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***273 HOW CAN I GIVE HER IV ANTIBIOTICS AT HOME WHEN I HAVE THREE OTHER CHILDREN TO CARE FOR?: USING DISPUTE SYSTEM DESIGN TO ADDRESS PATIENT PROVIDER CONFLICTS IN HEALTH CARE**

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As a general pediatrician who cares for hospitalized children and the chair of a hospital ethics committee and consultation service, my comments will focus on the first of the three categories of health care conflicts identified by the Dispute Resolution Institute's 2007 Symposium--patient provider conflicts. In attempting to identify principles that should govern the resolution of such conflicts, it is important to reflect on the types of conflicts envisioned. Dramatic cases, such as those involving medical "futility," are often used as exemplars. Unfortunately, little empirical data is available regarding the frequency and types of patient provider conflicts. I argue that more frequent, less dramatic cases should not be neglected. I use examples of both dramatic and mundane disputes to identify some of the characteristics of patient provider conflicts. It is unnecessary and counterproductive to argue that these characteristics are unique to health care. The shared characteristics make it possible to apply the general principles of dispute resolution system design to health care. These principles include focusing on interests and arranging processes from low- to high-cost. I also identify several current professional efforts that offer potential points of entry for dispute resolution professionals into this field. Among these characteristics, I emphasize that health care is not a single, unified "system" but is comprised of multiple independent subsystems and that practices which focus on individual cases may unintentionally perpetuate injustice. Thus, ***274** identifying and developing processes that focus on "system" reform is also important, particularly the interface between the subsystems.

Much attention in patient care conflicts focuses on end-of-life disputes. Consider the features in the following example: [\[FN2\]](#) Jesse is a six-year-old boy diagnosed with a brain tumor after several weeks of headaches and vomiting. At the time of the diagnosis, the cancer had already spread and was blocking the flow of fluid from the inside to the outside of his brain. While his parents agreed to surgery to remove part of the tumor and insert a medical device to bypass the blockage, they took him to another state to receive complementary and alternative medicine (CAM) in lieu of conventional chemotherapy. Jesse's condition worsened; he became comatose and required mechanical ventilation. His parents eventually took him to Mexico for further treatment, including the injection of cells from blue shark embryos, and his condition improved to the point that he could re-

turn home on a commercial airline. [FN3]

His parents again sought CAM in another state, but Jesse was immediately referred to a hospital, admitted to the pediatric intensive care unit, and placed back on a ventilator. After several weeks, his condition acutely deteriorated. His physicians believed that the tumor had continued to grow and eventually pushed essential parts of his brain through the hole at the bottom of his skull. After testing was complete, they reported that Jesse fulfilled the neurological criteria for death. Jesse's parents believed their son's deterioration was caused by the mismanagement of his blood pressure medication and that he might recover, as he had in Mexico, if he was treated with CAM. However, the hospital informed the family that it would discontinue the ventilator in twenty-four hours. The family then sought and obtained a *275 temporary restraining order, [FN4] and Jesse was eventually discharged from the hospital. [FN5] Jesse's heart stopped beating approximately one month later and it could not be restarted. [FN6]

Cases such as this have a number of attributes which may make their resolution difficult: [FN7]

- The magnitude or finality of the consequences--Health care conflicts may involve the possibility of death or serious disability. In addition, medical actions may not be readily reversible. Jesse's family's ability to obtain redress would have been severely limited if the hospital had discontinued Jesse's mechanical ventilation and his heart had stopped. Jesse could not be restored to his prior condition, and other forms of compensation, such as money, are not commensurable.

- Constrained relationships--Parties may not have the freedom to curtail relationships. There may be a limited number of individuals or facilities capable of providing the care at issue. Health care providers are morally prohibited from abandoning patients, [FN8] and patients may in addition be constrained by geography, insurance coverage, and/or ability to pay. For example, the hospital *276 in the case described is the only children's hospital within 400 miles.

