



ADReport

**Alternative Dispute
Resolution Section**

Andrea Terry, **Chair**
David Simison, **Editor**

Maryland State Bar Association, Inc.

Volume Seven. No. Five
June 2011

ADR SECTION COUNCIL NOMINATIONS 2011

The Nominating Committee (Andrea Terry, Craig Distelhorst, Eric Imperial, Bob Rhudy and Jonathan Rosenthal) made the following nominations to the Section Council:

Secretary	Robert Mueller
3 year term	Susanne Henley Eric Johnson
2 year term	Linda Sorg Ostovitz Lindsay Barranco James Sauer
1 year term	Nicholas Monteleone

Elections will be held at the Annual Meeting in Ocean City, Thursday, June 9, 2011 at 8:00 a.m.

The Chair of the Section Council is filled by the Vice-Chair from the immediately preceding year. The Vice-Chair of the Section Council is filled by the Secretary from the immediately preceding year.

Section Council Members are elected to three year terms unless they are being elected to fill a vacancy in which case they are elected to serve the balance of the term that was vacated.

Message from the Chair

Dear Colleagues,

As my term as Chair of this terrific Section winds down, I am amazed at how fast the year went and how much we've accomplished. I want to thank my entire Council for their active participation, support and service to the Section. We are lucky to have such an experienced and thoughtful Council leading our Section. I wish all the best luck to in-coming Chair Craig Distelhorst for a banner year in 2011-12.

Among our goals met this year include presenting several timely informational programs for ADR practitioners. The Fall presentation on the proposed changes to Rule 17 regarding mediator fees was heavily attended, videotaped, and is now available on our website for those who were unable to attend. The same can be said for the Spring panel presentation on the uncertain state of confidentiality in mediation in Maryland and where it might be headed. Similarly, our section's presentations at the MSBA Annual Meeting in Ocean City on whether or not mediators should draft agreements will give participants a clear headed discussion from both sides and also some practical tips to consider when deciding what you will do in your practice. We partnered with the MSBA's newest section, the Construction Law section to co-present an Annual Meeting program addressing the use of ADR in complex construction disputes that will have good cross-section appeal.

Another goal set by our Section Council was to reach out to local bar ADR groups. This was well received by many

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Pizza and Professionalism

... when YOU get the subpoena

CONFIDENTIALITY IN MEDIATION

Roger Wolf
John Bickerman
Dan Dozier
Cecilia Paizs - Moderator

Tuesday, May 24, 2011

6:00 pm - 8:00 pm

University of Maryland

School of Law

Room 107

500 W. Baltimore St

Baltimore, Maryland

Free admission to ADR Section Members
\$5.00 admission to non-members

Collaborative Happenings-

~Maryland Judiciary Supports Collaborative Law Training~

By Suzy Eckstein

According to the International Academy of Collaborative Professionals, more than 30,000 professionals have been trained in Collaborative Practice throughout the world. Now the world of Collaborative Practice is expanding in Maryland thanks to the Administrative Office of Courts' sponsoring a training for over 100 Maryland attorneys this past March. The training was almost wholly financially supported by the AOC with attendees paying only a nominal fee. The Maryland State Bar Association partnered with the AOC to sponsor the training.

Many leaders in the community attended the training, including, Jana Singer, Professor at the University of Maryland Law School; Trish Weaver, President of the Montgomery County Bar Association; Master Paul Eason, Prince George's County; Neil Helfrich, Past President of the MSBA; and a member of the Attorney Grievance Commission.

The training team, CPTI- Collaborative Practice Training Institute, LLC, was one of the best in the country. Attendees noted that each of the trainers (18 total) were uniformly engaging and informative. The author of this article has coordinated and attended many basic and advanced trainings over the past seven (7) years both with trainers from all over the United States and from Canada, and in her opinion, this was the pre-eminent training. The power of collaborative as presented by the trainers was summed up by one attendee who commented, "this was the best moment in my professional life."

Connie Kratovil-Lavelle, Executive Director of the Family Law Administration arm of AOC, was the moving force in putting the training together. Connie was trained in collaborative practice several years ago and has an interest in promoting the practice and

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ADR Annual Spring Event at the AVAM

On April 27, 2011, the ADR section hosted its annual spring event at the American Visionary Art Museum in Baltimore. More than seventy members of the section and guests turned out to honor Judge Melanie Vaughn, this year's recipient of The Chief Judge Robert M. Bell Award for Outstanding Contribution to Alternative Dispute Resolution in Maryland. This award was created to honor the vision and accomplishments of Maryland Court of Appeals Chief Judge Robert M. Bell for his work in promoting the use of ADR in the Maryland judiciary, schools, government and communities.

Judge Vaughn was an early pioneer of the ADR movement in Maryland. She is an adjunct professor at the University of Baltimore School of Law where she teaches courses in law and conflict resolution. In addition to maintaining an active



Bell Awardee Hon. Melanie Vaughn and Section Chair Andrea Terry

ADR practice, Judge Vaughn has trained numerous ADR practitioners in skills-based mediation workshops. She was appointed by Chief Judge Bell to the Maryland Alternative Dispute Resolution Commission, and she is the past chair of the Maryland State Bar ADR Section. In accepting the award, Judge Vaughn graciously thanked her family and all the members of the ADR community that have supported her work through the years.

