REGULATING ETHICS COMMITTEES IN HEALTH CARE INSTITUTIONS—IS IT TIME?

DIANE E. HOFFMANN*

INTRODUCTION

Institutional ethics committees[1] are part of "a growing phenomenon"[2] in the American health care system.[3] By 1985, more than sixty percent of American hospitals and nearly ten percent of

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* Law School Assistant Professor, University of Maryland School of Law. A.B., Duke University, 1976; M.S., Harvard University, 1980; J.D., Harvard University, 1986.

1. The term "institutional ethics committee" describes a multidisciplinary committee of health care professionals and community representatives established to address the ethical dilemmas that occur within the health care institution. Most often these committees deal with issues regarding the withholding or withdrawal of life sustaining treatment from patients who lack decisionmaking capacities. *See* Cranford & Doudera, *The Emergence of Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 6-7 (R. Cranford & A. Doudera eds. 1984) [hereinafter INSTITUTIONAL ETHICS COMMITTEES]. At the present time, the use of these committees by patients, family members or health care providers is purely optional and the role of the committees is solely advisory.

2. Fleetwood, Arnold & Baron, *Giving Answers or Raising Questions?: The Problematic Role of Institutional Ethics Committees*, 15 J. MED. ETHICS 137 (1989).

3. Several studies have been conducted during the last decade to determine the number of hospitals that have established ethics committees, and incidentally showing the progression of their development. In a 1982 survey conducted by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Dr. Stuart Youngner found only 17 committees in the 400 hospitals with more than 200 beds that he surveyed, and no committees in the 202 hospitals he studied with less than 200 beds. Based on these observations he estimated that approximately 1% of hospitals had ethics committees in place. Cranford & Doudera, *supra* note 1, at 9 (citing Youngner, *A National Survey of Ethics Committees*, in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 446 (1983) [hereinafter PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT]) (Youngner defined ethics committees very narrowly as a committee with the potential to participate in the making of a clinical decision. *Id.* at 445.) A study of 396 hospitals in New York, New Jersey, Connecticut and Massachusetts that was conducted at approximately the same time found that 16.4% had ethics committees. *See* Cranford & Doudera, *supra* note 1, at 9. A 1983 survey by the Catholic Health Association indicated that 41% of its members had ethics committees. The authors of the Catholic study also reported a regional variation: in the Pacific and mountain states, 55% of respondents had ethics committees, whereas only 30% of the hospitals in the north central and east south central states had committees. *See id.* The percentage of hospitals with ethics committees responding to surveys conducted by the American Hospital Association's National Society for Patient Representatives increased from 26% in 1983 to 60% in 1985. Note, *Ethics Committees Double Since '83: Survey*, 59 HOSPITALS 60 (1985).

all nursing homes had established their own ethics committees.[4] The motivation for establishing most of these committees was internal—nurses, social workers, and physicians searching for a better way to think about and handle cases involving life-sustaining treatment, initiated the formation of the committees.[5] The stated purpose of the committees was to protect the interests of patients, especially those patients who could not speak for themselves.[6]

While most hospitals established these committees in response to internal pressures, a series of external events, including court cases,[7] a President's Commission report,[8] and federal regulations,[9]

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4. American Hospital Association News, Dec. 5, 1988, at 1, col. 1.

5. *See* McCormick, *Ethics Committees: Promise or Peril?*, 12 LAW, MED. & HEALTH CARE 150 (1984). McCormick offers a list of eight cultural variables and background conditions for the establishment of ethics committees by hospitals. These include (1) the growing complexity of medical problems; (2) the range of options available for treatment; (3) protection from legal liability; (4) the nature of judgments in clinical decisions; (5) the emergence of patient autonomy; (6) the emergence of economic considerations in health care; (7) religious convictions of some groups; (8) "individual decisions, as affected by the plurality of publics." *See id.* at 150-52.

6. *See* PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 164.

7. *See, e.g.*, *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). In the 1976 Karen Ann Quinlan case, the New Jersey Supreme Court quoted an article by Dr. Karen Teel which suggested that the way to improve medical decisionmaking was for each hospital to establish an "Ethics Committee composed of physicians, social workers, attorneys, and theologians . . . which [would serve] to review the individual circumstances of ethical dilemma[s] and which [would provide] much in the way of assistance and safeguards for patients and their medical caretakers." *Id.* at 49, 355 A.2d at 668 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 9 (1975)). Dr. Teel saw such a committee as being "advisory" rather than "enforcing," *see* Teel, *supra*, at 9, but the New Jersey Court in *Quinlan* suggested a greater role. *See* 70 N.J. at 49-51, 355 A.2d at 668-69. The *Quinlan* court noted that if there was an ethics committee and the committee agreed "that there [was] no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state," *id.* at 54, 355 A.2d at 671, the request of parents, guardians, and attending physicians to remove life-sustaining treatment could be acted upon without fear of civil or criminal liability. *See id.* Although the *Quinlan* court used the term "ethics committees," subsequent authorities who have commented on the case have used the term "prognosis committees" to describe the committees referred to in the *Quinlan* case and have insisted that they are not really ethics committees. *See, e.g.*, Robertson, *Committees as Decision Makers: Alternative Structures and Responsibilities*, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 1, at 86-87.

In response to *Quinlan*, the Attorney General of New Jersey "promulgated nonbinding guidelines concerning the role and function of prognosis committees." Cranford & Doudera, *supra* note 1, at 15. As of 1983, 84% of hospitals in New Jersey had established committees pursuant to these voluntary guidelines. *Id.*

Other cases that have mentioned the positive role that an ethics committee can play include: Severns v. Wilmington Medical Center, 421 A.2d 1334, 1350 (Del. Super. Ct. 1980) (ethics committees can assist in evidentiary hearings); *In re* Spring, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980) (opinion of ethics committee may be persuasive evi-

also motivated their formation. Although each of these external forces added to the impetus for hospitals to convene their own ethics committees, the establishment of the committees was voluntary in every state until 1987, when the Maryland Patient Care Advisory Committee Act[10] (the Act) became effective. The Act requires all hospitals in the state to establish a patient care advisory committee, or ethics committee, as they are referred to by most hospitals. Although other states have considered legislation that would make hospital ethics committees mandatory in their jurisdiction,[11] Mary-

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dence on issues of good faith and good medical practice); *In re* Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (ethics committee approval of a family decision to withhold or withdraw treatment could substitute for court review); *In re* Jobes, 108 N.J. 394, 451-53, 529 A.2d 434, 463-64 (1987) (Pollock, J., concurring) (ethics committees can assist family members and health care providers in determining whether to terminate life support).

8. In its 1983 report, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that in order to protect the interests of patients who lack decisionmaking capacity and to ensure their well-being and self-determination, hospitals "should explore and evaluate various . . . administrative arrangements for review and consultation, such as 'ethics committees' particularly for decisions that have life or death consequences . . . ." PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 5.

9. A third external motivating factor for the establishment of ethics committees was the promulgation in 1985 of the final regulations, 45 C.F.R. § 1340.15 (1991), issued by the United States Department of Health and Human Services, Office of Human Development Services, as authorized by 1984 amendments to the federal Child Abuse Prevention and Treatment Act, 42 U.S.C. §§ 5101-5107 (1988). The regulations, commonly referred to as the Infant Doe regulations, were a response to *In re* Infant Doe, No. GO 8204-004A (Monroe County Cir. Ct., Ind., Apr. 12, 1982), *cert. denied*, 464 U.S. 961 (1983). The regulations strongly encourage, but do not mandate, that hospitals caring for newborns establish infant care review committees to review cases where the withholding of life-sustaining treatment of a newborn is being considered. *See* 45 C.F.R. § 1340.15.

10. Act of May 27, 1986, ch. 749, 1986 MD. LAWS 2841 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 19-370 to -374 (1990 & Supp. 1990)). State Senator Paula Hollinger was motivated to introduce the bill by a variety of factors including state legislation dealing with so-called "Baby Doe" cases, continuing efforts by members of the state legislature to pass a living will statute, and by "numerous cases going to courts around the country that dealt with termination and initiation of treatment." Hollinger, *Hospital Ethics Committees Required by Law in Maryland*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 23. Hollinger, who trained and practiced as a nurse prior to being elected to public office, was particularly influenced by the 1983 Minnesota case, *In re* Torres, 357 N.W.2d 332 (Minn. 1984), in which the Minnesota Supreme Court reviewed the recommendations of three independent ethics committees in deciding whether to disconnect a respirator from a patient with irreversible brain damage. *See* Hollinger, *supra*.

11. For example, the New York State Task Force on Life and the Law has considered urging all hospitals in New York to create ethics committees, or "recommending the passage of legislation to require hospitals in New York State to establish committees." N.Y. Times, Mar. 4, 1990, § 12 at 1, col. 5 (L.I. ed.). In other states, "legislatures passed resolutions approving of hospital ethics committees, as did some state hospital associations, state medical associations, and insurance companies." J.W. ROSS, HANDBOOK FOR

land is the only state that has passed such legislation.

In October 1989, the voluntary nature of ethics committees in every other state was threatened when United States Senators John C. Danforth (R-Mo.) and Daniel Patrick Moynihan (D-NY) introduced a bill into the Senate entitled the Patient Self Determination Act.[12] Among other things,[13] the bill in its original form would have required all hospitals and nursing homes in the country to establish an ethics committee that would "initiate educational programs for staff, patients, residents, and the community on ethical issues in health care, advise on particular cases, and serve as a forum on such issues."[14]

There have also been some murmurings recently by members of the judicial and legal communities that the role and authority of ethics committees be expanded to allow them to substitute for judicial decisionmaking in certain cases. For example, in *In re A.C.*,[15] the Court of Appeals for the District of Columbia was called upon to determine "who has the right to decide the course of medical treatment for a patient who, although near death, is pregnant with a viable fetus" and "how that decision should be made if the patient cannot make it for herself."[16] Although the court ultimately ruled in the case, Judge Terry, speaking for the court, stated in a footnote:

> We observe . . . that it would be far better if judges were not called to patients' bedsides and required to make quick

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HOSPITAL ETHICS COMMITTEES 7 (1986). A Hawaii statute endorses ethics committees by granting them immunity from liability but does not mandate them. *See* HAW. REV. STAT. § 663-1.7 (1988 & Supp. 1990).

12. *See* S. 1766, 101st Cong., 1st Sess.

13. The purpose of the Act, according to Senator Danforth, was to ensure "that people are informed of their rights, under state law, to control decisions about their health care—even when they are no longer able to voice their wishes—through the use of advance directives for medical care." 135 CONG. REC. 13,566 (1989).

14. *Id.* at § 3(a)(3). The Patient Self-Determination Act passed as an amendment to Congress' budget deficit reduction package in November 1990 *without* a requirement that health care facilities establish ethics committees. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (1990) (to be codified at 42 U.S.C. § 1395). In its final form, the Act requires that hospitals and other facilities accepting Medicare or Medicaid payments inform patients of their right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, the right to appoint an agent or surrogate through a written power of attorney to make health care decisions on behalf of the patient, and the right to provide the hospital or other institution with written instructions concerning their own health care, including instructions for the disposition of their organs. *See* Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388 (1990). The Act further requires health care providers to document the treatment wishes of patients in the patient's medical record. *See id.*

15. 573 A.2d 1235 (D.C. 1990).

16. *Id.* at 1237.

> decisions on issues of life and death. Because judgment in such a case involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment—through legislation or otherwise—of another tribunal to make these decisions, with limited opportunity for judicial review.[17]

In line with this suggestion, members of the Health Law Section of the Maryland State Bar Association recommended recently that the state adopt legislation that would expand the authority of ethics committees by allowing them to substitute their views for judicial decisionmaking in cases where patients are in a persistent vegetative state and family members or health care providers wish to terminate or withhold life-sustaining treatment.[18]

This Article will examine the appropriateness of legislation that would mandate the establishment of ethics committees and expand the authority of these committees. A study of hospital ethics committees in Maryland, the District of Columbia, and Virginia, conducted in 1989 and 1990 by the University of Maryland's Law and Health Care Program, which sought to evaluate the effectiveness of the Maryland Act,[19] provides many of the empirical findings that serve as a basis for the discussion and conclusions of this Article.

Part I of the Article provides a description of the Maryland Patient Care Advisory Committee Act, the federal proposal for the establishment of ethics committees, and proposals to expand the decisionmaking authority of ethics committees. Part II analyzes the appropriateness of legislation that would mandate the establishment of ethics committees. This analysis includes a discussion of the likely effectiveness of such legislation and the justification and need for legislation in this area. Part III examines the judiciousness of legislation that would allow ethics committees to substitute for court proceedings in certain circumstances with limited opportunities for judicial review. This portion of the Article compares and contrasts the ethics committee as a decisionmaker with the patient's family and with the courts. The analysis considers the "quality" of deci-

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17. *Id.* at 1237 n.2.

18. *See* Health Law Section of the Maryland State Bar Association, Proposed Amendments to H.G. § 20-107: Individuals Who Are Terminally Ill or in a Persistent Vegetative State (Nov. 6, 1990) (copy on file with the *Maryland Law Review*) [hereinafter Md. Bar Proposal].

19. *See* Hoffmann, Does Legislating Hospital Ethics Committees Make a Difference?: A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia (1991) (to be published in a forthcoming issue of *Law, Medicine & Health Care*) (unpublished manuscript on file with the *Maryland Law Review*) [hereinafter Study].

sionmaking by these various entities as well as their cost effectiveness.

The Article concludes in Part IV that, although legislation requiring the establishment of ethics committees is not warranted at this time, legislation that would regulate the establishment and operation of ethics committees is justified from both a policy and a legal perspective. The Article further argues that the decisionmaking authority of ethics committees should be expanded to permit their use as an alternative to judicial decisionmaking only if the typical composition of ethics committees is fundamentally changed and numerous safeguards are implemented, including provisions for due process and the monitoring of committee deliberations and recommendations.