- Knowledge and power differentials--Patients and their families may have limited knowledge about the medical condition, the treatment options, and/or the health care "system." Given the relative monopoly that licensure provides, there are also significant power differentials between providers and patients. Jesse's family's ability to care for him outside the hospital without physician involvement was restricted by their knowledge and access to medications and equipment.

- Personal identity--Health care conflicts often involve issues of personal identity for patients and providers. Jesse's parents may have felt that by withdrawing mechanical ventilation they had failed to be good parents. Conversely, providers may feel that being forced to treat a child they consider dead is an affront to their sense of professionalism.

- Time constraints--The patient's clinical condition may continue to evolve, making it impossible to maintain the status quo while the conflict is being resolved. Jesse could have developed further complications, such as low blood pressure or excessive urine output, which would have required an escalation of "treatment" to keep his heart beating. The propriety of instituting such efforts would also have been the subject of dispute between the parties.

None of these individual attributes are necessarily unique to health care conflicts. For example, there may be significant knowledge and power differentials between divorcing spouses. [FN9] At most, health care conflicts may represent relatively unique *277 constellations of characteristics. Consistent with conflict resolution meth-

ods, one should consider whose interests are served by a strong assertion of uniqueness.

While such dramatic end-of-life cases highlight important features of health care conflicts, focusing on them may inappropriately skew the types of dispute resolution processes implemented. Pope and Waldman, for example, argue that futility cases--cases in which patients and their families and health care providers disagree about the appropriateness of continued treatment [FN10]-- demonstrate the shortcomings of mediation in health care. They focus on the need to modify the external legal context. [FN11]

Unfortunately, limited information is available on the types or frequency of patient provider conflicts. While there is some literature on reasons for ethics consultations, this literature has significant methodological limitations. DuVal et al, for example, conducted a cross-sectional telephone survey of internal medicine practices in the United States. Fifty-five percent of respondents (190/344) reported requesting ethics consultations. The stimulus for the consultation request was: wanting help resolving a conflict in thirty-five percent of the cases; wanting help interacting with a difficult patient or family in ten percent of the cases; and wanting help with an emotional cause of the conflict in nine percent of the cases. [FN12] Several questions can be raised about the conceptual grounding of this coding scheme. How does "wanting help resolving a conflict" differ from "wanting help interacting with a difficult patient or family?" Is "having an emotional trigger" within the same category as "wanting help resolving a conflict," or *278 is the emotional trigger better characterized as one of the many causes of conflict? More broadly, such studies have a significant ascertainment bias; the types of conflicts presented to ethics committees will be strongly influenced by the types of conflicts individuals perceive ethics committees are capable of resolving. The field of dispute resolution has valuable resources to contribute to strengthening this essential background research, such as typologies of the causes of conflict. [FN13]

Acknowledging the limitation of anecdotal data, I contend that many conflicts in health care are relegated to "lumping it" [FN14] due to the power differentials involved. Consider the following potential conflict: [FN15] Sarah is a twenty-five day old infant admitted to the hospital with a fever. Initial laboratory tests suggest a urinary tract infection, which is later confirmed by her urine culture. Based on the available evidence, treatment of a urinary tract infection in infants who are less than thirty days of age involves ten to fourteen days of intravenous antibiotics. [FN16] It is common to discharge patients to complete their treatment after placing a special intravenous (IV) line. While typical IVs need to *279 be replaced every two to three days, a peripherally inserted central catheter (a PICC line) [FN17] can last from weeks to months.

Home health providers typically come to the patient's home to change the PICC line dressings; however, the patient's families are expected to administer the antibiotics. Sarah's mother is very anxious about giving Sarah these antibiotics and would prefer Sarah remain in the hospital. In particular, she is worried about caring for her three older children in addition to her sick infant. Such potential conflicts are often made invisible by the power differentials that exist in health care. Patients or their parents do not forcefully assert their claims. Instead they accede to the health care providers' expectations because they do not perceive themselves as having enough power to negotiate effectively with the provider. A focus on these less dramatic, but potentially more frequent, conflicts may influence the dispute resolution systems or principles developed to resolve conflicts