The keynote speaker for the evening was Ambassador Stuart Eizenstat who spoke about his work providing belated justice

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Proposed ADR Section Council 2011-2012 Nominees in *Bold Italics*

Chair	Craig Distelhorst
Vice-Chair	David Simison
Secretary	<i>Robert Mueller</i>
Treasurer	Hon. Theresa Furnari
Immediate Past Chair	Andrea Terry
3 year term	<i>Susanne Henley</i> <i>Eric Johnson</i> <i>Linda Sorg Ostovitz</i>
2 year term	<i>Lindsay Barranco</i> Gary Norman Cecilia Paizs <i>James Sauer</i>
1 year term	Dan Dozier Neil Helfrich <i>Nicholas Monteleone</i> Ken Vogel

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Retiring Council Members:

Anita Deger
Ronna Jablow
Eric Imperial



Photo: Cecilia Paizs

Keynote Speaker Stuart Eizenstat



Photo: Cecilia Paizs

David Simison and Bell Awardee Melanie Vaughn



Photo: Cecilia Paizs

Bell Awardee Hon. Melanie Vaughn, Cecilia Paizs and Dan Dozier



Photo: Cecilia Paizs

Elizabeth Stoup, Bell Awardee Hon. Melanie Vaughn and Harry Fox



Photo: Cecilia Paizs

Roger Wolf and Eric Imperial

Mediation for Adult Guardianship Cases

By Carolyn Rodis and Ronna Jablow

Family communication had completely broken down. A daughter had filed for guardianship of the person and the property of her mother, alleging that her mother could not take care of her assets and was spending money unwisely. Her brother responded that he already held medical and financial powers of attorney for his mother, that his mother was receiving excellent care, and that guardianship was unnecessary. The mother, through her long-term attorney, also opposed the petition.

A lengthy trial of this contested guardianship case on legal issues would do little to encourage family members to address, let alone resolve, long-standing family controversies and gaps in communication with Mom. The case was referred to mediation.

Many judges and attorneys have seen the benefits to mediation in adult guardianship cases and have begun to refer or encourage mediation in their cases. Over the past year in twelve cases in the Baltimore City Circuit Court where mediation occurred, six resulted in settlement at the mediation session, three cases were partially settled and the issues were narrowed, and three cases were not resolved.

In adult guardianship cases, there are many issues that may benefit from mediation. These include disputes arising from health and medical care decisions, living and care giving arrangements. What kind of care is needed? Who should provide the care and where? Who should make medical decisions? There frequently are disputes regarding financial decisions. Breakdowns in communication and long-standing family dynamics often underlie the conflicts. Old wounds and sibling rivalries surface to prevent family members from having productive discussions. Through mediation, the underlying needs of the older person and family members – matters that are beyond the scope of the courtroom

- can be addressed and resolved.

Mediators are in charge of ensuring the fairness and accessibility of the mediation to everyone who needs to be heard. The process provides a safe, confidential place for the parties to speak and be heard. In adult guardianship cases, mediation ensures that the older person has a voice at the table. The autonomy of the parties is enhanced, and they report high satisfaction with the process. Mediation can occur before a petition for guardianship is filed, while a petition is pending, or after the court has appointed a guardian.

The mediator visited the mother to conduct intake - to begin to establish trust, to explain mediation, and to determine her capacity to mediate with support. He met Mom at her home and although she was somewhat confused, she was very clear that she did not want to attend the mediation and that she had faith in her son to take care of her.

The ultimate issue of whether or not a guardianship is necessary is not decided in mediation; only the court has that authority.* Through the mediation process, in which the mediators listen actively, identifying and reflecting the feelings and values of the parties, the parties are able to identify their needs. They usually gain a better understanding of each other's concerns and issues. The family can address miscommunications or lack of communication that might have led to distrust and suspicions. They are empowered to

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ADR Annual Spring Event...

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for victims of the Holocaust and other victims of Nazi tyranny during World War II. As Special Representative of the President and Secretary of State on Holocaust-Era Issues during the Clinton Administration, Ambassador Eizenstat successfully negotiated major agreements with Swiss, German, Austrian, French and other European governments and companies, covering restitution of property, payment for slave and forced laborers, recovery of looted art, bank accounts and payment of insurance policies. In his speech, he noted that "none of these accomplishments would have been possible without using alternative dispute resolution mechanisms to evaluate claims and structure payments to the victims." "The

resolution of claims over looted art through ADR has forever changed the way museums and private collectors buy and sell art," he explained, "as they must now follow certain guidelines to make sure that there no legitimate ownership claims by the heirs of prior owners."

Guests at the event not only enjoyed the award ceremony and keynote address but they also toured the "What Makes Us Smile?" exhibit at the museum and dined on the delicious fare provided by Sascha's Catering. The section is eager to build on the success of this year's spring event, and we look forward to another fabulous event next spring.

ADR Section Programs
Annual Meeting In Ocean City
Thursday, June 9, 2011

8:00 a.m.
8:30 - 10:30a.m.

Business Meeting and Elections
Drafting in Mediation
Only for the Stout of Heart

Presenters:
Gary Norman
Cecilia Paizs
David Simison

11:30 a.m. – 1:30 p.m. The Use of ADR in Complex Construction Disputes
(Joint program from the ADR and Construction Law Sections)

Moderator: Ken Vogel



Panelists:
Hon. Carol Smith; Hon. Edward Ketchen;
Rebecca E.R. Bleecker; Anthony Meagher

Message from the Chair...

(continued from page 1)

local bars who responded with requests for our newsletter and offers for our Council members to speak at some of their meetings. Our Council's legislative/rules committee drafted letters of support that were submitted for two laws being considered during this year's legislative session that would help improve the consumer experience in arbitrations, and would insert mediation into homeowner association dispute resolution processes. We polled the Section on the use of mandatory mediation in domestic cases so that we would be better prepared to respond in a way the membership would favor if legislation on that topic were to arise again as it did this year.