I. BACKGROUND

A. Legislation Mandating the Establishment of Ethics Committees

In July 1987, Maryland became the first, and is thus far the only, state to require all hospitals to establish their own patient care advisory committee or ethics committee.[20] Furthermore, in July 1990, the Maryland General Assembly expanded the scope of the Act to require that all nursing homes in the state establish their own ethics committees or participate in a multi-institutional ethics committee.[21]

In addition to requiring that all hospitals and nursing homes establish an ethics committee, the Maryland Act provides that at the request of a petitioner[22] committees must offer advice in medical cases involving individuals with life-threatening conditions.[23] The committee must have at least four members, including a physician, a nurse, a social worker, and a hospital's chief executive officer or designee.[24] Other members may be added as the hospital chooses, including representatives of the community and ethical advisors or

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20. *See* Act of May 27, 1986, ch. 749, 1986 MD. LAWS 2841 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 19-370 to -374 (1990)). Throughout this Article the Maryland committees will be referred to as "ethics committees" in accordance with popular usage, although technically under the statute they are termed "Patient Care Advisory Committees." *See id.* § 19-370.

21. *See* Act of May 29, 1990, 1990 Md. Laws, ch. 545 (codified at MD. HEALTH-GEN. CODE ANN. § 19-370(a) (1990 & Supp. 1990)).

22. The Act defines a petitioner as someone responsible for making a decision with a medical consequence for a patient. *See* MD. HEALTH-GEN. CODE ANN. § 19-370(d) (1990 & Supp. 1990).

23. *See id.* § 19-373(a).

24. *See id.* § 19-372(a)(1).

clergy.[25] Although providing consultation in cases involving life-threatening conditions is the only mandatory function of the committees, the statute states that the committees may also educate hospital personnel, patients, and patients' families concerning medical decisionmaking, and review and recommend institutional policies and guidelines concerning the withholding of medical treatment.[26]

In addition, the statute sets forth certain "due process" requirements that the committee must meet.[27] For example, each committee must set forth in writing how it shall be convened.[28] Further, the committee must make a good-faith effort to notify patients and their immediate family members of their rights to petition the committee for assistance;[29] to meet with the committee concerning "options for medical care and treatment";[30] and to receive an explanation of "the basis of the advisory committee's advice."[31] As part of its deliberations the advisory committee must consult all members of the patient's treatment team,[32] the patient,[33] and the patient's family.[34] Finally, the Act provides that members of these committees who give advice in good faith may not be held liable in court for the advice given;[35] that the proceedings of the committee are confidential;[36] and that the advice of the committee must become part of the patient's medical record.[37]

United States Senate Bill 1766, also referred to as the federal Patient Self-Determination Act, was introduced in the Senate in Oc-

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25. *See id.* § 19-372(a)(2).
26. *See id.* § 19-373(b).
27. *See id.* § 19-374(a).
28. *See id.* § 19-371(2).
29. *See id.* § 19-374(b)(i).
30. *Id.* § 19-374(b)(ii).
31. *Id.* § 19-374(b)(iii).
32. *See id.* § 19-372(a)(3)(i).
33. *See id.* § 19-372(a)(3)(ii).
34. *See id.* § 19-372(a)(3)(iii).
35. *See id.* § 19-374(c).
36. *See id.* § 19-374(d)(1). The Act provides that "[t]he proceedings and deliberations of an advisory committee are confidential as provided in § 14-601 of the Health Occupations Article," *id.* § 19-374(d)(1), and that any recommendation of the committee that is included in the patient's medical record is confidential under §§ 4-301 and 4-302 of the Health-General Article of the Maryland Code. *See id.* § 19-374(d)(2). Section 14-601 of the Health Occupations Article of the Maryland Code covers medical peer review committees and provides that the "proceedings" of such committees "are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee." MD. HEALTH-OCC. CODE ANN. § 14-601(d)(i) (1989).
37. *See* MD. HEALTH-GEN. CODE ANN. § 19-374(d)(2) (1990 & Supp. 1990).

tober 1989.[38] In its initial form, the bill required all hospitals and nursing homes in the country to establish an ethics committee.[39] Other than mandating that health care institutions establish these committees, that the committees be available for consultation on particular cases, and that the committees initiate educational programs on ethical issues in patient care, the bill said nothing about the committees.[40] Thus, the bill was silent as to the composition, structure, and operation of the committees, leaving those decisions to individual hospitals. The ethics committee requirements proposed by the bill were to be implemented as part of the Medicare conditions of participation for health care providers.[41]

The Subcommittee on Medicare and Long Term Care of the Senate Finance Committee conducted hearings on the bill on July 20, 1990.[42] Most of the public policy debate on the bill centered on its requirement that all health care providers inform and educate the public about advanced medical directives, such as living wills and durable powers of attorney for health care.[43] Surprisingly little comment was directed to the ethics committee provision. Of the nine individuals who testified at the hearing, only three commented on the ethics committee mandate and only one commentor devoted any substantial attention to the provision.[44] Furthermore, at the time of the hearing, Senator Danforth announced that he was planning to revise the bill.[45] The new version would not require that hospitals establish ethics committees. It would simply require that health care providers educate patients and their family members about advanced directives and ethical issues in patient care.[46]

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38. *See* S. 1766, 101st Cong., 1st Sess. (1989), *passed as amended* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (1990) (to be codified at 42 U.S.C. §§ 1395cc, 1396a).

39. *See id.* §§ 3(a)(3), 4(b)(3).

40. *See generally id.*

41. *See id.* § 3(a)(3); 42 U.S.C. § 1395cc (1988); *see also* S. 1766, § 4(b)(3) (proposed amendment to 42 U.S.C. § 1396a (1988)).

42. *See Living Wills: Hearings on S. 1766 Before the Subcomm. on Medicare and Long Term Care of the Senate Finance Comm.*, 101st Cong., 2d Sess. (1990) [hereinafter *Hearings*].

43. *See generally id.*

44. Only the testimony of Paul Rettig, Executive Vice President and Director, Washington Office of the American Hospital Association (AHA), addressed, at any length, the ethics committee requirement. The AHA opposed the requirement for two reasons: (1) the "AHA sees ethics committees as one option for resolving biomedical ethics dilemmas, but believes that the decision to establish such a body should be left to the discretion of each institution based upon its needs"; (2) "the scope of functions suggested by the Act exceeds what is appropriate for an ethics committee." *Id.* at 122, 123.

45. *See id.* at 123.

46. The reasons for the deletion of the ethics committee requirement do not appear in the public record but conversations with a member of Senator Danforth's staff re-

On April 3, 1990, Representative Sander Levin (D-Mich.) introduced a modified version of the Senate bill in the House.[47] The bill did not include a requirement that health care institutions establish ethics committees, although one provision called for providers to establish educational programs for staff and patients on ethical issues concerning patient self-determination.[48] Hearings on the House bill were held on May 22, 1990.[49] The Act as passed did not include the provision of the House bill regarding educational programs on ethical issues.[50]

B. Efforts to Allow Ethics Committees to Substitute for Judicial Decisionmaking

The primary sentiment for expanding the role of hospital ethics committees and allowing them to substitute for judicial decisionmaking stems from a handful of judicial decisions. In *In re Quinlan*,[51] the first case to promote the idea, the New Jersey Supreme Court stated that there would be no need for judicial review of cases involving the termination of life support from patients in a persistent vegetative state if a multidisciplinary ethics committee confirmed the patient's prognosis.[52] A number of other cases have requested legislative assistance in this area:

> [W]ith the exception of the Massachusetts Supreme Judicial Court's *Saikewicz* opinion, which appropriated to the courts the role of making all life and death decisions for incompetents, nearly every court confronted with such a decision has pleaded for legislative guidance, not judicial resolution, of these medical dilemmas.
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> The courts realize that frequently judicial involvement

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vealed that the primary motivations for the deletion were fear of "Baby Doe" type regulations in which the federal government would mandate the composition of the committees and the substantive criteria on which they must make their decisions, *see supra* note 9, and the belief that there has not been enough experience with ethics committees nor enough empirical studies of their effectiveness. Conversation with Liz McCloskey, legislative aide to Senator Danforth (Aug. 30, 1990).

47. *See* H.R. 4449, 101st Cong., 2d Sess. (1990), *reintroduced*, H.R. 5067, 101st Cong., 2d Sess. (1990).

48. *See* H.R. 4449, 101st. Cong., 2d Sess., §§ 2(a)(3), 3(a)(3); H.R. 5067, 101st. Cong., 2d Sess., § 2(a)(2) (1990).

49. *See Fiscal Year 1991 Reconciliation Issues Relating to Durable Medical Equipment, Clinical Laboratory Services, and Other Issues Under the Medicare Program, Hearing Before the Subcomm. on Health of the Comm. on Ways and Means*, 101st Cong., 2d Sess. (1990).

50. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (1990).

51. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

52. *See id.* at 50, 355 A.2d at 669.

> is nothing more than a facade designed to gain approval and immunity for the family-physician decision. When asked to make actual treatment decisions, the courts are acutely aware of their limitations and lack of clinical experience.[53]

This position was most recently taken by Judge Terry in the *In re A.C.* case.[54]

To date, there has been no legislation permitting ethics committees to substitute for judicial decisionmaking. But such legislation, or at least proposals for such legislation, may be offered in the near future. In Maryland, members of the Health Law Section of the Maryland State Bar Association recently proposed expanding the role of ethics committees.[55] The proposal would permit families, after consultation with the hospital's ethics committee, to bypass judicial approval for medical cases involving the withholding or withdrawal of life-sustaining procedures from relatives who are in a persistent vegetative state.[56] The rationale for this proposal is that under current state law, according to an Attorney General's Opinion, families with relatives in a persistent vegetative state are required to obtain a court order to terminate or withhold treatment.[57] Although the existing Maryland substituted consent statute[58] allows family members, in order of statutory priority, to consent to the furnishing of medical treatment for relatives who cannot consent on their own behalf, the Maryland Attorney General has opined that this ability to consent does not apply to the withholding or withdrawal of life-sustaining treatment.[59] The Attorney General has further concluded that there is a common-law right of family members to consent to the withholding or withdrawal of life-sustaining treatment from relatives who are unable to consent on their own behalf and who are terminally ill.[60] Families who wish to terminate or discontinue life support for nonterminal relatives must obtain a court order to do so.[61] The proposal by the Health Law Section of the Maryland State Bar Association calls for expanding the Maryland

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53. Paris & Reardon, *Ethics Committees in Critical Care*, 2 CRITICAL CARE CLINICS 111, 113 (1986).

54. 573 A.2d 1235, 1251-53 (D.C. 1990).

55. *See* Md. Bar Proposal, *supra* note 18, at 4.

56. *See id.*

57. *See* 73 Op. Atty. Gen. 253 (1988).

58. *See* MD. HEALTH-GEN. CODE ANN. § 20-107(d) (1990).

59. *See* 73 Op. Atty. Gen. 253, 287 n.43 (1988).

60. *See id.* at 290.

61. *See id.* at 291.

substituted consent statute to permit family members to consent to the withholding or withdrawal of life-sustaining procedures for patients who are terminally ill or in a persistent vegetative state.[62] For those patients who are in a persistent vegetative state, family members must certify that such withholding or withdrawal is what the patient would have wanted.[63] This conclusion must be confirmed by the hospital's ethics committee.[64]

II. AN EVALUATION OF PROPOSALS TO MANDATE THE ESTABLISHMENT OF ETHICS COMMITTEES

This Part examines the appropriateness of legislation that would mandate the establishment of hospital ethics committees by looking at the effectiveness, justification, and need for such legislation.

A. Effectiveness of Legislation

Experience in Maryland provides some clues as to the likely effectiveness of legislation mandating the establishment of ethics committees. Although the Maryland Act includes no penalties for noncompliance with the statute, the University of Maryland Law and Health Care Program's study of ethics committees in Maryland, the District of Columbia, and Virginia[65] found that technical compliance with the statute was very high: ninety-one percent of nonfederal hospitals in Maryland have established ethics committees.[66] A significant finding, however, is that of those committees that do exist,

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62. *See* Md. Bar Proposal, *supra* note 18, at 3.

63. *See id.* at 4.

64. *See id.*

65. *See* Study *supra* note 19. The study design included four phases. In Phase I, a questionnaire was mailed to the chief executive officer of every hospital in Maryland, the District of Columbia, and Virginia. This included 199 hospitals—63 in Maryland, 118 in Virginia, and 18 in the District of Columbia. The list of hospitals surveyed was taken from the membership of the hospital associations in the relevant jurisdictions. *See id.* § II. The chief executive officers were asked whether their hospitals had established an ethics committee; whether they had developed a written procedure by which the committee would be convened; what was the composition, by profession, of the committee; how long the committee had been in existence; for what purposes the committee had been convened; how patients and family members are notified about the committee and their right to request or attend a meeting; and how health professionals are notified about the committee and their right to use it.

66. The response rates to the question, "Does your hospital have an ethics committee or patient care advisory committee?" were 98% (Maryland), 100% (District of Columbia) and 97% (Virginia). *See id.* § III(1). If federal hospitals are included in the sample, 89% of hospitals in Maryland have established an ethics committee. *Id.* § III(1) n.5.

fifteen percent are inactive—that is, they have not met or meet very infrequently.[67] Thus, the Maryland statute has been very successful in motivating hospitals to establish such committees, but somewhat less successful in effectuating their operation.

In the District of Columbia, despite the fact that there is no statute mandating ethics committees, seventy-eight percent of hospitals in the jurisdiction have established such committees.[68] This large percentage may be attributed partially to the fact that a significant portion of the District's hospitals are large teaching hospitals.[69] Several studies indicate that both large hospitals and teaching hospitals are more likely to have ethics committees than small and nonteaching hospitals.[70] Moreover, the relatively small number of hospitals in the District increases the likelihood of information-shar-

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67. This figure was obtained from reviewing the results of both Phase I and II of the Maryland Study. Of those with committees in Maryland, 95% completed all of the Phase I questionnaire. In Virginia, 100% of hospitals with committees completed the Phase I survey and in the District of Columbia the percentage was 93%. *See id.* Phase II of the Study consisted of telephone interviews of chairpersons of committees. *Id.* § II. In this Phase, the chairpersons were asked whether the committees had done any case consultation, what types of cases the committees had dealt with, whether the committee had developed any policies regarding patient care and if so, what type of policies. *Id.* Chairpersons were also asked how many times the committee had met; how many cases the committee had reviewed in the past year; whether the committee's recommendations regarding a specific case go into the patient's medical record; and officially who is permitted to request the committee's services. *Id.* The total number of chairpersons interviewed was 65. *Id.* § III(2). In Maryland the chairpersons of 42 committees were interviewed, representing 76% of the hospitals with committees. Of the 52 hospitals that completed responses to Phase I, 10 respondents were not interviewed for the following reasons: committees had not yet met; hospitals would not give permission to interview their chairperson; chairperson had retired and had not been replaced; and in some hospitals surveyors were unable to contact the chairperson or the chairperson did not respond. In the District of Columbia, 8 out of 13 respondents to Phase I were interviewed, representing 57% of District hospitals with committees. One hospital would not give permission to interview the chairperson and surveyors were unable to reach the chairpersons of 4 committees. In Virginia surveyors were able to interview 15 (56%) of the 27 respondents to Phase I. Seven committees were inactive— they were just forming and had not yet met; and six chairpersons did not respond to the surveyors' attempts to reach them. *Id.*

68. *Id.* § III(1).

