not only waste time, but they also do not achieve anything worthwhile. An example of TFT includes the following scenario: One party's interest is that of 'saving' the patient before he passes away by having a clergyman 'bless' the patient before he passes, the negotiator for that party will concede that they hold off on terminating the life support until the clergyman can bless the patient. A TFT will be a concession from the other side to terminate the life-support now. The other party's concession is purely one that discount's the other party's interest in an eventual termination, but only after the patient has been blessed before dying. The other party's concession is made just to seek its own interest of terminating life-support.

d.) Identifying the Parties' Interest

A preferred resolution to an end-of-life dispute would identify and fulfill each party's interest.⁷⁶ In order to successfully settle end-of-life disputes, it is important to respect the interests of the parties involved and negotiate an outcome that is in the best interest of the patient.⁷⁷ Each party will bring different interests to the table.⁷⁸ The negotiator should prioritize the patient's interest because the decision will determine whether the patient lives or dies. It may be difficult to define the party's interest if the patient did not create an advanced directive before or specify intent. Then, the negotiator should consider the interests of the patient's family members. One side may be religious and not want artificial sustenance while the other side may also be religious and want to wait for the body to be blessed before entering the after-life. Alternatively, the other side may want to keep the patient alive in hopes of a full recovery. Another interest of a particular wealthy party where the patient did not compose an advanced directive could include wanting to cash out in an Estate. The negotiator may have an ethical dilemma if

⁷⁶ Shelton, David M., *supra* note 53, at 6.

⁷⁷ *Id.*, at 6.

⁷⁸ *Id.*, at 6.

confronted with advocating for this particular family. Should money play a role in terminating one's life? The following analysis will discuss the effect of the new 2010 Estate Law on end-of-life disputes.

e.) 2010 Legislation in Estate Law and its Effects on End-of-Life Disputes

For Estates in the year 2010 “that have a net worth of under \$5 million, the estate will be subject to the estate tax, but will not have to pay any federal estate taxes. This exemption applies per individual for the years 2010-2012.”⁷⁹ The law is effective only until 2013.⁸⁰ By 2013, “the amount of the estate that can be tax-free will return to \$1 million per person.”⁸¹ Further, the TRA 2010 law “reduces the top estate and gift tax rate to 35% in 2010-2012, and to transfers in 2013 and beyond, the top rate will return to 55%.”⁸² Unless Congress changes the law between now and 2013, “someone dying in 2013 will only be able to exclude \$1 million in income without incurring an estate tax.”⁸³ For individuals in an end-of-life dispute with wealthy individuals, the ones who wish to sustain life-support may want to terminate the patient before 2013 so that their estate could exclude up to \$5 million instead of \$1 million, the amount the estate could exclude in 2013. The incentive to terminate early, although it sounds suspect at first, could be interpreted as a way to protect the estate from losing more money. The side advocating for termination of life-support could propose that the patient intended to take care of her family and would be unhappy if the estate would be taxed more in 2013 if she could have saved her family \$4 million in estate taxes if she died in 2012.

Future of Negotiating End-of-Life Disputes

With the advancement of medical technology to prolong life and sustain otherwise ‘almost dead’ individuals, many patients may be spending their last moments on life support. Because the majority of individuals do not create an advanced directive or living will that clearly expresses one's intent should they fall comatose, end-of-life disputes continue to arise. It is impossible to predict how one's life will end, and this is

⁷⁹ See “President signs 2010 Tax Law.” Available at: <<http://www.jeffjoneslaw.com/site/index.php/new/68-president-signs-2010-tax-law>>, last visited, January 19, 2011.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

why many find it difficult to create an advanced directive.⁸⁴ Another option is a plan to discuss with their families and close friends about what they would want to do in the event one falls comatose.⁸⁵ These kinds of statements that are made continually may help determine what course of action to take in that given situation.⁸⁶ Also, doctors should suggest patients execute a power of attorney.⁸⁷ This arrangement is a “legal instrument that entitles a designated person to make decisions about the patient’s medical care when the patient is unable to do so.”⁸⁸ The power of attorney could be a sibling, parent, or a close friend.⁸⁹ If a patient has not created an advanced directive, this setup allows the decision to be made by a trusted individual.⁹⁰

Religious conviction, emotional attachment, financial interests, and the recent passing of the new Estate Law complicate the decision as to whether to maintain or terminate life-sustaining treatment. Also, financial hardships and dissatisfaction with Courts deciding personal end-of-life decisions have demanded an alternative way to resolve these kinds of disputes.