One of our Section's signature events occurs each Spring when we award the "Chief Judge Robert M. Bell Award for Outstanding Contribution to ADR in Maryland". This year was no different as we gathered for a beautiful evening in April at the Visionary Arts Museum in Baltimore to give

the award to Melanie Vaughn, and hear former U.S. Ambassador Stuart Eizenstadt give a riveting account of how he used ADR to help achieve justice for families and countries whose art, insurance policies, and other assets were lost or stolen during the Holocaust and World War II. Photos of the evening are in these pages! Finally, we reinstated the Section's newsletter this year, and in each of the editions you've received so far, there were well written, informative articles covering a wide variety of topics of interest to ADR practitioners, and we hope it helped to keep you apprised of your Section Council's efforts and activity.

It has been my privilege to serve as the Chair of this Section. I thank you for the opportunity and wish you all the best.

Sincerely,

Andrea C. Terry, Esq.

May, Should or Shall: What Does It Matter?

By Theresa A. Furnari, Family Division Master for the Circuit Court for Baltimore City and
Daniel Preston Dozier, Press, Potter & Dozier, LLC

May. Should. Shall. For many, the application of these words is unimportant. Not so for the legal community; the effect of these words can dictate standards of conduct, change the meaning of a contract and/or influence the outcome of a trial. Generally, “*may*” is discretionary. “*Should*” suggests encouraged but not required. And “*shall*” calls for mandatory action.

For the ADR community and the Maryland Bar generally, these distinctions are particularly relevant when interpreting the obligation of attorneys to counsel their clients about the use of ADR.

By way of background, in 2005 Maryland was one of 26 states to adopt almost verbatim the American Bar Association’s Model Rules of Professional Conduct. Model Rule 2.1 of the Maryland Rules of Professional Conduct (Model Rule), concerns the advice a lawyer offers to a client. Specifically, the Rule provides that when offering advice to a client, “a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors that may be relevant to the client’s situation.” Rule 1.4 concerns what, when and how a lawyer communicates to a client. When initially adopted, comment 5 of Model Rule 2.1, read: “Similarly, when a matter is likely to involve litigation, it *may* be necessary under Rule 1.4 to inform the client of forms of dispute resolution that might constitute reasonable alternative to litigation.” (Emphasis added.)

When some in the ADR community believed that this revision did not provide enough guidance to attorneys when advising clients about the availability of ADR and failed to promote greater use of ADR, comment 5 was revised in 2007 to read: “Similarly, when a matter is likely to involve litigation and, in the opinion of the lawyer, one or more forms of alternative dispute resolution are reasonable alternative to litigation, the lawyer *should* advise the client about those reasonable alternatives.” (Emphasis Added)

Despite the fact that this revision fell short of the objective of mandating attorneys to advise their clients about the use of ADR, those who sought the change believed the revision was a good first step.

Is it time to take another step forward and seek the mandatory language that eluded our grasp in 2007? There are already a handful of states that have adopted stronger language by replacing “*may*” with “*should*” or “*shall*.”¹

The biggest hurdles to ‘*shall*’ -- then and now -- are two-fold. One, there was concern that imposing a mandatory duty could subject an attorney to discipline when the attorney may have had good reasons not to give the information to the client. Of equal or greater concern was the fear that revision of the rule could expose an attorney to a malpractice claim when the attorney failed to advise the client about the use of ADR. These concerns have not opened the flood gates of litigation as warned. While there have been a few recent cases in Maryland and elsewhere in which the use of ADR was at issue, those cases have generally been about confidentiality, not about attorney malpractice for failure to properly advise clients about the availability of ADR options.

There is no reason why an attorney should not fully inform his/her client about all the possible courses of action he or she may pursue before resorting to litigation. In fact, as we all know, attorneys generally do advise clients about the various options and costs; failure to do so can, at the very least, lead to unhappy clients. Clients, not their attorneys make the major decisions about the case, obviously based on information from counsel.

Resistance to applying the mandatory language in the ethical standards may be rooted in a lack of understanding among some attorneys about the flexibility and variety of ADR sources and processes. However, until attorneys are able and willing to fully advise their client to the possible uses of ADR, Maryland will never have an informed client pool and attorneys will not have adequate knowledge about the procedural opportunities available when ADR is generally an option to consider.

To change how attorneys advise their clients -- and most importantly to better serve clients -- Maryland attorneys should be *required* to advise their clients about the opportunities of ADR in appropriate circumstances. As ADR becomes more commonly used throughout the country, if Maryland attorneys fail to advise clients about the appropriate and relevant ADR options, they risk unhappy clients and the debate about *may* versus *shall* could become irrelevant. Clients will ‘vote with their feet’ and select attorneys who are familiar with ADR options.

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May, Should or Shall...

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Footnotes:

¹ See for example, Comment 1 to Rule 1.2 of the Virginia State Bar Professional Guidelines: “Within those limits, a client also has a right to consult with the lawyer about the means to be used in pursuing those objectives. In that context, a lawyer *shall* advise the client about the advantages, disadvantages, and availability of dispute resolution processes that might be appropriate in pursuing these objectives.” (Emphasis added) (<http://www.vsb.org/pro-guidelines/index.php/rules/client-lawyer-relationship/rule1-2/>)

**There is Still
Time ~ Register
Now**

2011 MSBA
Annual Meeting



*June 8-11, 2011
Ocean City, MD*

Check out the ADR
Section Programs on
Page 6!

www.msbaannualmeeting.com

Sea. You. There.

Dan Dozier explains his newly found Vegan Diet

It started simply enough; I was given the opportunity to join a clinical trial comparing vegan diets to standard, non-vegetarian weight loss diets, such as those approved by the American Heart Association.

I'm overweight but otherwise healthy. I have been told by my doctor that if I fail to change my diet and lose weight I am at greater risk for diabetes because of a family history of diabetes. As you may know, diabetes is increasing in this country at an alarming rate.

According to WebMD, for example, more than half of all Americans are at risk of developing diabetes or pre-diabetes by 2020 unless our diet and exercise patterns change (see <http://diabetes.webmd.com/news/20101123/diabetes-epidemic-will-hit-half-of-us-by2020>).