69. Eighty-five percent of the hospitals in the District with committees are teaching hospitals and have over 250 beds.

70. A 1985 American Hospital Association study found that ethics committees were most prevalent in teaching hospitals. Sixty-seven percent of respondents with committees were teaching hospitals while only 25% of nonteaching hospitals reported having an ethics committee. Note, *Ethics Committees Double Since '83: Survey*, 59 HOSPITAL 60 (1985). This is consistent with the results of a recent Minnesota study, which found that the larger the hospital, the greater the probability of an ethics committee—in the study only 2 of the 20 hospitals with 200 or more beds did not have an ethics committee. *See Ethics Committee Survey Results*, 10 ETHICS NEWS 1 (1990).

ing about the benefits of committees among the hospitals—another factor contributing to their widespread establishment.

The Study also found that of those District of Columbia hospitals with committees that responded to the survey, all have active committees.[71] This fact supports the hypothesis that mandating committees will not necessarily ensure their operation. In addition, it suggests that committees that are voluntarily established are more likely to be active, perhaps because the members are motivated to see the committee function.

In Virginia, only twenty-five percent of the hospitals have established ethics committees.[72] This percentage is lower than the figure nationally reported that sixty percent of hospitals have established ethics committees.[73] Also, a substantial percentage (thirty-three percent) of the Virginia committees are inactive.[74] The inactivity, however, may be attributable to the fact that the committees have recently formed, rather than to the fact that they formed a year or more ago and have not yet met, as is the case with several of the inactive committees in Maryland.[75]

In Maryland, thirty-three percent of hospitals established their committees after the Maryland Act became effective.[76] Fifty-one percent of hospitals in the state had already established committees before the law was passed.[77] Although no statute was passed in the District of Columbia, the percentage of hospitals with and without committees before and after 1987 is quite similar to the percentages in Maryland before and after the statute.[78] In Virginia, twelve percent of hospitals had established committees before 1987 and eleven percent from 1987 through 1989.[79] Thus, even in states without a statute that requires the formation of ethics committees, the rate of development of the committees has not slowed.

Compliance with the Maryland statute varies according to its provisions. For example, one provision in Maryland's statute requires all committees to include at least one physician, one nurse,

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71. *See* Study, *supra* note 19, § III(1).
72. *Id.*
73. *See supra* note 2.
74. Study, *supra* note 19, § III(1).
75. *See id.* § III(1), table 4.
76. *Id.*
77. *Id.*
78. Prior to 1987, 44% of hospitals in the District of Columbia had established committees. From 1987 through 1989, 28% of hospitals in the District had established committees. *Id.*
79. *Id.*

one social worker, and the hospital chief executive officer or designee.[80] Compliance with this aspect of the law has been quite high. One hundred percent of the committees in Maryland have at least one physician, ninety-eight percent have at least one registered nurse, ninety-six percent include a social worker, and eighty-six percent include the hospital administrator or designee.[81]

The Maryland statute further mandates that each hospital establish a written procedure by which its committee will convene.[82] According to the Study, only seventy-three percent of the hospitals had complied with this provision.[83] Compliance with the statutory requirement that the advice of the committee concerning a patient's medical care be included in the patient's medical record occurred at a similar rate; seventy-one percent of active committees in Maryland included their recommendation on case consultation in the patient's record.[84] Yet, this figure was higher than that for committees in Virginia or the District of Columbia.[85]

Although most hospitals in Maryland have an operational ethics committee, utilization of the committees is quite low. Fifty percent of the active committees in Maryland conducted five or fewer case consultations within the year previous to the Study.[86] Many had done only one or two; some had not done any.[87]

Case consultation on the request of a petitioner is the only mandatory function of ethics committees in Maryland.[88] The fact that Maryland committees are not doing much case consultation

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80. *See* MD. HEALTH-GEN. CODE ANN. § 19-372(a)(1) (1990 & Supp. 1990).

81. Study, *supra* note 19, § III(1), table 3. All committees in the District of Columbia and Virginia also include at least one physician. *Id.* In the District of Columbia, 100% of the committees have at least one nurse and one social worker, but only 54% of the committees include the hospital administrator or designee. *Id.* In Virginia, 100% of the committees include at least one physician, 96% include at least one nurse, 74% include a social worker, and 82% include the hospital administrator or designee. *Id.*

82. *See* MD. HEALTH-GEN. CODE ANN. § 19-371 (1990).

83. *See* Study, *supra* note 19, § III(1). In the District of Columbia and Virginia, where there is no such requirement, the percentages of hospitals that had established such a procedure were 85% and 58%, respectively. *Id.*

84. *Id.* § III(2).

85. The comparable figures in the District of Columbia and Virginia were 63% and 50%, respectively. *Id.*

86. Eighty percent performed 10 or fewer. *Id.* § III(2), table 10. Utilization is comparably low in Virginia as well, where 78% of the committees performed 10 or fewer consultations in 1989. *Id.* Committees in the District, however, are doing more case consultation than committees in either Maryland or Virginia. Thirty-eight percent of the District committees performed 11-15 consultations in 1989 and 25% performed 16 or more. *Id.*

87. *Id.*

88. *See* MD. HEALTH-GEN. CODE ANN. § 19-373(a) (1990 & Supp. 1990).

suggests that legislation that does not require use of the committees for certain determinations may result in the establishment of committees that are not used. It appears that additional efforts, such as educating patients, family members, and health care providers, are necessary to increase committee use. The Study revealed that Maryland hospitals in fact made greater efforts to notify patients and family members generally about the committees and their rights to use them than hospitals in the District of Columbia or Virginia. Eighty-nine percent of Maryland hospitals had instituted a formal mechanism for notifying patients and families about the committees, while fewer than fifty percent of hospitals in the District of Columbia and Virginia had established such a mechanism.[89] In spite of these formal mechanisms, which include notices in the patient handbook and in admission materials, it is not clear how many patients or family members actually know of the committees.

Infrequent use of these committees also may be accounted for by the fact that many health care providers are unaware of the existence of these committees. The Study found that thirty-nine percent of respondents did not know whether their hospital had an ethics committee.[90] The Study further found that hospitals in the District of Columbia and Virginia had made better efforts to notify health care providers about the existence of the committees than hospitals in Maryland.[91] Only sixty-six percent of hospitals in Maryland had some formal mechanism to inform health care providers about the committee, while ninety-two percent of hospitals in the District and seventy-four percent of hospitals in Virginia had such a mechanism.[92]

In sum, technical compliance with the Maryland statute is fairly high, in spite of the fact that the statute includes no penalty provisions. Thus, it is possible that the rate of compliance could be increased with sanctions for noncompliance. However, it is not at all clear that even if sanctions for noncompliance were imposed that

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89. Study, *supra* note 19, § III(1).

90. This finding was based on Phase IV of the study, which consisted of a survey of the staff of five Maryland hospitals to gauge their knowledge of the existence of an ethics committee within their hospital and to determine their perceptions of the committee. The hospitals selected were among the hospitals in Maryland where committees had been in existence at least two years and had conducted more than five case consultations within the last year. A written questionnaire was sent to a random sample of physicians, residents, nurses, and social workers at these five hospitals. The total sample size was approximately 2000. The response rate was 29%. *Id.* § II.

91. *See id.* § III(1).

92. *Id.* Such mechanisms included staff meetings, statements in personnel policies and procedures, and continuing education conferences. *Id.* § III(1), table 6.

such legislation could achieve "well functioning" committees. Successful committees require members who are committed to the task and have the requisite expertise or other qualities necessary to deal with difficult ethical dilemmas.

B. Analysis of Policy Arguments for Legislating the Establishment of Ethics Committees

Because it appears that legislation is likely to be effective at increasing the number of hospitals with ethics committees, we must ask whether such legislation makes sense as a policy matter. In addressing the question, this subpart first asks whether such legislation is justified and, second, whether there is a need for such legislation.

1. Justification for Legislation.—This Article does not dispute the potential benefits ethics committees may offer health care institutions and patients.[93] At issue here is whether and to what extent legislation mandating the establishment of these committees would be beneficial. The question speaks to the goal of such legislation. Two plausible goals include providing access to those who desire the services of an ethics committee and controlling the quality of such committees.

(a) Access.—A likely goal of legislation mandating the establishment of ethics committees is to provide access for all patients and health care providers to a multidisciplinary group that can provide them with sound advice on ethical dilemmas involved in the treatment of patients.[94] Whether requiring all health care institutions to

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93. This Article does not address the issue of whether ethics committees are functioning well or effectively, but assumes that these committees have the potential to work well and provide some benefit to their users. Whether or not these committees are beneficial is an empirical question demanding a great deal more research. The Maryland Study results indicated that there are some problems with a number of ethics committees that must be addressed. *See* Study, *supra* note 19, § IV. Some of the early writings on ethics committees listed the following among their purported benefits:

- Ethics committees will "satisfy the need for a more systematic and principled approach to the contemporary dilemmas of medical/ethical decision making within our hospitals and long term care facilities."
- Ethics committees "can serve as a link between societal values and the actual developments occurring in the institutions that care for and treat the particular patients whose cases manifest these dilemmas."
- Ethics committees will help us distinguish between those ethical dilemmas where a consensus seems to exist and those where no consensus seems achievable.

Cranford & Doudera, INSTITUTIONAL ETHICS COMMITTEES, *supra* note 1, at 9-11.

94. *See* Hollinger, *supra* note 10.

establish an ethics committee is the best way to meet this goal is open to debate. If we simply look at access, legislation requiring all hospitals to have an ethics committee will achieve that goal. But if the goal is to provide access to high quality committees in a cost-effective manner, then requiring each hospital to establish a committee will not achieve that result.

One problem with an approach that requires all health care institutions to establish an ethics committee is that the approach assumes that all such institutions have the resources and "expertise" necessary to operate a committee in a way that will provide petitioners with a useful and high quality service. The "quality" of ethics committees is likely to vary considerably. Large teaching hospitals in urban centers, for example, are much more likely to have the resources and access to individuals with expertise in medical ethics that are necessary to operate a successful committee, whereas small hospitals and nursing homes in rural areas may have difficulty finding these ingredients.[95]

Requiring each health care facility to have an ethics committee is arguably a waste of resources. The goal of access could be more efficiently achieved by having community committees or joint committees that would serve more than one hospital.[96] With fewer committees, more resources could be spent on educating members and improving the quality of the committee's services.

At least one argument against joint committees, however, is that health care institutions are unique and committees need to be attuned to the unique characteristics of each institution and to its staff.[97] This uniqueness may be important for the committee's role

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95. In his testimony on the Patient Self-Determination Act before the Subcommittee on Medicare and Long Term Care, the American Hospital Association's representative acknowledged the potential usefulness of ethics committees but stated that the AHA does not endorse their use in all hospitals and specifically stated that "an ethics committee may not be the appropriate forum for all hospitals, particularly small and rural hospitals." *Hearings*, *supra* note 42, at 122-23; *see also* Niemira, *Grassroots Grappling: Ethics Committees at Rural Hospitals*, 109 ANNALS INTERNAL MED. 981 (1988); Niemira, Orr & Culver, *Ethics Committees in Small Hospitals* 5 J. RURAL HEALTH 19 (1989).

96. This approach was authorized in recent amendments to Maryland's Patient Care Advisory Committee Act. *See* Act of May 29, 1990, ch. 545, 1990 MD. LAWS 545 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 19-370 to -374 (1990 & Supp. 1990)). The Act now permits ethics committees at nursing homes to function solely at that institution or to function jointly with an ethics committee representing up to 30 nursing homes. *See* MD. HEALTH-GEN. CODE ANN. § 19-371 (1990 & Supp. 1990).

97. However, the fact that physicians typically have privileges at a number of institutions suggests that they are familiar with the "uniqueness" of several hospitals and adds to the plausibility of establishing ethics committees that would serve more than one health care institution.

of policy development, but seems less important with respect to the committee's case consultation and educational roles. Nevertheless, a joint committee could develop model policies subject to modification by the medical staff of each facility. Such model policies would avoid much duplication of effort on the part of health care institutions. The role of educating hospital staff, patients, and their family members may be better filled by a single ethics committee serving several facilities than by several ethics committees each serving a single institution. Members themselves are likely to be better educated on a committee that serves multiple institutions because more resources are likely to be available for the education of committee members. Similarly, such a joint committee could spend more resources on workshops for hospital staff and would be more likely to educate potential patients and their families through community education programs. Case consultation may also be improved by joint committees, not only because committee members are likely to be better educated, but also because the committee will be less susceptible to the criticism that it is representing the interests of the institution rather than those of the patient.

Thus, the goal of access for all patients and health care providers to well-functioning ethics committees will not necessarily be met by legislation that mandates the establishment of these committees in individual hospitals. Legislation that would establish joint or community ethics committees seems to have some justification, at least if the goal of such legislation is providing access to well-functioning committees. Whether such legislation is necessary, however, will be addressed below.

(b) Quality Control.—Perhaps the strongest justification for legislation addressing ethics committees is not to mandate the establishment of committees but rather to provide "quality control" for such committees and to protect patients from them. Ethics committees, although they may serve a useful purpose, also can pose a danger.