I suggest that Ury, Brett, and Goldberg's principles of dispute system design are broadly applicable to patient provider conflicts. These scholars identify six principles of dispute system design:

1. Put the focus on interests.
2. Build in "loop-backs" to negotiation.

3. Provide low-cost rights and power backups.
4. Build in consultation before, feedback after.
5. Arrange procedures in a low-to-high-cost sequence.
6. Provide the necessary motivation, skills, and resources. [\[FN18\]](#)

***280** I focus on the first, third, fifth, and sixth principles, emphasizing the congruence between these principles and ongoing reform efforts. These efforts provide a potential point of entry for dispute resolution professionals into a potentially closed system.

Ury, Brett and Goldberg emphasize reconciling the disputant's interests. They identify a number of procedures for focusing on interests including commencing negotiation as early as possible, establishing a negotiation procedure, and designing multiple-step negotiation. [\[FN19\]](#) In both Jesse's and Sarah's cases, there is a fundamental role for principle-based negotiation. In Jesse's case, effective negotiation regarding complementary and alternative medicine may have modified the context in which the dispute over the definition of death and continuation of mechanical ventilation occurred. Relevant principles in such a negotiation may include patient autonomy and recognition of medical pluralism in addition to beneficence and nonmaleficence. [\[FN20\]](#)

In Sarah's case, negotiation could shift the focus away from positions regarding when Sarah will be discharged, to the parents and providers' shared interest in Sarah's health. They might recognize that Sarah's mother's anxiety may adversely affect Sarah's health and generate alternatives such as delaying discharge for additional teaching or identifying alternative individuals to administer medication or provide childcare. Providing patients, their families, and health care providers the necessary motivation, skills, and resources to encourage such negotiation thus becomes essential. [\[FN21\]](#)

While the explicit language of principle-based negotiation may not be familiar to health care providers, this approach is congruent with the American Council of Graduate Medical Education's (ACGME's) Outcomes Project. [\[FN22\]](#) The Outcomes ***281** Project emphasizes evaluating residency programs in terms of the program's outcomes rather than its structure or processes. As part of the Project, the ACGME identified six general competencies. These general competencies focus not only on knowledge, but also on skills and attitudes. While medical knowledge is one competency, they also include patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. [\[FN23\]](#) While instruction in interpersonal and communication skills often focuses on topics such as breaking bad news or discussing advanced directives, it could also include negotiation. Alternative dispute resolution providers could partner with residency training programs to provide skill training to residents.

Ury, Brett and Goldberg also emphasize the role of mediation as part of the focus on interests and sequencing procedures from low- to high-cost. [\[FN24\]](#) Mediation may be applicable in each of Jesse and Sarah's cases. In regards to Jesse's case, mediation may have a variety of benefits over litigation, including lower cost, more rapid resolution, and privacy. For example, the temporary restraining order established a trial date of two weeks later. [\[FN25\]](#) While this delay may represent an encouragement for the parties to use other means to resolve the dispute, it does not necessarily afford the parties a timely resolution. Litigation is also ***282** a public process and, while publicity may be a mechanism to redress the power differential, families may want to maintain their privacy. While working to improve health care providers' negotiation skills, mediation may be beneficial when negotiations break down. If the parties in Sarah's case reach an impasse, by focusing on positions rather than in-

terests or not sufficiently separating option generation from option evaluation, the involvement of a third party may be helpful. Mediation may be beneficial as an alternative to “lumping” it or litigation in a wide variety of patient provider conflicts.

One way in which mediation is already being incorporated into health care systems is through ethics consultation. [FN26] It is estimated that eighty-one percent of all general hospitals in the United States provide ethics consultation services. [FN27] Not only is the role of conflict incorporated into ASBH's definition of ethics consultation, but ethics facilitation is also a component of its proposed method of consultation. The Core Competencies for Health Care Ethics Consultation contends that the most appropriate approach to consultation is ethics facilitation, “identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus.” [FN28] The report's primary objective is to describe the core knowledge and skills for ethics consultation. The skills are broadly divided into ethical assessment, process, and interpersonal skills. The skills include the ability to identify key decision-makers and involved parties and include them in discussion; to engage in creative problem solving; to listen well and to communicate interest, respect, support, and *283 empathy to involved parties; and to enable the involved parties to communicate effectively and be heard by other parties. [FN29] Many of these skills are components of dispute resolution and dispute resolution professionals can contribute to the training of individuals performing ethics consultations.