I do not want to get diabetes; I do want to lose weight. I already exercise. So I joined the trial and was randomly assigned to the vegan diet.

It has literally changed my life and certainly my diet.

The clinical trial has been managed by Dr. Neil Barnard, head of the Physician's Committee for Responsible Medicine (www.pcrm.org), a nonprofit organization supported by physicians and laypersons to combine the efforts of medical experts and grassroots individuals to promote preventative medicine and to encourage higher standards for ethics and effectiveness in research. Visit the PCRM web site for information about their programs and for information about the strong evidence that vegan diets prevent or cure diabetes.

I have never been a fan of diets; I don't like the fuss and bother to keep track of calories and the limits on how much I can eat and so on.

The vegan diet, for me, has been different. I don't have to pay attention to how *much* I eat, just *what* I eat. As long as I avoid meat, dairy and eggs, and try to keep my consumption of oils (vegetable oils, obviously) down, I'm free to eat whatever plant-based food I wish.

Surprisingly, I haven't found this diet difficult to stay on and it's been nearly 20 weeks. I've lost about a pound a week over that time and I still enjoy the food. After about a week of adjustment, I have found that vegan food is delicious. I can and do eat a lot of rice and pasta; I have found that I like tofu in many variations. In addition to being healthy, vegan foods have a much lower impact on our environment, cost less and, for me at least, taste better.

Maybe I'm crazy, but for my health – and for the health of the earth – this diet works. I didn't initially choose to become a vegan, but I have become one and will remain on a generally vegan diet for a very long time, perhaps for the rest of my life.

Collaborative Happenings...

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training Maryland lawyers to further the mission of the Family Law Administration arm of the AOC. Future AOC happenings include a one-day collaborative training planned to educate court personnel, and to working with local practice groups to form a low bono collaborative program to help families who might not otherwise be able to afford the services of collaborative practitioners.

The training sparked interest from many sectors including:

- the attorney grievance commission attendee expressing interest in sponsoring future trainings
- interest from a large civil practitioner contingency that practices in areas outside family law
- the development of a law school curriculum for collaborative practice in both the family law and civil arenas

Other collaborative news in Maryland includes the formation of the Enact UCLA Committee of the Maryland Statewide Collaborative Organization- the Maryland Collaborative Practice Council (MCPC). The Uniform Collaborative Law Act (UCLA) was passed by the Uniform Law Commission in 2009 (amended 2010) and the Act has already been passed by Utah and is pending in several other states. The MCPC Enact UCLA Committee

has already met with members of the legislature and others important to the passage of the Act to lay the groundwork to introduce the Act in the 2012 Legislative Session. The UCLA was introduced into the D.C. Council recently and should be reported out of committee sometime this summer.

A special note regarding happenings in Montgomery County and Howard County, as the author of this article is the proud first co-chair, along with Darcy Shoop, of the state's first County Bar Collaborative Law Section. The Montgomery County Bar Association Executive Committee unanimously approved the formation of a Collaborative Law Section in January of 2011. The first meeting was held on March 7, 2011. The Howard County Bar Association quickly followed suit and formed a Collaborative Law Committee. All practitioners, including family law and civil attorneys practicing outside of family law, the trained and not yet trained, are invited to the upcoming Montgomery County Collaborative Law Section Meetings which are held on the first Thursday of each month in the Bar Office. In addition, the three (3) hour CLE this Fall will center upon "Civil and Commercial Applications in Collaborative Practice."

Anyone interested in future trainings or learning more about Collaborative Practice can find additional information at www.collaborative-practice.com or by contacting the author suzyeckstein@aol.com.

Mediation for Adult Guardianship...

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make decisions and reach solutions that work for them. As a result, demands on court time are reduced and they are less likely to return to court in the future.

The daughter, her attorney, the son, his attorney, the mother's attorney and the mediator attended the mediation session. The brother explained that Mom was doing well and was happy in her home with her caregivers. The brother spoke with his mother daily, and visited regularly for dinners.

The daughter, a biomedical researcher, prided herself on her professional accomplishments. She was still mourning the recent loss of her father. When her father died, her mother re-wrote the powers of attorney, removing her as co-agent and appointing her brother alone. The daughter felt excluded, and didn't visit her mother either at her house or when she was in the hospital. She said that her brother, a car salesman, didn't have the training to make good medical and financial decisions. She tearfully admitted she was worried about her own health and how she would support herself if she were unable to work.

The parties, with the help of their attorneys, were able to reach

a resolution of the contested case: the son would provide an accounting of all Mom's expenses on a quarterly basis and the daughter would dismiss her petition for guardianship. The daughter was invited to re-establish her relationship with her mother through telephone calls and visits. The son agreed to notify her immediately if there were any change in Mom's circumstances, such as a medical emergency or hospitalization, and agreed to discuss decisions with her.

The judge, having heard the parties in his courtroom before referral to mediation, was amazed that they had reached a resolution of the bitterly contested matters.