Congress has acknowledged the need to implement a rule where hospitals notify patients about the option to form an advanced directive. In 1990, Congress passed “The Patients’ Self-Determination Act.”⁹¹ This Act requires all hospitals “that sponsor Medicare or Medicaid to ask all adult inpatients if they have advanced directives, to document their answers, and to provide information on state laws and hospital policies.”⁹² Hospices and Home Health agencies have employed comparable requirements.⁹³ This advancement in the American legislature has assisted with informing people on understanding about and creating advanced directives. There are some limitations to the law. The Act does not apply to doctors who practice outside of hospitals.⁹⁴ So those individuals who seek private care may not be advised on the necessity to create an

⁸⁴ “Medical Ethics and Advanced Directives,” *Available at*: <http://www.uic.edu/depts/mcam/ethics/adv_dir.htm>, last visited January 22, 2011.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *State of Washington, et. al. v. Glucksberg, M.D., et. al*, 117 S.Ct. 37, U.S. *Amicus Brief*, 1996, at 24.

⁹² *Id.*, at 24.

⁹³ *Id.*, at 24.

⁹⁴ *Id.*, at 24.

advanced directive. This is why it is important for individuals to discuss with their family and close friends what they would want to happen should they fall comatose.

Critics continue to disapprove of alternative dispute resolution (ADR) in the health care system, particularly in the arena of end-of-life disputes. These individuals argue that, “ADR challenges the integrity of the medical profession whenever the agreement required the doctor to uphold the patient’s wishes.”⁹⁵ The respect of the medical profession is an important societal interest that should be balanced with patient autonomy.⁹⁶

Other opponents to ADR may fear that negotiators who are not necessarily Estate Planning lawyers are not equipped for the highly emotional and difficult end-of-life disputes. Parties to end-of-life disputes include doctors and hospitals and their attorneys, the family members who want to sustain life-support and their attorneys, and the attorneys of the parties who want to terminate life-support. The negotiator of end-of-life disputes must be well trained to negotiate with professionals, understand the area of Estate law, and comprehend bioethics. While the ABA has not implemented a specific training program for negotiators of end-of-life disputes, it would be advantageous for negotiators to have some training in bioethics and experience in negotiating end-of-life disputes through class simulations. It is important for the negotiator to have these skills in order to facilitate collaborative dialogue with the other parties.

FINAL THOUGHTS

The decision to end life-sustaining treatment for a family member is one of the toughest choices a family will make. While the court is an option for individuals who have problems making a decision and who have the financial means to litigate, the process itself is a grueling and time-consuming one. For the majority of individuals who face end-of-life disputes, the legal system only further complicates the situation. Court proceedings take anywhere from six months to two years or longer. Litigation also bankrupts families when they incur excessive attorney fees. Since cases that go to Court become public record, the family’s private lives will be exposed and the dignity of the patient tarnished. The intimate details of the family’s conflict and the patient’s health

⁹⁵ Thaddeus M. Pope and Ellen A. Waldman, “Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure,” 23 Ohio St. J. on Disp. Resol. 143, January 18, 2007, at 13.

⁹⁶ *Id.*

predicament are available for just about anyone to read. Individuals who are dissatisfied with the Courts deciding end-of-life disputes seek an alternative way to resolve these kinds of disputes.

Compared to litigation, collaborative negotiation is cost-effective. While litigation may destroy the relationship between the disputing parties, collaborative negotiation attempts to create an outcome where both parties are pleased with the results. In end-of-life disputes, time is of the essence for a decision to end or sustain one's life. The litigation process can take months or years before a decision is made. The patient may pass away before a Court even releases a verdict. The procedural guidelines implemented by the Joint Commission on Health Care and ADR provide for a quicker way to resolve end-of-life disputes.

Negotiation allows each party to voice his or her respective emotional, financial, and moral interests to either terminate or maintain the life-support. The process also allows the parties to create resolutions without having a judge make the decision for them. The negotiation is confidential and the privacy of the patient and the family is respected. It is immature to say that all negotiations will provide an optimum result all the time. Still, in a situation where parties cannot afford litigation or agree to litigate for a case where a family member's last moments are spent on life-support, the final negotiation will be expected to be carried out in a timely, private, respectful, and collaborative way for the voice-less individual whose life depends on the ultimate decision.