Dispute resolution professionals might also participate in consultations themselves. Ethics consultations may be performed by individual consultants, teams, or committees and the Core Competencies remains agnostic regarding the best approach. [FN30] If utilizing teams or committees, at least one member of the group requires advanced interpersonal and process skills. [FN31] Dispute resolution professionals could participate in consultations, contributing their knowledge and expertise to a team or committee. However, patient confidentiality and other considerations may create perceived barriers to such participation. A potential point of entry for conflict resolution professionals may be to volunteer to serve as a lay member of a hospital's ethics committee. [FN32] From this position, conflict resolution professionals could educate the other committee members about dispute resolution and may develop sufficiently trustworthy relationships as to permit them to participate in ethics consultations.

Ury, Brett and Goldberg also recommend low-cost rights and power backups and arranging procedures in a low- to high-cost sequence. [FN33] This represents a substantial area for development in patient provider conflicts. Ethics consultation developed as an alternative to litigation. For example, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated:

*284 The Commission believes that ethics committees and other institutional responses can be more rapid and sensitive than judicial review: they are closer to the treatment setting, their deliberations are informal and typically private. . .and they are able to reconvene easily or delegate decisions to a separate group of members. [FN34]

The dominant methods of ethics consultation are, however, best characterized as hybrid processes, [FN35] and the potential benefits of separating the interest-based and rights-based components and developing distinct rights based back-ups are inadequately addressed. The Core Competencies characterizes ethics consultants as facilitating consensus within the domain of ethically acceptable options which the consultants themselves have defined. [FN36] Such hybrid processes have been criticized as impeding the process because of the possibility the third party may eventually make a decision for the parties [FN37] and as violating due process because the third party may base his/her decision on information learned in caucus to which the other party has not had *285 an opportunity to respond. [FN38] Significant additional research is necessary to determine what characteristic

of conflicts, if any, makes it preferable to arrange distinct processes hierarchically or to combine them into hybrid processes.

In envisioning dispute resolution processes in health care, another feature of the health care “system” and disputes must be acknowledged. The health care “system” is complex, and a shortcoming in one part of the “system” may create problems in another. [FN39] For example, each of the patient provider conflicts described earlier could also be characterized as coverage or competence disputes. In the first case, does the family's health insurance cover Jesse's continued “treatment” once he fulfills the neurological criteria for death and, if not, can the family afford to pay for the ongoing treatment out-of-pocket? In addition, the move to outpatient treatment represented in the Sarah's case is largely driven by efforts to control health care spending.

Issues of provider competence are also implicated in both cases. With Jesse, the family's options are significantly constrained by their inability to obtain medications and medical devices without prescription. In the Sarah's case, the historic emphasis of licensure processes on medical knowledge may have limited health care provider training in the skills and attitudes which would have focused on the patient and family's broader needs. Inattention to the ways in which the various parts of the health care “system” interact may perpetuate injustice.

Dispute resolution mechanisms which focus on system design and implementation are needed to complement case-based approaches, such as mediation and arbitration. Potential limitations of case-based approaches include the inability to *286 establish precedent, the disaggregation of collective interests, and the difficulty of enforcing important social norms. [FN40] Mediation and arbitration will need to be complemented by broader system-based processes which incorporate employers, insurers, hospitals, and universities. Health care may not be unique in this regard, and potential models may be found in the area of environmental mediation. [FN41]

Patient provider conflicts in health care may contain distinctive combinations of individual features which are also found in other conflicts. Such conflicts may be addressed by encouraging health care provider training in negotiation and creating opportunities for mediation and arbitration before resorting to litigation. Ethics consultation represents an existing practice that can be incorporated into such a dispute resolution system. Efforts to evaluate outcomes of residency programs and train individuals performing ethics consultations in process and interpersonal skills provide points of entry for dispute resolution professionals. As this work proceeds, broader attention to the complex interactions within the health care “system” will also need to be addressed to prevent the creation or perpetuation of injustice.