Carolyn Rodis is a mediator in private practice, concentrating in elder mediation. contact her at cjrodis@yahoo.com, 410-279-0942 and Ronna Jablow is the ADR Program Manager for the Baltimore City Circuit Court, contact her at ronna.jablow@courts.state.md.us 410-396-7374

*The circuit courts have exclusive jurisdiction over protective proceedings for disabled persons. Md. Code Ann. Estates & Trusts, Section 13-105(b) (2010). The Court may appoint a guardian of a disabled person. Section 13-704. A person may be deemed "disabled" if he is unable to manage his property or unable to provide for his daily needs sufficiently to protect his health or safety. Section 13-101

Commentary on Resolving Disputes Between People with Disabilities and Healthcare Providers

By Gary C. Norman, L.L.M.¹

“So let us begin anew--remembering on both sides that civility is not a sign of weakness, and sincerity is always subject to proof. Let us never negotiate out of fear. However, let us never fear to negotiate.” (President John F. Kennedy)²

Because of the issuance of the new accreditation standards of the Joint Commission,³ an awareness of Alternative Dispute Resolution among providers will continue to emerge. This article consequently emphasizes that applying Alternative Dispute Resolution in a comprehensive way to resolve issues of people with disabilities with the healthcare system is beneficial, logical, and helpful.⁴ The kinds of disputes that this article contends should be increasingly subject to mediation, includes: 1). accessibility concerns (e.g. a lack of reasonable accommodations), 2). Various issues related to transition of people with disabilities of any age from hospitals and other institutions to the community, including but not limited to discharge planning and mandatory mediation in guardianship, and 3). End-of-life concerns (e.g. various issues relating to the termination of treatment, such as Do Not Resuscitate orders). As Maryland constitutes a leader respecting the creation or promotion of Alternative Dispute Resolution programs, it would be fitting to discuss one potential approach by which a comprehensive conflict resolution program would be established in the state.⁵

Resource limitations and health disparities that exacerbate existing conditions and impairments have an impact on people with disabilities, young, old alike, and the able-bodied populous.⁶ As a population, however, “...they also face a host of unique and often intractable problems.”⁷ The kinds of unique disputes that this population experiences, includes, but is not limited to, disputes involving “...discriminatory treatment because of a disability, possibly in violation of the ADA,” and “Health care conflicts, including bioethical disputes over end-of-life decision-making, and other care issues in both acute and long-term care settings.”⁸

State agencies and departments in Maryland⁹ can undertake steps to educate the medical community and the public about Alternative Dispute Resolution. Agencies and departments in Maryland can collaborate with such institutions as, the Bloomberg School of Public Health at John Hopkins and organizations, such as Senior Mediation and Decision-Making, Inc., to host a series of workshops and conferences. As an outgrowth of the workshops and confer-

ences, a more formalized, comprehensive approach to these disputes can be encouraged, instituted, and operated as a collaborative framework. In such a framework, (possibly structured through Memoranda of Understanding), Providers, and people with disabilities of any age, who have a dispute, would submit their claim for mediation to a third party. The organization, who would operate this program, would provide the training, would have a roster of mediators from which it would draw the third party neutral or neutrals, would coordinate with the disputing parties, and would be involved with pre-mediation and post-mediation related matters.

Alternatively, the Department of Health and Human Services could show leadership by incorporating, ala the Joint Commission,¹⁰ a requirement for conflict resolution programs within the Medicare Conditions of Participation.¹¹ Advocating within governmental institutions can be like The Myth of Sisyphus.¹² For an aggressive approach that could quickly result in the mandatory usage of mediation, states, such as Maryland could adopt affirmative legislation. Maryland can, although in an expanded way, turn to legislation enacted in its Mid-Atlantic neighbor New York for an example.¹³ In New York, legislation requires hospitals to adopt “a dispute resolution system” to address conflicts relative to end-of-life care, i.e. Do Not Resuscitate Orders.¹⁴ This author would propose a bill for the 2012 session of the Maryland General Assembly in which disputes involving accessibility to healthcare services, disputes concerning discharge and discharge planning, and end-of-life conflicts would be submitted to mediation. Under the bill, one avenue for conducting the mediation would constitute the MD Healthcare Dispute Resolution Office.¹⁵

Subfields of ADR practice known as ADA mediation,¹⁶ senior mediation,¹⁷ and Structured Negotiation¹⁸ can be applied, and have been applied, to resolve the healthcare conflicts of people with disabilities of any age. Mediation, such as ADA mediation,¹⁹ has resolved disputes of people with disabilities in a variety of policy areas, including but not limited to healthcare.²⁰ Arguably, addressing disputes and forms of dispute resolution on a piecemeal basis has been the past practice or approach; for example, a bioethics mediation program or mechanism might be established at a hospital, but not a program to resolve the accessibility con-

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Commentary on Resolving...

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cerns of people with disabilities. Thus, it is logical to establish a comprehensive program, operating under the auspices of a non-profit organization, who has developed a body of experience in interacting with and serving the special needs or concerns of people with disabilities and older adults.

Arguably, Providers already have mechanisms for conflict resolution in place, obviating the need for additional approaches. For instance, hospitals often have ombudsman or patient safety programs.²¹ Despite an emerging awareness of the need for Alternative Dispute Resolution to promote patient safety and healthcare quality, hospitals are arguably not adequate sources of dispute resolution. Because of the omnipresent issue of neutrality posed by an entity involved in a conflict serving as a third party neutral, these programs are not the best solution.²² Galvanizing change seemingly does not often constitute the loadstone of such programs. Therefore, ombudsman programs at hospitals would arguably not be the best model on which to formulate a solution. Long-term care ombudsman programs,²³ however, may not be well-positioned to serve as a paradigm on which to formulate a solution in that their role is, in most circumstances, to advocate for the patient or beneficiary, rather than, serving as a referee among disputing parties.²⁴ The long-term care ombudsman is typically underfunded and is frequently short of staff and training.²⁵ A mediation program operated through an independent source of funding, such as the Maryland Conflict Resolution Office,²⁶ but that is partnered with Providers, is arguably the best way which to furnish a neutral third party.²⁷

Regarding bioethical disputes, hospitals have arguably ethics committees.²⁸ These committees fail their purpose because of professional bias and a lack of specific training of Providers about ethics.²⁹ For similar concerns about transparency and neutrality, this argument is also not compelling.³⁰ Moreover, because these committees are, in the majority of circumstances, composed of Providers, they are not immune to financial interests and concerns.³¹ As such, utilizing bioethical mediation approaches, even where ethics committees staff are involved as medical experts, would be a better alternative.³² In short, "The end-of-life dispute mediator, acting as a process guide, gives patients and providers the space to communicate their concerns and work together so they will reach a mutually agreeable resolution...."³³