The theoretical underpinning for the use of ethics committees relates generally to the advantages of committees as opposed to individual decisionmakers for the fundamental life and death decisions that ethics committees are called to consult upon. Committee members and observers argue that committees "have an advantage in grappling with an ethical challenge because the different individuals represented have more cumulative moral experiences and ethical

resources than just one person."[98] Moreover, committees "can correct for individual idiosyncrasies and biases."[99] Yet there are some disadvantages of committees as decisionmakers generally and of ethics committees specifically. The general problems of committees as decisionmakers, such as "group think," have been reported and analyzed with respect to ethics committees.[100]

In addition to the interpersonal decisionmaking problems characterized as "group think," there are institutional problems with committees that have authority to give advice or make decisions with serious consequences for individuals. The most troublesome of these problems is that committees allow for diffusion of responsibility among many decisionmakers so that no single decisionmaker is responsible for the committee's actions.[101] This is especially problematic when the committee is neither accountable to a single individual or group, nor responsible for its advice.[102] Such committees might be labeled "aresponsible."[103] Decisions by these aresponsible committees are perhaps most suspect when the committees provide no rationale for their positions. When this is true, observers may feel that committee decisions or recommendations are arbitrary or biased in some way.[104]

In spite of these misgivings, we often resort to committees, such as juries, to make difficult societal decisions because we, as a society, cannot agree on a clear-cut rule to apply to certain cases. Because we are "unwilling to endure clear statements" of relative values that could be obtained by resort to more "hierarchic, responsible and political decisionmaking,"[105] we resort to committees that are broadly representative of the values within our society to resolve our most difficult dilemmas based on the facts of a specific case.

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98. Callahan, *Ethics by Committee?*, HEALTH PROGRESS, Oct. 1988, at 76.

99. *Id.*

100. *Id.* at 77. One author defines "Groupthink" as "a term for the flaws in the groups that are too homogeneous, too cohesive, and too isolated from dissenting and diverse opinions of outsiders." *Id.*; *see also* Povar, *Evaluating Ethics Committees: What Do We Mean by Success?*, 50 MD. L. REV. 904, 917 (1991).

101. *See* G. CALABRESI & P. BOBBITT, TRAGIC CHOICES 57 (1978).

102. *See id.*

103. *Id.* The term "aresponsible agency" was used by Calabresi and Bobbitt to describe agencies characterized by representation, decentralization, and decisionmaking without public rationale. *See id.* An example of a "pure aresponsible agency" is the jury.

104. *Id.* at 59-60. In particular, we become suspicious of decisions without reasons where there is either a troublesome pattern of outcomes, for example, black defendants seem to receive harsher penalties in criminal trials, or there is *no* discernable pattern of outcomes. This latter observation leads to criticisms that similar standards are not being applied or that decisions are being made arbitrarily. *See id.*

105. *Id.* at 67.

This is, it appears, one of the redeeming qualities of juries— they are, at least in theory, representative of the community's mores and values.[106] We seem to tolerate the often inconsistent treatment of cases by juries because we cling to the notion that if a group is truly representative and includes all relevant perspectives, then its decision must represent what the broader community thinks is just:

> [I]f a series of juries is viewed as representative, then the pattern of decisions which emerges from that series can also be taken to reflect the values of the community. Similarly, the lack of a pattern may be viewed as reflecting values so sensitive to the nuances of slightly varying facts, or in such flux, as to disrupt any discernible pattern. These are values which true juries of one's peers discern at any given moment in the life of the community.[107]

Ethics committees share many of the characteristics of juries but differ in some significant aspects. In fact, they seem to have many of the problems of the aresponsible committee, but few of its redeeming qualities. For example, ethics committees often are not accountable to a single individual or group within a hospital. Although in many cases the committee reports to the medical staff or to the hospital governing board, often they report to both or to a combination of other groups.[108] Neither are they clearly accountable to patients whom they are theoretically obligated to serve. Moreover, few ethics committees justify their advice, either in writing or orally, to patients and family members.[109] In these two respects ethics committees are similar to juries. Ethics committees differ from juries in that they are generally not representative of a cross section of community values. Like other "modified aresponsible" committees, ethics committees "tend to have a sizable

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106. *See id.* at 57.

107. *Id.* at 63.

108. The Maryland Study found that over 20% of committees reported to no single entity. *See* Study, *supra* note 19, at § III(2). Rather they reported to a combination of bodies such as the governing board and medical staff or the chief executive officer and the governing board. Even in the cases where the committee reported to a single entity it was often another committee, such as the medical executive committee, or "committee-like" body such as the governing board. In 5% of the cases, the committees stated that they reported to no one. At one hospital there was an internal conflict over whether the ethics committee should report to the administration or the medical staff. *Id.*

109. Although there is no hard data on this, in my experience, many committees do not appear to contact patients and family members at all. To the extent that committees provide some indication of their recommendation in a patient's chart, the statement is generally very brief and conclusory without a rationale for the position taken. *See id.* at § IV.

number of technical experts among their memberships."[110] For the most part, the committees are made up of health care providers, primarily doctors and nurses with some social workers and clergy.[111] A minority of committees include lay persons or community representatives, but such individuals generally make up a very small percentage of the total committee membership.[112]

A contributing factor to the underrepresentation of certain groups on ethics committees is the relatively constant membership of the committees. The theoretical advantages of such constancy are consistency in methods and outcomes in factually similar situations. But such constancy also exacerbates the perception that the committee may be biased. Committees with consistency in their membership may be criticized both for a pattern of decisionmaking and for the lack of a pattern:

> Continuity of aresponsible decision making affords greater opportunities for caprice and corruption. Whether or not these sins are actually committed, the suspicion that they have been committed is virtually inevitable. . . . [T]hough a discernible pattern in the decisions of a continuous aresponsible agency may prompt criticism, the absence of such a pattern is worse. The pattern can be taken as a sign of bias (because the composition of the agency is not representative of the community as a whole) or even as a sign that the agency is on retainer to the advantaged group. But the lack of a pattern is taken as clear evidence

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110. G. CALABRESI & P. BOBBITT, *supra* note 101, at 65. According to Calabresi and Bobbit, this tendency to include experts is not based on the fact that the decisions the committees are required to make are necessarily of a technical nature, but rather that invoking the need for experts "permits the inference to be drawn that the resulting aresponsible decision is based on minute and therefore nonpatterned concatenations of technical data. This inference serves much the same purpose as its true jury analogue, which justifies unpatterned decisions as reflecting fragmented, or at least extremely complex, combinations of values." *Id.* at 65-66.

111. PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 164.

112. Calabresi and Bobbitt point out that:

> Since the presence of experts further limits the availability of peer-representative members, the remaining representation on these agencies will typically be the result of a conscious attempt to include representatives of relevant groups or views, and not of the random selection typified by the jury. The minister, the social worker, the various relevant minorities, are all put on the committee intentionally. Thus, with fewer members and without the full benefit of the crucial representativeness achieved through use of a series of juries, it is nonetheless hoped to create an aresponsible agency which will seem to be representative.

G. CALABRESI & P. BOBBITT, *supra* note 101, at 66.

> that each case is decided merely on the basis of favoritism.[113]

In addition to the generic problems of lack of accountability, absence of a rationale for their recommendations, and lack of broad-based representation characteristic of many aresponsible committees, ethics committees have their own unique problems. Chief among these is their unclear purpose. Although the stated purpose of ethics committees since their inception has been to protect the patient, concerns have arisen that the committees may have conflicting goals of protecting the patient, protecting the health care providers, and protecting the health care institution.[114] Such a lack of priorities or focus makes patients particularly vulnerable. This shortcoming, as well as those listed above, should make us wary of the unsupervised role of ethics committees.

Given the proliferation of ethics committees and the responsibilities they are being given,[115] legislation that at a minimum would include certain procedural protections for patients and their surrogates appears justified. Nevertheless, arguments against legislation establishing or regulating ethics committees have been more persuasive than those favoring such legislation.[116] Critics focus on the

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113. *Id.* at 64.

114. *See* Cohen, *The Social Transformation of Some American Ethics Committees*, HASTINGS CENTER REP., Sept.-Oct. 1989, at 21. Cohen presents evidence that ethics committees are

> experiencing new pressures to safeguard the institution's financial interests. Some [committees] report they have been asked to help meet institutional marketing goals to the detriment of patient care. Others assert that they have been encouraged to gloss over especially difficult cases to avoid expensive legal maneuvers that could work to the institution's disadvantage. The structure of some committees has been designed to protect institutional interests: a few are chaired by legal counsel for the institution, others are composed almost entirely of members of the board who 'have an interest in ethics.'

Id.

115. Some argue that because ethics committees are only advisory in nature they can do no harm, but numerous individuals have asserted that such a view is mistaken. *See, e.g.*, Ritchie, *When It's Not Really Optional*, HASTINGS CENTER REP., Aug.-Sept. 1988, at 25; Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 800, 833-36 (1991). In fact, the advice of an ethics committee might be considered akin to the advice of a doctor or a lawyer. Those seeking their advice are reluctant to disagree with the committee's recommendations. The fact that such committees are generally dominated by physicians makes it particularly difficult for physicians to ignore the committee's advice, especially when the politics of the hospital medical system encourage agreement with one's colleagues. Furthermore, the Study found that a considerable number of health care providers, in fact, perceive the role of the ethics committee as that of decisionmaking rather than advisory. *See* Study, *supra* note 19, § III(4), table 18.

116. Samuel Sherman, M.D., and chairman of the Judicial Council of the AMA urged

fact that because the committees are relatively new, there has not yet been time to experiment and to determine what are the most effective structures and procedures for their operation.[117] This argument is losing ground, however, given that ethics committees have now been in existence, at least in some cases, for more than a dozen years and in a significant number of cases for more than five years.[118]

2. Need for Legislation.—The previous section suggests that there is some justification for legislation that would encourage the establishment of joint ethics committees and regulate the establishment and operation of ethics committees. Prior to advocating such legislation, however, we must ask whether as a policy matter it is needed. Whether or not there is a "need" for such legislation depends on whether or not there are alternative, less intrusive approaches than legislation that might achieve the same results.

In determining whether a need exists for legislation that would encourage the establishment of joint ethics committees, the reasons why individual hospitals have established their own ethics committees prove particularly instructive. For the most part these hospitals have formed ethics committees without any legislative push.[119] In most cases it is likely that hospitals decided either explicitly or implicitly that the costs of the committees (namely, a few disgruntled physicians, the time of a few health care providers, and a few dollars) were outweighed by the potential benefits (increased morale on the part of some doctors, nurses, and other health care providers and a potential reduction in legal liability arising out of disputes between families and health care providers over the treatment of patients). The unregulated environment has, in fact, done a fairly

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that ethics committees be allowed to "evolve slowly according to the needs expressed at the local level" and that questions as to their role "be resolved locally through the establishment of local guidelines and following local needs" rather than through state or federal guidelines or regulations. *See* Cranford & Doudera, *supra* note 1, at 8; *see also* Cranford & Roberts, *Biomedical Ethics Committees*, 13 BIOMEDICAL ETHICS 327, 337 (1986), stating that government regulation is a "danger. As they become more prevalent, the committees risk being coerced away from their role as advisor and supported toward those of whistle blower and even arbitrator in life-and-death treatment decisions." *Id.*

117. *See, e.g.*, Cranford, Hester & Ashley, *Institutional Ethics Committees: Issues of Confidentiality and Immunity*, 13 LAW, MED. & HEALTH CARE 52, 59 (1985).

118. Cynthia Cohen summarizes a series of articles on ethics committees by stating that they imply that "ethics committees are now sufficiently mature that they can cogently explain in some detail the substantive and procedural framework within which they carry out case reviews." Cohen, *Who Will Guard the Guardians?*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 19; *see also* Wolf, *supra* note 115, at 807-08.

119. *See generally* Study, *supra* note 19, § III(1).

good job of motivating hospitals to establish such committees, given the large percentage of hospitals in the country that currently have them. In some jurisdictions, such as the District of Columbia, the external factors encouraging establishment of the committees seem to have been much more persuasive than they have been in other jurisdictions, such as Virginia.[120] It appears that the benefits of the committees to the District of Columbia's hospitals have become more widely recognized than they have in Virginia or that the costs of establishment of the committees in Virginia, in terms of physician opposition, have been greater than in the District.

These same costs and benefits, however, are unlikely to apply to the establishment of a joint ethics committee because no single hospital has the motivation to take on such a project. The individual health care institution is likely to ask "Why should we take on the additional costs of such a multiservice committee, unless we receive some benefit or some compensation for our efforts?" Health care institutions are unlikely to come together to plan joint committees because of the transaction costs of such an effort and because of the insular view of most institutions.[121] In this situation, where substantial transaction costs obstruct the undertaking of the activity, legislation can be instrumental in motivating hospitals to act. Yet what form should such legislation take? Should the legislature require the state or federal government to take the lead in establishing the committees, deciding how many are necessary and who should participate in them, or should the legislature simply provide incentives for their establishment?

Strong policy arguments support legislation that would simply provide incentives for the establishment of joint ethics committees as opposed to authorizing a government agency to set up such committees. Such incentives might include disseminating information about the benefits of joint ethics committees, issuing grants to groups of hospitals or other health care institutions that are interested in establishing a joint ethics committee, or providing immunity from legal liability for members of joint committees. The arguments for providing incentives as opposed to mandating the activity go in large part to the relative expertise and knowledge of the government and the regulated industry. Health care institutions are more likely to know who in their community would be best qualified

120. *See id.* (78% of District of Columbia hospitals have ethics committees, whereas only 25% of Virginia hospitals have them).

121. Yet, such joint committees are not unheard of. The Study uncovered two such committees in Virginia. Each committee served two hospitals. *Id.* at § II(1).

to serve on such committees and which institutions can best work together. Furthermore, individual health care institutions are in a better position to decide if participation in a community or joint committee is "worth it" for them or whether they would be better off with their own ethics committee.

There also appears to be a need for legislation that would regulate the establishment and operation of ethics committees. At this time, few pressures exist for health care institutions to incorporate procedural safeguards into the operations of their ethics committees. The benefit of such safeguards has not yet become evident to many health care institutions. Indeed, the benefits may not become clear until more patients know about the committees and begin to use them or until court cases reviewing committee decisions begin to mention the lack of due-process safeguards in committee procedures. If as a policy goal we wish to establish uniform procedural safeguards for patients and family members, legislation mandating such safeguards is more likely to achieve this result than legislation providing incentives for health care institutions to operate with due process.[122]

III. LEGISLATING AN EXPANDED ROLE FOR ETHICS COMMITTEES—PROS AND CONS

This Part examines the judiciousness of a proposal to expand the role of ethics committees by giving them authority to make decisions where judicial decisionmaking previously has been required. The proposed expansion would obviate the need for judicial approval but would permit dissatisfied patients or family members to appeal the committee's decision to a court.