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[FN2]. This is an actual case and all information used to describe it is available in public sources see infra notes 3-6.

[FN3]. Lois M. Collins & Linda Thomson, Boy Focus of Life-Death Battle, *Deseret Morning News*, Oct. 14, 2004, at A1; Jesse Koochin: Brain Cancer Survivor, <http://www.jessekoochin.com> (last visited Nov. 1, 2004).

[FN4]. *Id.*

[FN5]. Lois M. Collins & Linda Thomson, Parents Remove Boy from Hospital, *Deseret Morning News*, Oct. 16, 2004, at B1; Lois M. Collins, Boy on Life Support is Leaving Hospital, *Deseret Morning News*, Oct. 15, 2004, at A1.

[FN6]. Lois M. Collins & Linda Thomson, Jesse Loses his Battle with Brain Tumor, *Deseret Morning News*, Nov. 20, 2004, at B1.

[FN7]. Nancy N. Dubler & Carol B. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* 21-22 (United Hospital Fund 2004) (describing unique factors in bioethics mediation including “deciding not to reach a resolution is not an option” and “the playing field is usually uneven for patients and their families.”).

[FN8]. Council on Ethical & Judicial Affairs, *Code of Medical Ethics: Current Opinions and Annotations* § 8.115 (2000-2001 ed.), <http://www.ama-assn.org/ama/pub/category/8496.html>.

[FN9]. See generally Michael Lang, *Understanding and Responding to Power in Mediation, Divorce and Family Mediation: Models, Techniques, and Applications* 209 (Jay Folberg, Ann L. Milne, & Peter Salem, eds., 2004).

[FN10]. See generally Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 *Issues Law Med.* 3 (1995).

[FN11]. Thaddeus M. Pope & 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 (2007).

[FN12]. Gordon DuVal, Leah Sartorius, Brian Clarridge, Gary Gensler & Marion Danis, *What Triggers Requests for Ethics Consultations?*, 27 *J. Med. Ethics.* i24 (2001), available at http://jme.bmj.com/cgi/content/full/27/suppl_1/i24.

[FN13]. Christopher W. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* 64-65 (3d ed. 2003).

[FN14]. “Lumping it” refers to patients or their families dropping their claims or give into the health care providers' claims. William L. Ury, Jeanne M. Brett & Stephen B. Goldberg, *Getting Disputes Resolved: Designing Systems to Cut the Costs of Conflict* 9-10 (1988).

[FN15]. The treatment of urinary tract infections in infants is a common clinical issue. This case is a composite of several children I have cared for and contains no personal health information.

[FN16]. American Academy of Pediatrics, Committee on Quality Improvement, Subcommittee on Urinary Tract Infection, *Practice Parameter: The Diagnosis, Treatment, and Evaluation of the Initial Urinary Tract Infection in Febrile Infants and Young Children*, 103 *Pediatrics* 843, 848 (1999), available at <http://aapolicy.aapublications.org/cgi/reprint/pediatrics;10314/831.pdf> (excluding children under two months of age from the recommendation that oral antibiotics may be to treat well appearing infants).

[FN17]. A PICC line is an IV that goes through the skin near the elbow and is threaded through veins into the chest.

[FN18]. Ury, Brett & Goldberg, *supra* note 14, at 42; see also Cathy A. Costantino & Christina Sickles Merchant, *Designing Conflict Management Systems: A Guide to Creating Productive and Healthy Organizations*

44-46 (1996).

[FN19]. *Id.* at 42-6.

[FN20]. S. Vohra & M. H. Cohen, Ethics of Complementary and Alternative Medicine Use in Children, 54 *Pediatr. Clin. North Am.* 875, 876 (2007).