The challenge is to promote innovation in healthcare science and technology, while striving, through an array of religious, legal, and bioethical safeguards, principles, and mechanisms, against such innovation causing grievous wrong.³⁴

Science and technology must be kept on a tempered keel, such that people with disabilities realize its benefits but are not subject to the historical deviance of mankind, e.g. the institutionalization and sterilization of the so called insane or the medical experimentation of the so called defective. To ensure that people with disabilities fully enjoy equality to healthcare, imbuing science with a moral compass and a commitment to affirmative civil and human rights must be an international priority. As one of the leading states in the union regarding the application of Alternative Dispute Resolution, Maryland should be at the vanguard of this charge by instituting programs to foster conflict resolution, at an early stage in the life cycle of a dispute between the disabled and Providers.

(Endnotes)

¹ Gary is a Commissioner of the Commission on Civil Rights. His comments do not reflect the position of the Commission or of the federal or state government.

² The Inaugural Address of President John f. Kennedy (Friday, Jan. 20, 1961), http://avalon.law.yale.edu/20th_century/kennedy.asp.

³ See e.g. Greenebaum, Doll, & McDonald, PLLC, *Conflict Management and Leadership: the Joint Commission's New Focus*, 3 *Law Letter* (June 2007), <http://www.gdm.com/pubs/xprPubDetail.aspx?xpST=PubDetail&pub=176>.

⁴ While this instant proposed, solution could be applied to any state in the U.S. This article will reference its application in Maryland where the author is a mediator. In full disclosure, this author is Vice President and Secretary of Senior Mediation & Decision-Making, Inc. See, Senior Mediation and Decision-Making, Inc. <http://senior-mediation.com>. Finally, possessing wonderful mentors, who are also friends, Robert J. Rhudy, and Carolyn J. Rodess, is an honor. My colleague Debra T. Berube and I have presented on the issue of applying Alternative Dispute Resolution to resolve healthcare conflict. We will present on, or we will have presented, on this topic in April 2011, in Denver, Colorado.

⁵ Power Point: Md. Mediation and Conflict Resolution Office, Maryland Judiciary, ADR Growth in Maryland 1998-2007 (On file with author).

⁶ Monique M. Williams, M.D. *Article, Invisible, Unequal, and Forgotten: Health Disparities In the Elderly*, in *Symposium On Aging America*, 21 *NOTRE DAME J. L. ETHICS & PUB. POL'Y.* 441, 477 (2007) ("Disparities in health care for the elderly are a pervasive problem. Older persons confront both institutional and individual ageism. Moreover, soci-

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ety presents negative stereotypes of older adults, and the citizenry at large may interact with the elderly in adverse manners, with the cumulative effect of such bombardment of experienced negative perceptions of the elderly serving to occasion adverse psychological and other health consequences.”)

⁷ *Id.*

⁸ *Id.*

⁹ They would, include, the Maryland Department of Health and Mental Hygiene, the Maryland Department of Disabilities, and the Maryland Department of Aging. By the time that this article is published, Aging and Disability may have been combined in Maryland as part of the budgetary reduction of the Governor.

¹⁰ See e.g. Donald L. Mellman, *Mediation In Healthcare: An External Solution To Internal Problems*, 36(6) PHYSICIAN EXECUTIVE J. 58 2010 WLNR 23383107 (Nov. 1, 2010) (“Health care is prone to such conflict because the fears, real and imagined, are faced by all. Because of the negative effect on patient safety and quality of care, the Joint Commission mandated standards for conflict management that hospitals must meet to achieve certification.”).

¹¹ By including a provision within these Conditions, if Providers fail to comply, then, a potential, albeit remote, consequence is suspension. See e.g. *Litigation And Administrative Appeal Of CMS's Attempt To Terminate Medicare Participation Of Two Rivers Psychiatric Hospitals* (Feb. 26, 2009), [http://www.wikinvest.com/stock/Universal_Health_Services_\(UHS\)/Litigation_Administrative_Appeal_Cmss_Attempt_Terminate_Medicare_Participation](http://www.wikinvest.com/stock/Universal_Health_Services_(UHS)/Litigation_Administrative_Appeal_Cmss_Attempt_Terminate_Medicare_Participation) (Last visited Mar. 28, 2011).

¹² See e.g. Rick Garlikov, *The Value of Labor and the Myth of Sisyphus*, <http://www.garlikov.com/philosophy/Sisyphus.html> (Last visited Mar. 28, 2011) (“But there is one remaining attribute of Sisyphus' labor, and I see no way to imagine it produces happiness, nobility, or redemption. It has nothing to do with the receptiveness of the act, its difficulty, the brevity of its achievement, or its potential futility. It is that the act of rolling this boulder up this hill serves no useful purpose other than to punish Sisyphus. It is meaningless to move this rock to the top of this hill otherwise. There is no merit in getting the rock to the summit. The task is a worthless one. The achievement is an achievement in name only. It accomplishes nothing but getting the rock from here to there. Even if the task of Sisyphus were merely to get this rock up this hill one time, whatever amount of time he spends doing it, whether long or short, is time squandered from how he better could have spent it doing something worthwhile and useful. Even if it were to make him stronger, he would have been better off becoming stronger

by doing strenuous work that was actually useful.”).

¹³ N.Y. Pub. Health §2972 (June 1, 2010).