The types of decisions that the committees might be asked to make include: (1) whether to withhold or withdraw life-sustaining treatment when a patient is unable to communicate and is terminally ill or in a persistent vegetative state; (2) whether to sterilize a mentally retarded adult; (3) whether to treat a seriously handicapped newborn; and (4) how to resolve maternal-fetal conflicts. The appropriateness of the committees' substituting for judicial decisionmaking may differ depending on which decision we are asking the committee to make. The analysis in this Part will focus exclusively

122. Legislation would prove more effective than incentives, unless, of course, the state could provide significant sums of money to hospitals for compliance. Given the current financial situation of most states, it seems unrealistic to hope for such monetary awards.

on the question of allowing committees to make decisions regarding withholding or withdrawal of life-sustaining treatment from adult patients who are unable to speak for themselves.

Most commentators argue that authorizing ethics committees to make decisions rather than authorizing them to give advice would be inappropriate.[123] Those taking this position argue that giving the committees decisionmaking power would change their nature significantly.[124] They posit that committees given such authority would become much more concerned with the legality of their recommendations than with ethical issues and would need to be concerned to a much greater extent with legal due process.[125] However, whether or not an ethics committee is the appropriate body to decide ethical controversies that arise in the care of patients depends on the relative merits of the committee as a decisionmaker when compared to the likely alternatives: family members and courts. Such a comparison requires consideration of the relative quality and costs of the decisions by these alternative entities. This Article has previously reviewed the potential problems of using ethics committees but the question in deciding whether to give them more authority is whether these problems are any more or less intractable than those associated with the use of the other options.

In deciding whether a family, a court, or an ethics committee is the most appropriate body to take on the role of decisionmaker in these cases, the function and essential characteristics of the decisionmaking body must first be clearly defined. The decision to discontinue or withhold life sustaining treatment from an adult who is unable to communicate initially requires some medical expertise. Such expertise is necessary to understand the medical facts presented and to determine whether the medical facts at issue indicate that the individual is mentally incapacitated, terminally ill, or in a persistent vegetative state. Some observers have argued that such decisions are purely medical and therefore outside the realm of ethical or legal determination. In reality, however, the decisionmaker cannot easily divorce the medical prognosis from the ethical and legal analysis. For example, not all cases will come to the decisionmaker with a clear medical prognosis that the patient is "termi-

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123. *See, e.g.*, Paris & Reardon, *supra* note 53, at 120.

124. *Id.* at 119-20.

125. Paris and Reardon argue that a danger of allowing ethics committees to substitute for courts is that they will "evolve into administrative tribunals or legal forums in which the law and due process, not ethics and the interests of the patient, are the paramount concerns." *Id.* at 120.

nally ill" or in a "persistent vegetative state." The link between the medical prognosis and the legal analysis arises from the existence of these categories that are necessary for the application of the law, not the care of the patient. Furthermore, the definition of some of the categories may differ depending on the context and the decisionmaker. For example, the definition of terminal illness for purposes of Medicare reimbursement for hospice care is an illness for which one can expect a patient to live not more than six months.[126] Most would agree that this is different from the definition in many living will statutes defining terminal illness as one from which death is imminent. Because the meaning of these terms is to some extent defined by the law, the decisionmaker may need to discuss with the health care providers whether the patient's condition fits into one of the "key" prognoses.

A second function of the decisionmaker in these cases is to gather facts, evaluate the quality of the facts, and to draw inferences from them. In a withdrawal-of-life-sustaining-treatment case, the decisionmaker will need to determine whether there is any evidence indicating the wishes of the patient, evaluate the quality of that evidence, and extrapolate from it to determine if it covers the present circumstances. In legal jargon, these activities would comprise the application of a substituted-judgment test.[127] From an ethics perspective, such an approach is justified by the ethical principle of autonomy.[128]

A decisionmaker charged with carrying out this function ideally would be one who knows the patient and shares the patient's values but who has no conflicts of interest that would prevent an unbiased reporting of the facts. Such a decisionmaker would be in the best position to determine whether there is evidence of what the patient would have wanted, and to evaluate the credibility of that evidence. A decisionmaker who has values close to the patient or who has a sense of the values of the patient may be in the best position to extrapolate from the evidence to the current situation of the patient. For example, the patient at one time may have said, "I never wish to be kept alive like my mother was." The patient's mother lived in a

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126. *See* 42 U.S.C. § 1395x(dd)(3)(A) (1988); 42 C.F.R. § 418.3 (1989).

127. A number of courts have applied a substituted judgment test when there is evidence as to what the patient would have wanted under the circumstances presented. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Spring, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980); *In re* Jobes, 108 N.J. 394, 450-53, 529 A.2d 434, 463-64 (1987) (Pollack, J., concurring).

128. *See* T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 67 (1989).

nursing home for five years after experiencing a stroke. She was paralyzed below the neck, bedridden, and had to be spoon fed. The patient is currently also in a nursing home but is in a persistent vegetative state, being kept alive by artificially administered nutrition and hydration. Should the feeding tubes be withdrawn? The answer to the question depends on the decisionmaker's own interpretation of the facts. That interpretation will necessarily be colored by the decisionmaker's own values and point of view on this issue. To the extent that the decisionmaker's values are closely aligned with those of the patient, it is more likely that the final decision will reflect the patient's wishes.

If there is little or no evidence as to what the patient would have wanted, the decisionmaker will most likely attempt to choose the course of treatment that, from an ethical perspective, will do the most good for the patient[129] or, from a legal perspective, is in the "best interests" of the patient. In making such a determination, a decisionmaker ideally would take into account whatever information exists regarding the patient's preferences along with an assessment of what the reasonable person in such circumstances would want.[130] If no information exists as to what the patient would have wanted, the decisionmaker would rely on his or her assessment of what the reasonable person in similar circumstances would want.[131] This requires applying values about quality of life to various scenarios—including life with pain and life in a debilitating condition.[132] It may

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129. This approach is based on the ethical principle of beneficence, meaning to do good. *See id.* at 194.

130. Although this approach has not been embraced in court opinions, an effort in this direction was made in *In re* Conroy, 98 N.J. 321, 364-65, 486 A.2d 1209, 1231-32 (1985), in which the court adopted a limited objective standard. The test was satisfied upon a showing of trustworthy evidence that the patient would have refused treatment and the burdens of continued treatment objectively outweigh its benefits.

131. This has been termed a "pure objective test." *See id.* at 366-67, 486 A.2d at 1232. Cases that have applied the best interest test have included cases where the patient was never competent to refuse treatment as well as cases where there was no or little evidence of what type of treatment the patient would have wanted. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *In re* Beth Israel Medical Center, 136 Misc. 2d 931, 519 N.Y.S.2d 511 (Sup. Ct. 1987); *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

132. In applying a best interests test courts generally have engaged in a utilitarian calculus—balancing the burdens and benefits of the proposed course of action. In determining these burdens and benefits, courts have considered (1) the age of the patient; (2) the patient's life expectancy with and without treatment; (3) the anticipated degree of pain with and without treatment; (4) the extent of the patient's disability and helplessness; (5) statements made by the patient that imply or specify views about the treatment at issue; (6) the foreseeable quality of the patient's life with or without the treatment; (7)

also require an understanding of religious and other competing values that may enter into such a decision. The decisionmaker who would apply a best-interests test must possess the ability to assess what society views as reasonable in the given situation.[133]

A. The Family Versus the Ethics Committee as Decisionmaker

Numerous arguments support the notion that family members should make life and death decisions for their relatives who are terminally ill or in a persistent vegetative state.[134] After all, in most cases, family members are in the best position to know what the patient would have wanted in these tragic circumstances. A recent

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the potential risks, undesirable side effects, and degree of invasiveness of the treatment; (8) the religious or ethical beliefs of the patient; (9) the views of those close to the patient, and of the attending physician; (10) the kind of care the patient will require if life is prolonged, and its likely availability. *See Beth Israel*, 136 Misc. 2d at 940, 519 N.Y.S.2d at 517.

133. Criteria for the decisionmaking body will differ, depending on the decision to be made. For example, under our current legal framework, the qualities necessary for a decisionmaker to decide whether to withhold or withdraw life support from a severely handicapped newborn are very different from those required of the entity who will decide on life support for an adult. The legal framework in most states requires the application of "reasonable medical judgment" to determine if the infant is "chronically and irreversibly comatose" and whether the provision of treatment would be "futile" or "inhumane." These criteria are based on regulations promulgated under the federal Child Abuse and Neglect Prevention and Treatment Program, 45 C.F.R. § 1340 (1990). The regulations require that as a condition of receiving state grants under the Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101-5107 (1988), states must establish programs and/or procedures within their child protective service systems to respond to reports of medical neglect, including reports of the withholding of medically indicated treatment for disabled infants with life-threatening conditions. *See* 45 C.F.R. 1340.14. "Withholding of medically indicated treatment" is defined as the failure to respond to an infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions. *See id.* at 1340.15(2). Exceptions to the requirement to provide treatment (but not the requirement to provide appropriate nutrition, hydration, and medication) may be made only in cases in which:

> (1) The infant is chronically and irreversibly comatose;
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> (2) The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or
>
> (3) The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

Id.

134. *See, e.g.*, Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988). Rhoden criticizes the substituted-judgment and best-interest tests adopted by courts in right-to-die cases, and argues instead for a legal presumption in favor of family decisionmaking. *See id.* at 437-45. *But see* Puri & Weber, *Limiting the Role of the Family in Discontinuation of Life Sustaining Treatment*, 11 J. MED. HUM. 91 (1990).

public opinion poll as well as state statutes and court decisions, reflect this view.[135] For example, in *In re Jobes*,[136] the New Jersey Supreme Court stated:

> Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds to him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests, . . . and they who treat the patient as a person, rather than a symbol of a cause.[137]

Furthermore, twelve states[138] and the District of Columbia[139] have passed legislation authorizing family members to consent to the termination or withholding of life-sustaining treatment for specified

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135. The poll, conducted by the Times Mirror Center for the People and the Press on right-to-die issues, found that a substantial number of individuals have talked with their family members about what type of medical treatment they would want if terminally ill or severely debilitated. TIMES MIRROR, CENTER FOR THE PEOPLE AND THE PRESS, REFLECTIONS OF THE TIMES: THE RIGHT TO DIE 12 (1990) [hereinafter TIMES MIRROR]. Forty-three percent of adults have spoken to their mothers about their mothers' wishes for medical treatment. (Women were more likely to have spoken to their mothers about this issue than men. Also, individuals with mothers 70 years old or older are more likely to have spoken to their mothers about this issue. *Id.* at 12.) Fewer adults, only 28%, however, have had such discussions with their fathers. *Id.* Half of the married people surveyed (51%) have talked to their mates about their wishes for medical treatment. *Id.* Differences do exist, however, among groups with respect to education, race, and income, as to the likelihood of discussing this issue with a spouse. People who have not attended college discuss their spouses' wishes less than those who have attended college, and blacks "are much less likely than whites to have had any family discussions about medical treatment wishes, whether with a spouse, mother or father." *Id.* at 13. Finally, affluent individuals "those with $50,000 or more in annual household income, have these conversations more often than those who are less well off." *Id.* at 12.

The Times Mirror Poll further found that 70% of Americans think that family members should be allowed to make decisions about medical treatment for their ill relatives. *See id.* at 3. According to the study, "[o]nly about one in six adults overall, and a slightly greater proportion of blacks, thinks such proxy decision making should not be allowed." *Id.*

136. 108 N.J. 394, 529 A.2d 434 (1987).

137. *Id.* at 416, 529 A.2d at 445.

138. *See* ARK. STAT. ANN. § 20-17-214 (1987); CONN. GEN. STAT. § 19a-571 (1986); FLA. STAT. § 765.07 (1986); IOWA CODE § 144A.7 (1989); LA. REV. STAT. ANN. § 40:1299.58.5 (West 1977 and Supp. 1990); ME. REV. STAT. ANN. tit. 18-A, § 5-707 (1981); N.M. STAT. ANN. § 24-7-8.1 (1986); N.C. GEN. STAT. § 90-322 (1985); OR. REV. STAT. § 97.03 (1990); TEX. REV. CIV. STAT. ANN. art. 4590h-4(C) (Vernon 1976 & Supp. 1990); UTAH CODE ANN. § 75-2-1105(2) (1978 & Supp. 1990); VA. CODE ANN. § 54:1-2986 (1988).

139. *See* D.C. CODE ANN. § 21-2210 (1989).

patients.[140] Similarly, courts in several jurisdictions have permitted family members to consent to the withholding or withdrawal of life support for a relative who is terminally ill or in a persistent vegetative state.[141]

Notwithstanding such precedent, there are reasons to be cautious about delegating authority to family members to make decisions involving withholding or withdrawal of life support. Most often raised is the possibility that family members may have conflicting interests or be taking their own interests too heavily into account when deciding how to deal with a sick relative. Such interests include the financial and emotional burden of caring for someone who cannot care for him or herself over a long period of time and the potential financial gain from inheritance that may come to family members when the patient dies. More likely, family members make decisions out of their own "guilt" or emotional needs rather than based on what is in the best interests of the patient. Moreover, in some cases, "[f]amily members who are not closely involved with the life of the patient may be called upon to participate in important decisions."[142]

A separate concern about family decisionmaking is that family members may not understand the technical medical facts or physiological concepts presented. Family members may hold out too much hope or too little hope for recovery of the patient based on misunderstanding of the facts presented to them.

In spite of these "dangers," family members in most cases will try to do what they think their relative would have wanted or what they think is in the patient's best interest. Thus, requiring all fami-

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140. Of these 13 jurisdictions, 10 require that the patient be "terminally ill" or in a "terminal condition" as well as incapable of deciding treatment issues for him or herself. The three jurisdictions that do not invoke that requirement are the District of Columbia, Florida, and Oregon. *See* D.C. CODE ANN. § 21-2210 (1989); FLA. STAT. § 765.07 (1986); OR. REV. STAT. § 97.03 (1990).

141. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (role of the court is simply to resolve disputes among physicians, family members, and others); *In re* Conservatorship of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988) (familial consent recognized as a factor); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (consent of husband considered); *In re* Guardianship of Grant, 109 Wash.2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988). The case law on this issue contrasts with the statutes. The majority of cases permitting families to refuse life-sustaining treatment for their relatives have involved patients in a persistent vegetative state whereas the majority of the statutes would not allow family decisionmaking for patients in a persistent vegetative state.

142. Puri & Weber, *supra* note 134, at 92.

lies to obtain ethics committee approval prior to the termination of life support for their ill relatives might be unduly burdensome.