[FN21]. Ury, Brett & Goldberg, *supra* note 14, at 46-48.

[FN22]. The ACGME is a private, non-profit organization that evaluates and accredits medical residency programs in the United States. The ACGME at a Glance, http://www.acgme.org/acWebsite/newsRoom/newsRm_acGlance.asp (last visited Mar. 23, 2007).

[FN23]. ACGME Outcome Project, <http://www.acgme.org/outcome/project/proHome.asp> (last visited Mar. 23, 2007); Common Program Requirements: General Competencies, <http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf> (last visited Jan. 17, 2007).

[FN24]. Mediation is characterized as both negotiation assisted by a third party and as an interest-based procedure which is immediately above negotiation in their “dispute resolution ladder.” Ury, Brett & Goldberg, *supra* note 14, at 49-52, 62-63.

[FN25]. *Ex Parte* Temporary Restraining Order, *In re* Jesse Steven Koochin, 3d Jud. Dist., Salt Lake County (Oct. 13, 2004); see also Collins & Thomson, *supra* note 4.

[FN26]. The American Society for Bioethics and Humanities (ASBH) defines health care ethics consultation as “a service provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties to address uncertainty or conflict regarding value-laden issues that emerge in health care.” American Society for Bioethics and Humanities, Core Competencies for Health Care Ethics Consultation 3 (1998), <http://www.asbh.org/publications/core.html>.

[FN27]. Ellen Fox, Sarah Myers & Robert A. Pearlman, Ethics Consultation in United States Hospitals: A National Survey, 7 *Am. J. Bioeth.* 13 (2007).

[FN28]. *Id.* at 6.

[FN29]. *Id.* at 12-16.

[FN30]. *Id.* at 11-12.

[FN31]. *Id.* at 15.

[FN32]. Ethics committees typically review ethics consultations and frequently include lay or community members. Judith Wilson Ross with Sister Corrine Bayley, Vicki Michel & Deborah Pugh, *Handbook for Hospital Ethics Committees* 56-63, 40-42 (1986).

[FN33]. Ury, Brett & Goldberg, *supra* note 14, at 42.

[FN34]. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in*

Treatment Decisions 168-69 (1983), http://www.bioethics.gov/reports/past_commissions/deciding_to_forego_tx.pdf.

[FN35]. See generally Arnold Shienvold, Hybrid Processes, Divorce & Family Mediation: Models, Techniques, and Applications 112 (Jay Folberg, Ann L. Milne, & Peter Salem, eds., 2004).

[FN36]. American Society for Bioethics and Humanities, *supra* note 26, at 4-8; see also Dubler & Liebman, *supra* note 7, at 13-14, 24-25.

[FN37]. E.g., Kimberlee K. Kovach & Lela P. Love, [Mapping Mediation: The Risks of Riskin's Grid](#), 3 *Harv. Negot. L. Rev.* 71, 99 (1998). "If the neutral assumes an evaluative role or orientation, the parties' focus during the process shifts towards influencing the neutral decision-maker and away from crafting outcomes for themselves." *Id.*

[FN38]. Barry C. Bartel, Note: [Med-Arb as a Distinct Method of Dispute Resolution: History, Analysis, and Potential](#), 27 *Willamette L. Rev.* 661, 679, 685-88 (1991); Karen L. Henry, Note: [Med-Arb: An Alternative to Interest Arbitration in the Resolution of Contract Negotiation Disputes](#), 3 *Ohio St. J. on Disp. Resol.* 385, 396-97 (1988).

[FN39]. Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* 3-4 (2006).

[FN40]. Robert A. Baruch Bush & Joseph P. Folger, *The Promise of Mediation: The Transformative Model for Conflict Resolution* 15-8 (Rev. ed. 2005).

[FN41]. Gabriel P. Soto, [Environmental Regulatory Mediation](#), 8 *Tex. Tech. Admin. L. J.* 253, 256, 263 (2007) (noting the involvement of multiple parties, including private corporations, state and federal agencies, and public interest groups, and the importance of public interests, not necessarily represented by private parties).

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