¹⁴ *Id.*

¹⁵ See, Md. Alt. Disp. Resol. Office, Md. Manual Online, <http://www.msa.md.gov/msa/mdmanual/25ind/http/42healc.html> (Last visited Mar. 29, 2011) (This Office is directly involved with resolving, early on, medical malpractice disputes. There is no reason arguing against this role, with proper funding, being expanded. Certainly, technical experts, such as SMDM could be contractors to this Office. By having outside third parties take a leadership role, any institutional bias acquired from decades of arbitrating medical malpractice claims of Providers could be avoided.)

¹⁶ ADA Mediation Standards Workgroup, ADA Mediation Guidelines (2000).

¹⁷ See, E-mail from Robert J. Rhudy, Esq. To Gary C. Norman (Mar. 3, 2010) (“In the nursing home and hospital (and other) settings, I respect ombudsmen programs, but I believe that mediation may frequently be a more neutral and better alternative. The ombudsman, in my understanding, needs to have something of a soft advocacy role for the individual consumer, where sometimes the more neutral role of the mediator may be required.” Interview conducted by author is on file).

¹⁸ With its early record of accomplishment, structured negotiation will clearly constitute an important tool in resolving disputes involving the access and quality of people with disabilities to healthcare. Structured negotiation constitutes, and has proven to constitute, a mighty tool in addressing inaccessibility to such goods and services of places of public accommodations or public entities as point of sell machines and signalized intersections. Structured negotiation constitutes “an alternative to litigation emphasizing collaboration and focusing on solution”. Arguably, just like arbitration, structured negotiation constitutes a hybrid between adversarial and non-adversarial dispute resolution tools. Essentially, the demand correspondence conveyed to an opposing party requests that, in lieu of filing in court, legal counsel, and technical experts meet, in a structured way, with plaintiffs to resolve an inaccessibility issue. If the opposing party is amenable to addressing the issue through this form of ADR, then the parties sign an agreement to engage in the process. The agreement governs the process, providing for among other details, attorney fees. See e.g. Steven Mendelsohn, *Legal Developments In Assistive Technology: Year In Review*, in *Bridges to Better Advocacy Conference* (Austin, Tex. Oct. 21-23, 2009) at III, www.nls.org/conf09/year%20

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in%20review.pdf, Matthew Hirsch, Structured Negotiation, Law.com (July 2007), <http://llegal.com/2007/07/law-com-article/>.

¹⁹ See, Cohen note supra.

²⁰ See, the discussion of structured negotiation in this article. Additionally, this author recently served as a legal advisor in a mediation involving a lady and her assistance dog at a provider.

²¹ Comprehending the role of an ombudsman within providers does not tax the mental faculties. In hospitals, an ombudsman, also called a “patient representative”, “... investigate[s]... and mediate[s]... problems and complaints in relation to a hospital’s services.” *Ombudsman*, Mosbey’s Med. Dictionary (8th Ed. 2009); See also, Ileen Beel, CSU’s On-line Courses Prep Patient Advocates For The Field, 25(51) Crain’s Clev. Bus. 2004 WLNR 1457808 (Dec. 20, 2004) at 13 (“Patient advocacy is an evolving profession. Most patient advocates started out as nurses, social workers, counselors, ministers or marketing or customer service specialists who were good with patients.”).

²² See e.g. Patricia Ruffin, R.N. & Patti Bertschler, Mediate.com (Seoapt. 2004) Elder Mediation: New Role In Healthcare, (“Because mediators are intended to remain neutral, it makes sense for hospitals not to hire mediators internally. Case workers, social workers and other teams who work with families need to learn that they can refer for Elder Mediation, help resolve family disputes and come to some agreements that allow the family to return to the hospital with decisions that are made either prior to, during, or after the crisis,” says local mediator, Dr. John Bertschler of Northcoast Conflict Solutions in Independence, OH.”), <http://www.mediate.com/articles/ruffinP1.cfm> (Last visited Mar. 31, 2011).

²³ Long-term care ombudsman typically believe that advocacy for patients and their families constitute a rewarding but exhausting vocation. Laura N. (Trotter) Norman, L.G.S.W., *A Day In The Life Of A Long-term Care Ombudsman*, in *Days in the Lives of Gerontological Social Workers* 145 (Linda May Grobman, A.C.S.W., L.S.W., and Dara Bergel Bourassa, Ph.D., M.S.W., L.S.W. Eds. 2009). These professionals strive daily to achieve results in: 1.) Receiving, investigating and attempting to resolve complaints made by or on behalf of residents, 2.) Protecting rights of residents in a myriad of institutional settings, including, but not limited to, nursing homes, 3.) Providing information and connections to resources, and 4.) Advocating for positive change on behalf of residents and their families. Problems that ombudsman programs resolve or attempt to resolve, specifically include, but are not limited to, 1.) Patient and resident rights and 2.) Adequacy or quality of

care or treatment, ranging from admission... [And] health service,” to “drugs... [And] transfer or discharge”. Furthermore, ombudsman performs a myriad of activities to meet these roles. Id. The scope of the portfolio of most staff ombudsman is compelling. Id. In a recent book chapter, an author describes how her manifold caseload ranged from a simple dispute involving an older adult, frail woman, who desired to keep a furtive caterpillar, to the serious issue of improper discharge. Id. For an in-depth discussion of the long-term care ombudsman, see also, Anna Kaluzny, Note, *The Patient Care Ombudsman: Who Should It Be?* 17 ELDER L. J. 343, 354 (2010).

²⁴ E-mail from Robert J. Rhudy, Esq. note supra (“In the nursing home and hospital (and other) settings, I respect ombudsmen programs, but I believe that mediation may frequently be a more neutral and better alternative. The ombudsman, in my understanding, needs to have something of a soft advocacy role for the individual consumer, where sometimes the more neutral role of the mediator may be required.” Interview conducted by author and Bob is on file with author).