There are emotional costs for family members who subject themselves to any type of decisionmaking body, whether it be an ethics committee or a court.[143] The President's Commission expressed a serious concern about the requirement of using an ethics committee for decisions that have largely been dealt with by family members. According to the Commission's report:

> Ironically, the very fact that ethics committees will probably be less formal and burdensome than judicial review in any particular case may cause their total impact on the health care system to be excessively burdensome. This could occur if the apparent accessibility of ethics committees was to lead to routine review of an ever larger number and wider range of medical decisions than would previously have had judicial review. If the existing process of decisionmaking, which is largely private and unreviewed, has been appropriate and has resulted in decisions that are in the aggregate as "good" as those arrived at by an ethics committee, then creating committees will complicate the total process, not improve it.[144]

Furthermore, it seems clear that the option of allowing the family to make the decision privately will be less costly to the family, as well as to the health care industry, than requiring approval by an ethics committee. The crucial question, however, is whether the incremental cost of ethics committee approval will be justified by the incremental benefit. The incremental benefit will be measured by the number of cases where the committee does not agree with the family's decision as to what the patient would have wanted or as to what is in the patient's best interest. Although it is likely that there will be few cases where the ethics committee will disagree with a family's determination, the sufficiency of the incremental benefit will depend on the value attached to those few cases where the ethics committee was able to "correct" the family's decision and the costs of requiring all families to appear before an ethics committee.

Without any empirical data, there is no reason to believe that ethics committee review would significantly improve family deci-

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143. For a particularly poignant account of the emotional costs of taking such decisions to court, see *Hearings*, *supra* note 42, at 61, 91.

144. PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 165.

sionmaking.[145] Thus, it seems that in jurisdictions where family members are permitted to make these decisions, the family should maintain that authority unless there is a dispute among family members or between family members and health care providers.[146] In those cases, the issue is whether the ethics committee or the court provides a better forum for resolving the dispute. The question is also relevant when a patient has no family. In that case the issue is not which would be the better forum for dispute resolution, but rather, which body would be the better decisionmaker.

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145. This seems to be especially true for the application of a substituted judgment or "limited-objective" best-interests test. There is more room for argument concerning the application of a pure objective test.

146. The conclusion that family members should have the authority to make life and death decisions for patients is limited to cases involving adults who are terminally ill or in a persistent vegetative state. The arguments as to why family members are best suited as decisionmakers for adult patients do not necessarily hold for cases involving newborns, maternal-fetal conflicts or the sterilization of the mentally retarded. The family is arguably best suited to make treatment decisions for formerly competent adults because the legal standard for such decisions is what the patient would have wanted or what is in the patient's best interest, and a family has a sense of what the patient would have wanted and a sense of the patient's values. The legal standard or framework for deciding whether or not to withdraw or withhold treatment from disabled infants with life-threatening conditions requires medical judgment. Under this framework, the family would not be the appropriate body to make such a decision. Even if we were to move away from the existing medical criteria for newborns to something closer to a best-interests standard, it is unclear whether the infant's parents are in the best position to make that decision. The Hastings Center Special Report on imperiled newborns states that under a best-interest test the decisionmaker should be one who is: (1) most likely to advance the interests of the infant; (2) intimately involved in caring for the child; (3) highly knowledgeable about the medical problems; (4) experienced in dealing with these problems; and (5) able to look at the facts comprehensively and impartially. The report concludes that "no one decision maker may be able to fulfill all these conditions." Hastings Center, *Special Report: Imperiled Newborns*, HASTINGS CENTER REP., Dec. 1987, at 17.

Nor may the family be the best decisionmaker in cases involving the sterilization of incompetent adults. In a number of cases, sterilization of mentally retarded adults has been sought for the convenience of the patient and his or her family. *See, e.g.*, Wentzel v. Montgomery Gen. Hosp., Inc., 293 Md. 685, 447 A.2d 1244, *cert. denied*, 459 U.S. 1147 (1983) (mere facts that an incompetent 13-year-old experienced pain during her menstrual cycle and that she could not care for a child if she gave birth, did not justify authorizing her guardian to consent to her sterilization); *In re* Terwilliger, 304 Pa. Super. 553, 450 A.2d 1376 (1982) (decision whether to sterilize an incompetent should be based only on the best interests of the incompetent person, not on the interests or convenience of the individual's parents or society). Because the recent judicial opinions in this area have rejected requests for sterilizations if less restrictive alternatives apply, some check on family decisionmaking is probably appropriate. *See, e.g., In re* Grady, 170 N.J. Super. 98, 405 A.2d 851 (1979) (granting parents' application for sterilization of a female Down's Syndrome child only after stringent court review). *See also* Robertson, *supra* note 7, at 92.

B. The Court Versus the Ethics Committee as Decisionmaker

Some observers argue that judicial bodies are better qualified to make these life and death determinations than ethics committees. The Supreme Judicial Court of Massachusetts articulated this view in its opinion in *Superintendent of Belchertown State School v. Saikewicz*:[147]

> [Q]uestions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility . . . and not to be entrusted to any other group purporting to represent the 'morality and conscience of our society,' no matter how highly motivated or impressively constituted.[148]

The *Saikewicz* court's skepticism towards ethics committees may in part have been due to the relative newness of ethics committees at the time the case was decided.[149] Ethics committees have proliferated since 1977 when *Saikewicz* was decided, and hospitals have gained considerable experience with them. Yet, even today, the President's Commission's arguments as to why a court may be the appropriate tribunal for resolving these disputes still have merit:

> Certain aspects of the judicial process do commend it for use [in these circumstances.] First, the judicial process is a public one. Judges' actions are subject to scrutiny by the public, the press, and legal scholars. Second, judicial decisionmaking is (ideally at least) principled—with like cases decided alike and pains taken to develop reasoned bases for decisions. Third, the judicial process seeks impartiality by applying rules of evidence and by using disinterested decisionmakers. Finally, the adversarial nature of the pro-

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147. 373 Mass. 728, 370 N.E.2d 417 (1977).

148. *Id.* at 759, 370 N.E.2d at 435.

149. In another relatively early opinion, a lower New York court in *In re* Eichner, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 958 (1981), argued that all cases involving termination of life support should go to the courts and stated that "the ethics committee, as an *institution*, is an ill-defined, amorphous body, which in some hospitals may not even exist . . . [h]ence, uniformity could never be guaranteed under the *Quinlan* model." *Id.* at 474-75, 426 N.Y.S.2d at 549 (emphasis in the original). Subsequently the Court of Appeals of New York, concerned that injecting the judicial process into all such cases would be unduly burdensome, modified the lower court's opinion stating that application to the courts for "prior assessment of conduct which may subject [petitioners] to civil and criminal liability" is not required by the common law or existing statutes. The court noted that any mandatory approval process should come from the legislature. *In re* Storar, 52 N.Y.2d at 383, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

> cess seeks to render a full and fair hearing by encouraging proponents of opposing positions to bring evidence and to present arguments before a neutral judge.[150]

On the other hand, some of these seemingly positive aspects of judicial decisionmaking make the judicial process inappropriate for life and death decisions involving patients, families, and health care providers. For example, the openness of the judicial process "exposes ordinarily quite private matters to the scrutiny of 'the public' and sometimes even to the glare of the . . . media."[151] Moreover, the judicial process

> has limited value in handling bioethical conflicts, such as withholding life-sustaining treatment . . . . First, legal services are expensive, and the judicial system's bureaucratic, adversarial approach is not designed to address humanely the emotional issues faced by patients and health care professionals struggling with life-threatening issues. Second, the legal system often is not responsive to the time pressures of ethical conflicts in medicine, court decisions are frequently announced months after the patient has either died or left the hospital. Finally, retrospective court judgments do not fulfill health professionals' need for hospital policies to help resolve ethical problems before they reach an impasse.[152]

Some courts recognize their ineptitude in this area and take a more benevolent view of ethics committees than the *Saikewicz* court. In *In re Torres*,[153] the Supreme Court of Minnesota stated that an affirmation by an ethics committee of a family's decision to withdraw life-prolonging treatment from a patient in a persistent vegetative state would eliminate the need for judicial approval.[154] Although *Torres* is the only case recognizing such a function of ethics committees, other cases have "expressed their willingness to consider such committees' findings, especially in determining the good faith and good medical practice of the parties involved."[155]

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150. PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 159.

151. *Id.*

152. Fleetwood, Arnold & Baron, *supra* note 2, at 138.

153. 357 N.W.2d 332 (Minn. 1984).

154. *See id.* at 341. *Torres* dealt with a patient who had no immediate family; a court order was deemed necessary to terminate support. However, the court remarked in a footnote to its holding that a court order would not be required where physicians, family, and hospital ethics committees were all in agreement. *See id.* at 341 n.4.

155. Rowan, *Hospital Ethics Committees: A Challenge*, 34 MED. TRIAL TECHNIQUE Q. 476, 489 (1988). *See, e.g.*, Severns v. Wilmington Medical Center, 421 A.2d 1334, 1350 (Del.

In comparing the "quality" of judicial and ethics committee determinations, we must also recognize that the decisionmaker in cases involving court permission for the withholding or withdrawing of life-sustaining treatment is a judge. Juries do not play a role in prospective decisions where the parties are seeking interpretation of the law.

Complicating matters, the cases often require the judge to make a swift determination after only relatively brief reflection. And often, courts have neither the time nor the necessary resources to obtain all the relevant facts.[156] Other cases may not require immediate attention. This may be true where a family member is requesting the withdrawal of feeding tubes from a patient in a persistent vegetative state. In these cases, judicial procedures, themselves, may hamper a thorough review of the issues. For example, several months may pass between a trial court decision and an appellate court ruling, and during this time significant changes can take place in the health of the patient. "Legal procedure . . . does not allow appeals courts to gather evidence that is more up to date but limits them to the evidence introduced at the trial court hearing."[157] A more flexible forum, such as an ethics committee, could easily obtain and address the more recent and relevant information.

Moreover, although the issue presented to the court is a matter of legal interpretation, the application of the law to cases involving withholding or withdrawal of life support is often not straightforward. If there is evidence of what a patient would have wanted, the decision for the judge is somewhat easier than if no such information exists because the judge may base the decision on the sufficiency of the evidence. However, if the judge applies a relatively low evidentiary standard, such as preponderance of the evidence, the judge may be put in the position of extrapolating from evidence

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Super. Ct. 1980) (ethics committees can assist in evidentiary hearings); *In re* Spring, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980) (opinions of ethics committees may be persuasive evidence on issues of good faith and good medical practices). Moreover, a few courts, allowing the family to consent to the withholding or withdrawal of life support for incapacitated patients, have spoken favorably of the role of ethics committees in assisting family members and health care providers in making such decisions. *See, e.g., In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

156. One judge reported at a recent conference on right-to-die issues that in some cases involving medical decisionmaking for an alleged incompetent, she did not even receive a copy of the patient's medical record. G. Kessler (Judge, D.C. Super. Ct.), Remarks at Medical Decision-Making and the "Right to Die" after *Cruzan* (Sept. 14-15, 1990).

157. Lo, Rouse & Dornbrand, *Family Decision-Making on Trial*, 322 NEW ENG. J. MED. 1228, 1229 (1990).

as to general preferences of the patient regarding medical care and quality of life and applying such evidence to the facts at hand. The ability of judges intuitively to draw such inferences would seem to be inferior to that of the patient's family. Whether judges or ethics committees are best suited to draw such inferences remains open to debate. To the extent that an ethics committee includes individuals likely to share the values of the patient, an ethics committee would probably be in a better position to apply the substituted-judgment test.

If the decision requires application of the best-interests test, the judge must determine what is, in fact, in the best interests of the patient or whether the burdens of continued treatment outweigh the benefits. Although such a test ideally requires total objectivity, this ideal is virtually impossible to achieve and judges or any decisionmakers undoubtedly will filter the decision through the screen of their own values. In the absence of any evidence to the contrary, it is doubtful that the judge has any better ability or qualifications than a group of broadly representative individuals to apply appropriate values to a given case.

Finally, judges do not possess the medical expertise available to an ethics committee. Although judges arguably could call on medical experts to provide this information, an ethics committee seems much more suited than a judge to make medical decisions and to evaluate the quality of medical opinions on issues such as prognosis.

Although we also theoretically can compare the quality of ethics committee decisionmaking to that of a jury, the comparison is of little relevance because most of these cases are not heard by a jury. But, if we make the assumption that a jury will be involved or alter the judicial process so that more of these cases are heard by a jury, it might be worthwhile to ask whether the jury is in any better position to evaluate the evidence or impose its values on the situation than members of an ethics committee. The various distinctions between the aresponsible committee and the modified aresponsible committee are relevant in responding to this question. Criticisms of the modified aresponsible committee include the observation that it lacks representativeness. Thus, whether the jury or ethics committee is best qualified to make these life and death decisions will depend, in part, on the composition of the ethics committee. A committee that is heavily dominated by medical professionals may not share the same values as the patients that come before it. Such committees, as pointed out by at least one author, are likely to be dominated by white, upper middle class professionals who value in-

tellectual pursuits and an "intellectual life."[158]

A jury composed of lay persons representing a cross section of the community may have values that are closer to those of the patient.[159] Yet, in practice, juries may not actually be all that representative either:

> At best the [jury] consists of a representative sample of the community, with a few members having genuine expertise, a large number who are simply average citizens, and a few others who are distinctly below average. In practice, many of the better-educated jurors are excused from service, and others who show knowledge or ability relevant to the particular case at trial may be challenged during the voir dire. Attorneys select jurors for incompetence. Thus, some have argued that the average jury is not only less competent than the average judge, but is also less competent than a random sample of twelve citizens from the community.[160]

Other problems with using juries in these cases are the difficulty of convening a jury in the time allotted to resolve the case and the lack of continuity in members of the jury. There is value in having some consistency in the way these issues are decided, at least at the same hospital.[161] Consistency in process is more likely to result if there is continuity in the members of the relevant "tribunal." Given these

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158. Glantz, *Contrasting Institutional Review Boards with Institutional Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 1, at 134. In fact, most ethics committees are extremely homogeneous in nature. Although not all members are physicians, most are well educated, having graduate as well as undergraduate degrees. Most are white, healthy, and from an upper socioeconomic class. *See generally* Study, *supra* note 19, at § III.

The recent Times Mirror public opinion poll found that there are in fact differences in patient preferences for medical treatment based on religion, race, age, sex, income, and education. According to the poll results, blacks, born-again Christians, people who are very religious, people over age 65, and people who are not college graduates are slightly more likely than the general population to think that a patient's life should always be saved. *See* TIMES MIRROR, *supra* note 135, at 2. Those surveyed were asked how they would want their own medical treatment handled (1) if they were terminally ill and suffering great pain, (2) if they had an illness that made them totally dependent on another family member for all daily care, and (3) if they had a terminal disease that made it difficult to function in day to day activities. *Id.* at 10. Blacks were less likely than whites to think they would opt to have treatment stopped in all three situations investigated. *Id.* at 10.

159. As stated earlier, such values may come into play in either the application of a substituted-judgment or a best-interest test. *See supra* notes 131-133.

160. Ellsworth, *Are Twelve Heads Better than One?*, 52 LAW & CONTEMP. PROBS. 205, 206-07 (1989).

161. Although consistency in outcomes may not be possible because the substituted-judgment and best-interests tests are individualized standards, consistency in method is possible and should be sought. For example, a decisionmaker should consistently con-

shortcomings of juries, more representative ethics committees may be better equipped than either a judge or jury to resolve certain ethical dilemmas in patient care.

With respect to cost effectiveness, going to court is a much more costly alternative than consulting with an ethics committee. The issue thus is whether the court is likely to make decisions that are qualitatively better than those an ethics committee would make and whether the "benefit" of those decisions can outweigh economic and other costs.

In 1983, the President's Commission took the position that ethics committees can be more efficient and more sensitive than a judicial body.[162] The Commission considered committees' closer proximity to the treatment setting, their informal and typically private deliberations, and their ability "to reconvene easily or delegate decisions to a separate group of members," as weighing in favor of their widespread use.[163] In 1987, the New Jersey Supreme Court echoed these views in *In re Jobes*.[164] In addressing the efficacy of a nursing home ethics committee, the court quoted the President's Commission's position that "[w]hen ethics committees serve as reviewers, they do not supplant the principal decisionmaker (that is, families and practitioners) but they do provide for efficient review without regularly incurring the liabilities of judicial review."[165]

C. *The Ethics Committee as Decisionmaker*

Ethics committees as decisionmakers in these cases have some advantages over both the family and the courts. With respect to

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sider the same factors when applying a best-interests test. Factors should not be ignored in some cases and applied in others.

162. See PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 169.

163. *Id.* Yet, at the same time the Commission stated specifically that it would not recommend widespread adoption—much less that consultation with ethics committees become a "uniform requirement imposed by the Federal government or by hospital accreditation bodies"—until questions about the advantages and disadvantages of the committees are answered. *See id.* at 169.

164. 108 N.J. 394, 450, 529 A.2d 434, 463 (1987) (Pollack, J., concurring).

165. *Id.* at 451, 529 A.2d at 463 (Pollack, J., concurring) (quoting PRESIDENT'S COMMISSION, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 3, at 164). In concurring with the *Jobes* decision, Judge Pollack said that ethics committees "cannot only perform an educational and policy-making role, but also act as an advisor to the patient's family and physician." *Id.* These complementary views of ethics committees, however, were both aimed at cases involving the termination of treatment for an adult. Whether or not the same arguments apply for surrendering judicial review of cases involving termination of life support for severely handicapped newborns or sterilization of mentally retarded individuals is less clear.

medical expertise, ethics committees are clearly in a better position to interpret medical facts and weigh differing medical views than are either families or judges. Second, an ethics committee that includes representatives from the community as well as the hospital may have an advantage over the courts by bringing into the decisionmaking process values that more closely reflect the values of the patient. The advantage of a broadly constituted committee is that it brings to bear on the issue the diverse views of a variety of individuals. Thus, in a sense, by consensus the committee provides an assurance that the decision is ethical—or at least that a representative body thinks it is ethical. This consensus is helpful because the law and ethical principles that can be applied by decisionmakers have significant limitations. They provide a framework, such as the best-interests test, and a variety of ethical and legal options, but they do not provide a single answer. The committee can provide a single answer by consensus. The notion that such a group confirms a particular course of action can bring relief to health care providers and family members who are unsure what to do in a given situation and are looking for guidance and assurances that others do not think that what they are proposing is somehow "wrong" or "unethical."

The conclusion that ethics committees are relatively better decisionmakers in some cases than families or courts does not mean they are without deficiencies. As noted above, ethics committees have many potential problems. Just as families may in some cases have conflicts of interest in making decisions for patients, there is a danger that ethics committees may act as "puppets" of the health care institution in which they sit. Such a danger supports the position that ethics committees should include members from outside the health care institution or that ethics committees represent more than one institution. Also, ethics committees often lack substantive guidelines for decisionmaking and the due process protections of a court. For these reasons, any legislation or court decisions that give ethics committees more authority should also give those committees both substantive and procedural guidelines for decisionmaking.

IV. RECOMMENDATIONS

A. Legislating Committees

Other than their speculative benefit, there are no valid policy reasons for legislation mandating the establishment of ethics com-

mittees.[166] However, legislation that would regulate the establishment and operation of the committees as well as legislation that would encourage better quality in the operation of the committees may be appropriate. This Part includes recommendations for such legislation.

1. Legislation Regulating the Establishment and Operation of Ethics Committees.—The purpose of legislation regulating the establishment and operation of ethics committees is to protect the patients who use the committees or who are the subjects of the committees' deliberations and to improve the quality of committee decisionmaking. Issues that should be considered in drafting such legislation include: (1) the definition of ethics committee; (2) the composition of such committees; (3) what patient protections will be most effective; and (4) what provisions are likely to improve the committee's decisionmaking.

Legislation regulating the establishment and operation of ethics committees needs to include a broad definition of ethics committees in order to capture the possible variations of such committees among health care institutions and to ensure that they are covered under the statute. Such a broad definition might be "any committee established by a hospital or nursing home or group of hospitals or nursing homes to deal with the ethical issues involved in patient care."

Such legislation should also set forth guidelines for committee composition. As previously stated, the Maryland Act requires that at a minimum a committee include a physician, a nurse, a social worker, and the hospital administrator or designee.[167] The federal guidelines for the establishment of infant-care review committees, which are similar to ethics committees, recommend that such com-

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166. In contrast, the results of Phase III of the Study showed that a fairly high percentage of committee members in all jurisdictions felt that the establishment of ethics committees in all hospitals should be mandatory. *See* Study, *supra* note 19, § III(3). In Maryland, 84% of the committee members agreed that the establishment of ethics committees should be mandatory. *Id.* In the District of Columbia, 92% of members felt that such committees should be mandatory and in Virginia 72% agreed. *Id.*

Phase III of the Maryland Study consisted of telephone interviews of three to four members of committees that had been in existence for over one year and that had done more than one case consultation—a total of 38 committees and 124 individuals. *Id.* § II. Among other questions, committee members were asked whether they thought that the establishment of ethics committees should be mandatory in all hospitals. The high percentage of positive responses may be due to a selection bias of respondents "committed" to the committee process. *Id.* A sampling of hospital staff that are not members of an ethics committee might be a less "biased" sample.

167. *See supra* note 24 and accompanying text.

mittees include a representative of the legal profession, a representative of a disability group, a lay community member, and a member of the clergy.[168] New legislation might also require the inclusion of a bioethicist or someone with training in bioethics. Based on the preceding discussion of the representativeness of ethics committees, membership on ethics committees should extend beyond medical professionals and hospital staff.

Perhaps the most important components of any legislation regulating the establishment and operation of ethics committees are due process provisions. In this respect, the Maryland law can provide a model for other states. The statute includes a number of what might be termed "procedural due process" provisions for patients and their family members. For example, it allows anyone (including the patient)[169] responsible for making a decision "with a medical consequence for a patient"[170] to request the services of the committee. It also provides that the petitioner may be accompanied by any persons the petitioner desires when consulting the committee.[171] As part of the committee's deliberations, the statute states that the advisory committee, "in appropriate cases, shall consult: (i) all members of the patient's treatment team; (ii) the patient; and (iii) the patient's family."[172] This provision would be strengthened by requiring consultation in all cases where the patient is competent or where family members are available. Finally, the statute provides:

> The advisory committee shall make a good faith effort to notify a patient, a patient's immediate family members, a patient's guardian and an individual with a power of attorney to make a decision with a medical consequence for a patient of the individual's right: (i) To be a petitioner; (ii) To meet with the advisory committee concerning the options for medical care and treatment; and (iii) To receive an explanation of the basis of the advisory committee's advice.[173]

An important element of legislation purporting to protect patients' interests is a confidentiality provision. Such a provision will facilitate consultations with patients and their families who believe these deliberations are deeply personal and private matters. There

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168. *See* 45 C.F.R. § 84.55(f)(a) (1989).
169. *See* MD. HEALTH-GEN. CODE ANN. § 19-370(d) (1990 & Supp. 1990).
170. *Id.* § 19-374(a).
171. *See id.* § 19-372(3)(b).
172. *Id.* § 19-372(2)(3).
173. *Id.* § 19-374(b)(1).

are two confidentiality issues that are relevant to the interests of the patient: what information can be disclosed to an ethics committee by a health care provider without the patient's or surrogate's consent?; and what information about a patient, if any, can the committee disclose, and to whom?

The first issue has been the subject of some debate. Some health care providers have analogized the physician's consult with the ethics committee to that of a consult with another physician. Such consults are commonplace and occur routinely without the permission of the patient. Yet such consults may also occur without the patient's physician disclosing any identifying characteristics of the patient. Nondisclosure is theoretically possible in the case of a consult with an ethics committee, but committees would not be doing a very good job of fact finding if they did not consult the patient, if competent, or the patient's surrogate decisionmakers, and the patient's other health care providers. If a specific patient is the subject of an ethics committee consultation, the consent of the patient or patient's surrogate should be obtained prior to the committee's discussing the case. Discussion of the patient's case without consent would violate the patient's right to confidentiality.[174] Thus, new legislation in this area should require that any petitioner of an ethics committee, other than the patient or patient's surrogate, obtain the consent of the patient (or surrogate) prior to seeking the committee's assistance.

The issue of whether, or under what conditions, the facts of a case discussed by an ethics committee may be disclosed to "outsiders" has been addressed rather extensively.[175] Cranford, Hester, and Ashley discuss the pros and cons of confidential ethics committee deliberations in great detail and conclude that, although confidentiality is a valid objective, "[t]otal confidentiality may be undesirable and impossible to achieve."[176] Yet, these authors look at the rationale for confidentiality as a means to protect committees rather than patients.[177] If our goal is to protect patients, every effort should be made to keep the committee's notes and records confidential and to permit disclosure only with the permission of the

174. For an extended discussion of this issue, see Veatch, *Advice and Consent*, 19 HASTINGS CENTER REP., Jan.-Feb. 1989, at 20.

175. *See, e.g.*, Cranford, Hester & Ashley, *supra* note 117, at 52, 53-56.

176. *Id.* at 56.

177. *See id.*

patient or as required by law,[178] unless all patient identifying characteristics are deleted from such notes or records.[179] Such strict confidentiality requirements may also be necessary to convince patients to use ethics committees, especially when such use is voluntary. To further protect the patient and to ensure compliance with these confidentiality provisions, penalties could be imposed for unauthorized disclosure.[180]

Finally, such legislation should include provisions to improve the quality of ethics committee deliberations. These provisions could take a variety of forms such as a requirement that a government agency issue training materials for ethics committee members or that ethics committee members receive training in bioethics prior to their appointment to the committee.

The legislation might also encourage hospitals to establish joint committees. Such encouragement might take the form of economic incentives. Because a major justification for legislation for joint committees is the need to overcome the transaction costs of establishing and operating these committees, some type of funding for joint committees is probably necessary. The funds might take the form of grants to be disbursed to hospitals that submit proposals to a state office for the establishment of a joint ethics committee. The legislation could delegate the drafting of regulations or guidelines for such proposals to the designated state office. Criteria for funding might include: (1) the number of participating health care institutions; (2) the qualifications of committee members;[181] (3) the

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178. Circumstances under which disclosure may be required by law include criminal prosecution of physicians or other health care providers, and child abuse reporting. *Id.*

179. Fairness would require, however, that if a patient or surrogate plans to use committee records in a malpractice suit against a physician, other health care providers or the hospital, then the health care provider and hospital should also have access to the records.

180. These recommendations differ from the Maryland Act, which provides that the proceedings and deliberations of the ethics committee have the same protection from discovery as deliberations of medical peer review committees. *See* MD. HEALTH-GEN. CODE ANN. § 19-374(e)(1) (1990 & Supp. 1990). In Maryland, the recommendation of the committee placed in the medical record is further subject to the confidentiality provisions of the medical record statute. *See id.* § 19-374(e)(2). Although patients may have access to their medical records, they would not have access to any committee notes about their case if they wanted to use such information in a malpractice suit against a physician. *See id.* The rationale for such a provision is to ensure full and open discussion by committee members. The issues brought to the committee may include concerns about a particular health care provider's competence, or relationships with patients, family members, and other health care providers. Committee members are less likely to discuss these issues openly if the information is discoverable in a law suit.

181. By allowing hospitals to submit their own ideas for a joint committee, the composition of the committees can be left flexible to provide hospitals with room for experi-

inclusion of an educational plan for members; (4) the extent of community education outreach efforts; and (5) the total cost. This type of funding mechanism, in effect, would allow a state to establish "Centers of Excellence" in bioethics decisionmaking. These Centers might produce model policies and educational materials for use by other hospitals or health care institutions that want to establish their own committees.[182] Such Centers might also provide consulting services to other institutional ethics committees that need assistance in particularly difficult cases.

Such funding, however, also requires a financing mechanism. Funds for the program could be obtained from a variety of sources. For example, the state could impose a small tax on each hospital[183] or a hospital could charge patients for an ethics consultation and pass along a certain percentage to the state fund.[184]

B. Legislation Expanding the Role of Ethics Committees

The more controversial question posed by this Article is not whether ethics committees should be mandated but whether their role should be expanded to allow them to substitute for judicial decisionmaking in some cases. This Article concludes that giving committees decisionmaking authority for cases that would otherwise require judicial approval is worthy of more consideration, but that any legislation that allows such decisionmaking by ethics committees should include changes in the typical composition of ethics committees and should be accompanied by significant safeguards for patients.

This subpart discusses the specific issues that should be addressed in any legislation giving committees decisionmaking author-

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mentation. However, some minimum criteria might be set that would require that all committees include at least one health care provider from each hospital, a bioethicist, and a community representative. "Bioethicist" and "community representative" might also be defined to provide additional direction to the committees.