²⁵ Governmental support, including funding, plague these critical, “quality assurance” programs. See, Donna Schuyler, J.D., & Brian A. Liang, M.D./Ph.D./J.D., *Article, RE-CONCEPTUALIZING ELDER ABUSE: TREATING THE DISEASE OF SENIOR COMMUNITY EXCLUSION*, 15 ANNALS HEALTH L. 275, 285 (Summ. 2006) (“Sufficient funding is a major issue for programs aimed at fighting elder abuse. Many program implementation centers, such as APS, are consistently underfunded by the federal government. For example, only 2% of federal funding devoted to dealing with citizen abuse goes to elder abuse and less than 1% of research money for aging issues addresses elder abuse.”); see also, National Association of State Units on Aging et al., *Obtaining Medicaid Funding For The Long-term Care Ombudsman Program: The Experience Of Eight States* (June 2001), www.nasua.org/pdf/Medicaid%20Funding%20paper.pdf. The Older Americans Act Amendments of 2006, however, reflect the support of Congress in that they reauthorized this program until 2011. Also notable is that, as part of healthcare reform, Congress passed and President Obama signed two pieces of legislation, The Elder Justice Act and the Patient Safety and Abuse Prevention Act. See, §2043 of the Elder Justice Act of 2010, 111 Pub. L. 148, 796(a) (1) (A)-(C), 124 Stat. 119 (Mar. 23, 2010) (To be scattered at various sections of Title 42). Augmenting the prevention of and the response to elder abuse and neglect constitutes the goal of these Acts. Specifically,

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the Elder Justice Act provides enhanced funding to Adult Protective Services and the long-term care ombudsman program. *Id.* As such, the financial condition of these programs are improving. In light of the pending financial crisis confronting the several states and the budgetary sword rankling of Congress, however, who knows whether these programs will actually improve in any of these issues.

²⁶ The Chief Judge of the Maryland Court of Appeals, the Honorable Judge Robert M. Bell, played an instrumental role in fostering the growth of Alternative Dispute Resolution in Maryland. The Chief Judge led the creation of the Maryland Mediation and Conflict Resolution Office “as an agency of the Maryland Judiciary to...promote ADR in the state”. A noteworthy national 2001 Significant Practical Achievement Award recognized the leadership of MACRO for its 1999 report and action plan called – Join the Resolution: The ADR Commission’s Practical Action Plan. See Robert J. Rudy, *Feature, Senior Mediation Reaching the Tipping Point*, in *Protecting the Elderly*, 41 MD. B. J. 12, 14 (Mar.-Apr. 2008) (Citing Maryland Mediation and Conflict Resolution Office, *Consumer’s Guide: Alternative Dispute Resolution (ADR) Services in Maryland*, (3rd Ed., 2007) at 11). At the 2010 convention for Maryland mediators, this author facilitated a workshop that was concerned with healthcare disputes and mediation. At the workshop, the consensus of the speakers and of the attendees was that mediation, particularly senior mediation is still not at the “tipping point” even despite the orchestrated efforts of Senior Mediation and Decision-Making, Inc.

²⁷ See e.g. Jay E. Grenig, *Bioethics Disputes*, 1 ALT. DISP. RESOL. §20:22 (3d Ed.) (2010).

²⁸ *Id.*

²⁹ See, David M. Shelton, *Article, Keeping End-of-life decisions Away From Courts After Thirty Years Of Failure: Mediation As An Alternative for Resolving End-of-life Disputes*, 31 HAMLINE L. REV. 103, 113 (Winter 2008) (“The New Jersey Supreme Court in *Quinlan* endorsed the use of hospital ethics committees in assisting with end-of-life decisions. The New Jersey Supreme Court's belief that ethics committees may be better suited for the end-of-life decision-making process created a system with great ‘power to affect others' rights.’” Most health care institutions now use ethics committees to deal with end-of-life disputes. The ethics committees generally are composed of physicians, social workers, and nurses; however, no requirement exists for a person with formal training in ethics to sit on the committee.”).

³⁰ Shelton *Id.* At 115.”).

³¹ See *Id.* at 122-23 (“An additional interest of physicians and health care institutions involves the financial costs of

continuing treatment. Health care institutions may have an interest in keeping costs down while, unfortunately, the cost of life-sustaining treatment, as well as many other hospital treatments and health care, remains high. Health care institutions often are left unable to collect fees from uninsured or impoverished patients, and the patient's ability to pay for the costs of life-sustaining treatment may affect a health care institution's decision whether to continue or terminate life-sustaining treatment. This is not to say that the practice of removing life-sustaining treatment from patients who cannot afford the treatment is common practice, or even practiced at all, but that it is a real possibility that financial interests may be taken into account when health care institutions make end-of-life decisions.”).

³² Grenig note *supra*.

³³ See, Thaddeus M. Pope & Ellen A. Waldman, *Article, Mediation At The End-of-life: Getting Beyond The Limits Of The Talking Cure* in *Symposium, Alternative Dispute Resolution Strategies In End-of-life Decisions*, 23 OHIO ST. J. ON DISP. RESOL. 143, 158 (2007)d.

³⁴ See e.g. George P. Smith, II, *Article, Law, Medicine, And Religion: Toward A Dialogue And A Partnership In Biomedical Technology And Decision-making*, 21 J. CONTEMP. HEALTH L. & POL'Y. 169, 175-76 (Spring 2005) (“From this analysis it will be seen that, far from being antagonistic to law and medicine, religion and religious principles can stabilize the field of biomedicine and serve additionally as vectors in shaping both ethical and moral constructs for decision making. In turn, each of these three disciplines complements and strengthens what should be the ultimate goal of the state: to secure the happiness, spiritual tranquility, and well-being of its citizens. This purpose is, in turn, advanced and enhanced by safeguarding the genetic well-being and general health of its citizens.”).