182. *See, e.g.*, Fletcher, *The Bioethics Movement and Hospital Ethics Committees*, 50 MD. L. REV. 859 (1991).

183. Such a tax is not unprecedented. For example, the Maryland Health Resources Planning Commission is empowered to impose a "user fee" on health care facilities. *See* MD. HEALTH-GEN. CODE ANN. § 19-122 (1990). The Commission assesses user fees according to the number of admissions of each facility and the gross operating revenue of each facility. *See id.* § 19-122(c)(1).

184. The possibility of charging patients for case consultation was suggested in the Minnesota network newsletter. *See Ethics Committee Survey Results*, *supra* note 70. The problem with the suggestion is that few patients currently initiate consults. Should they have to pay for consults that are for the benefit of their physician and that they did not request?

ity. First, the legislature must confront the issue of when the committee's recommendation should substitute for that of a court. In Maryland, the proposal of the Health Law Section of the Maryland State Bar Association would limit ethics committees' decisionmaking powers to cases in which the patient is in a persistent vegetative state and the family wishes to withhold or withdraw life sustaining treatment.[185] Although this Article argues that such decisions can best be made by family members,[186] the use of ethics committees may be a palatable political compromise in jurisdictions that currently require court approval for such determinations. The committee could also take on more decisions for which court approval is currently sought, such as cases involving the withholding or withdrawing of medical treatment for severely disabled infants with life-threatening conditions; cases involving sterilization of mentally retarded adults, or cases involving maternal-fetal conflicts. Before delegating decisionmaking authority in these areas to ethics committees, however, more analysis is necessary to determine the relative merits of ethics committees as decisionmakers in these cases.

In addition to the substantive issues that the committee will be permitted to address, the legislation must be specific about the circumstances under which the committee will be able to make a decision. In cases involving the withholding or withdrawal of life support from adults, the legislation must be clear as to the standard of decisionmaking the committees must apply, for example, should the ethics committee decide cases only where there is evidence of what the patient would have wanted or should the committee be given the authority to decide what is in the best interest of the patient? The Maryland State Bar Association's proposal would limit committee authority to cases where there is evidence of what the patient would have wanted.[187] Yet, there is no reason why committees could not also apply a best-interest test. In fact, ethics committees may be in a better position to apply such a standard than the courts.[188]

The legislature must also consider whether to provide evidentiary standards for the committee's deliberations or to address how

185. *See* Md. Bar Proposal, *supra* note 18, at 3. The proposal would not significantly change the law in cases where the patient is terminally ill. In those cases family decisionmaking is currently permitted. The proposal does not address cases where the patient is not terminally ill and not in a persistent vegetative state. Withholding or withdrawal of life support from patients in the latter group would still require court approval.

186. *See generally In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *see also supra* note 146.

187. *See* Md. Bar Proposal, *supra* note 18, at 4.

188. *See supra* note 132.

to allocate the burden of proof among the parties. For example, the process might require that the family establish by clear and convincing evidence that a particular decision is what the patient would have wanted or is in the patient's best interest. Alternatively, the process might give greater weight to the family's decision and require the ethics committee to approve the family's decision unless the patient's health care provider presents evidence that the family members are not acting in the best interest of the patient or that the family has a clear conflict of interest or is abusing its authority. This latter alternative establishes an adversary process wherein the family and the ethics committee are pitted against one another. A third option is to use the ethics committee as a fact finder, gathering information from all parties, including family members, health care providers, and friends, and making an independent decision as to what the patient would have wanted or what is in the patient's best interest. These issues, in particular, demonstrate the difficulty of allowing ethics committees to make these decisions and the danger of slipping into a "legal framework."

A legislature will also want to establish the standards a committee must meet before it may substitute its judgment for a judicial decision. These standards might include the composition of the committee, the qualifications of its members, and the degree to which a committee is representative of the community at large. It would be appropriate to require that a significant percentage of the members of an ethics committee be from outside of the hospital and that these "community members" reflect the composition of the institution's patient population with respect to such factors as race, age, gender, income, education, and religion. In addition to facilitating decisions that better reflect the values of the patient, representative committees that include a substantial number of "outsiders" can "reduce the potential for institutional prejudices, biases, or 'cover-ups' which would ultimately affect the patient involved."[189] Any committee that is to serve in a decisionmaking capacity should also be required to include a formally trained bioethicist.

In addition, the legislation should include a requirement that all committee members receive some training in biomedical ethics or that in selecting committee members, hospitals give preference to individuals who have some formal training in ethics. The level of

189. Comment, *Recognizing the Value of Hospital Ethics Committees: Time for a Judicial Reassessment*, 18 U. TOL. L. REV. 195, 200 (1986).

training necessary, the content of such training, and the source of such training all are issues deserving of considerable thought and are beyond the scope of this Article; but individuals who serve on a committee that literally makes "life and death" decisions for patients should have some understanding of the ethical and legal issues involved. Compassion and a concern for the sick are not sufficient qualifications for membership on a committee of this nature. Guidelines that include a suggested training program or qualifications for individual members should accompany any proposed legislation.

If legislation permits substitution of committee decisions for court decisions, due process protections become even more important than they are when the committee's role is purely advisory. Although the provisions in the Maryland statute are a start, additional provisions will be important if the committee's role is expanded. For example, committees should be required to inform patients and their family members of their right to bring an advocate with them when they meet with the committee, and required to issue a written statement of the basis for their decision.

Furthermore, committees will need guidance as to what is considered a "committee decision"—whether committees must reach unanimity on any decision, whether a majority or supermajority vote is sufficient. Consensus will be more difficult to achieve within a more heterogeneous committee, yet a simple majority or even a two-thirds majority, where a committee is composed only of one-third "outsiders," would permit hospital staff to dominate outcomes. In such a case, a three-fourths majority might be more appropriate.

Any discussion of legislation allowing ethics committees to substitute for court action will necessarily involve issues of confidentiality and immunity. For example, if a committee is authorized to substitute its judgment for judicial decisions, the arguments for greater openness and public scrutiny of committee proceedings have merit. Allowing committees to operate behind closed doors under the guise of protecting the patient's confidentiality may let committees abuse their powers. A provision that keeps the proceedings confidential with some exceptions for monitoring of quality might satisfy both concerns. This goal might be achieved by allowing committees to meet and deliberate in private but by requiring that all notes of meetings and recommendations be kept available for judicial review, or review by a state agency assigned to monitor committee activities.

One of the more controversial provisions of the Maryland statute is the provision immunizing members from liability.[190] The statute provides that an advisory committee or member who gives "advice in good faith may not be held liable in court for the advice given."[191] The provision has recently been expanded to protect "related institutions," or nursing homes, that fail to follow the advice of an ethics committee if the advice is inconsistent with the written policies of the related institution.[192] An obvious benefit of the provision is that it encourages the establishment of committees by allowing their members to operate without fear of lawsuits, similar to the way medical peer review committees operate. Committee members may be reluctant to discuss cases fully and openly if they fear liability for themselves or others. They may be concerned about protecting the patient or health care providers and thus fail to make statements that are important to their deliberations.

On the other hand, some observers argue that members who serve on the committee should be held to a standard of care and should be accountable for their decisionmaking. According to one commentator, "it would be inappropriate for members of ethics committees to expect total, unqualified immunity, because their deliberations affect the fundamental rights and interests of patients."[193]

Many of the arguments for protecting committee members from liability are the same as those made for members of quality review committees within hospitals. These committees, in order to operate effectively, must be free from concerns of liability. In order to respond to these concerns, in 1986, Congress passed the Health Care Quality Improvement Act (HCQIA),[194] which provided immunity for such quality review committees under certain specified circumstances.[195] The provisions of the HCQIA provide a useful model for legislation immunizing ethics committees from suit. Based on these provisions, ethics committee immunity might only

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190. The Hawaii statute similarly confers immunity for any member of an ethics committee "for any acts done in the furtherance of the purpose for which the . . . ethics committee . . . was established; provided that: (1) The member . . . acted without malice; and (2) . . . the member was authorized to perform in the manner in which the member did." HAW. REV. STAT. § 663-1.7(b) (1988 & Supp. 1990).

191. MD. HEALTH-GEN. CODE ANN. § 19-374(c) (1990 & Supp. 1990).

192. *See id.* § 19-374(f).

193. Merritt, *Assessing the Risk of Legal Liability for Ethics Committees*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 13, 14.

194. 42 U.S.C. § 11101 (1988).

195. *See id.* § 11111(a)-(b).

apply if (1) the ethics committee meets the statutory requirements of composition and education of its members; (2) the committee is acting in the "best interests of the patient" and has not considered such factors as the costs to the hospital of continued care of the patient; and (3) the committee made its decision after a reasonable effort to obtain the facts of the matter.[196]

To the extent that ethics committees remain liable, the health care institution in which the committee sits should be vicariously liable for the committee's action. Such extension of liability is appropriate to ensure that the hospital establishes a committee that conforms to the statutory requirements and is composed of qualified members.[197]

V. JUDICIAL REVIEW

Legislation authorizing the use of ethics committees as an alternative to judicial decisionmaking should make clear that the decision of the ethics committee may be appealed to the courts. Review is appropriate given that the committee's deliberations are not open to public scrutiny. The specter of judicial review will also motivate ethics committees to operate fairly and in good faith. Although judicial review is clearly warranted when ethics committee opinions are appealed, such review may be limited in scope. Limited review has been generally applied by courts to hospital medical staff privilege revocations[198] and to decisions made by state medical boards in revoking physicians' licenses.[199] In those cases the courts have deferred to the "expertise" of the decisionmaking body and the judicial role has been confined to determining substantiality of evidence and assuring that the decisionmaking body has followed its own rules and procedures.

Thus far, with the exception of the *Torres* case, in which the court regarded the committee recommendation as evidence and

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196. Although an argument can be made that without the immunity provision, hospitals will not be able to find practitioners who will serve on the committee. With the exception of Maryland and Hawaii, in every other state where ethics committees are operating, there is no statutory immunity from liability. Thus far only one case against a hospital ethics committee has been filed. The suit was dismissed, however. *See* Bouvia v. Glenchur, No. C 583828 (Cal. Super. Ct. Los Angeles County, deemed filed Oct. 7, 1986, by court order granting leave to amend). For a discussion of *Bouvia*, see Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1250-51 (1987).

197. Exemption of such institutional liability may be appropriate, however, for multi-institutional committees in order to encourage the establishment of such committees.

198. *E.g.*, Rao v. St. Elizabeth's Hosp., 140 Ill. App. 3d 442, 488 N.E.2d 685 (1986).

199. *E.g.*, Kansas State Bd. of Healing Art v. Foote, 200 Kan. 447, 436 P.2d 828 (1968).

"seemed to regard the committees as authorities on moral issues,"[200] courts have not given much credence to the opinions of ethics committees. In the few judicial opinions where an ethics committee was consulted prior to the case going to court, at least three opinions made no apparent use of the ethics committee's determination.[201] In the other cases, the courts have stated that a judge may consider the recommendations of an ethics committee, but is not required to do so.[202]

These varied treatments of ethics committees by the courts make sense given that in virtually all states but Maryland the concept of an ethics committee has not been well defined or agreed upon. Given the variation in composition, experience, expertise and procedures of most ethics committees, courts are justified in treating them on a case-by-case basis. However, if legislation were passed that provided some uniformity in the composition, training, and procedures of these committees, and required monitoring of ethics committees' activities by the state, a limited role for the courts would be justified.

In reviewing ethics committee determinations, a court should consider whether the ethics committee members have the qualifications mandated by statute and if the committee followed the due process requirements of the statute. If a committee meets these prerequisites, a court should only overturn the committee's decision if it finds that the decision was arbitrary or capricious.

In addition to these provisions, any legislation permitting use of committees as an alternative to judicial decisionmaking must include a monitoring and evaluation component. In order to ensure accountability and to provide a basis for the continued use of committees, legislation should require hospitals to keep records of case consultations and to establish a mechanism for evaluation of committee performance. Such records should be made available for in-

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200. Wolf, *Ethics Committees in the Courts*, HASTINGS CENTER REP. June 1986, at 12 (describing *In re Torres*, 357 N.W.2d 332 (1984)).

201. *See In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (committee's determination was briefly noted along with the committee's membership); *In re* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (court noted the ethics committee recommendation but did not consider the recommendation in its analysis); *In re* Eberhardy, 102 Wis. 2d 539, 307 N.W.2d 881 (1981) (court did not acknowledge the fact that an ethics committee had approved the sterilization of a mentally retarded adult).

202. *See* Severns v. The Wilmington Medical Center, 421 A.2d 1334, 1350 (Del. Super. Ct. 1980); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

spection by representatives from the relevant state regulatory agency.

Given that some ethics committees will not meet the standards allowing them to substitute for judicial decisionmaking, legislation giving certain committees this authority should also address access issues. Such legislation might encourage the establishment of joint committees or community committees that provide services to patients at a number of hospitals. Alternatively, the legislation might provide that patients or their surrogates who are in a hospital that does not have an "approved" committee may request the services of an approved committee. Approved committees may give priority to patients within their own hospitals but should also be required to provide access to patients from other hospitals.[203]

Finally, any legislation expanding the role of ethics committees to permit them to substitute for judicial decisionmaking should incorporate some amount of public funding for education, monitoring and enforcement. For example, the funds might be used to establish an office on institutional ethics committees that would be responsible for providing consultation services to hospitals and nursing homes that want to establish committees. The responsibility of the office would be to provide information and educational services to hospitals, to educate the public about ethics committees, and to conduct studies on ethics committees throughout the state. This would be a valuable service to all hospitals and patients. Furthermore, the funds would be used by the office to review records of ethics committee decisionmaking and to perform monitoring functions.

CONCLUSION

Although recently there has been some interest at the federal level and in some states in mandating the establishment of ethics committees, at this time such legislation is not warranted. Rather, legislatures should be focusing on legislation that will protect the rights of patients in the ethics committee deliberation process. Legislation that would permit the use of committees as an alternative to the courts deserves further consideration. But in any case, such legislation must include numerous safeguards, in particular, due process protection for patients and their surrogate decisionmakers.

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203. If approved committees become overwhelmed with requests for their services and unable to handle the caseload, the legislation might permit committees to charge for their services or the state might provide payment to the hospital for each out-of-hospital request for services provided by the hospital's ethics committee.