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Symposium

HOSPITAL ETHICS COMMITTEES AND THE LAW INTRODUCTION

PAULA C. HOLLINGER*

On July 1, 1987, Maryland became the first state to enact legislation requiring all hospitals to establish their own "patient care advisory committees."¹ Designed in response to increasing nationwide debate over treatment of patients with life-threatening illnesses, Maryland's law provides that each hospital will have a committee available to offer advice concerning options for the medical care of individuals with life-threatening conditions.²

I worked for three years to get this legislation enacted. I sought input from doctors, social workers, members of the clergy, hospital executives, the Maryland Catholic Conference, the Attorney General's Office, and others. The enactment of federal regulations in 1985³ resulted in the complete reworking of original drafts of the legislation. In its final form, the law is general enough to cover the myriad of factors that go into a just and moral decision and specific enough to assure that all the considerations relevant to each individual case are addressed as these most difficult decisions are made.

My service on the House of Delegates Environmental Matters Committee provided the impetus for this legislation. This committee considered a series of bills dealing with so-called Baby Doe cases,⁴ with abortion, and with the "living will" question.⁵ All over the country, numerous cases were going to court in search of judicial guidance on issues of termination and initiation of treatment. I

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1. 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)).

2. MD. HEALTH-GEN. CODE ANN. § 19-371 (1990).

3. See Child Abuse and Neglect Prevention and Treatment, 45 C.F.R. § 1340.15 (1990).

4. See, e.g., *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986) (striking down federal regulations that withheld grants from hospitals that did not aggressively treat deformed infants).

5. A "living will" is a document expressing a patient's wishes regarding medical treatment should he or she become terminally ill and incompetent. See Matthews, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707, 711 n.30 (1987); *infra* note 22 and accompanying text.

was particularly motivated by *In re Quinlan*⁶ and by the 1983 Minnesota case of *In re Torres*.⁷ In *Torres*, a court for the first time considered the recommendations of three independent biomedical ethics committees dealing with a patient who had been in a coma for sixteen months after suffering irreversible brain damage.⁸ After hearing the advice of the two committees, the court ruled that the respirator could be disconnected if the patient's legal guardian so directed.⁹

Maryland's patient care advisory committee law includes a variety of provisions. First, the law defines a petitioner as one of the following individuals responsible for making a decision with a medical consequence for a patient: the patient, physician, registered nurse, social worker, family member, guardian, individual with a power of attorney to make a decision with a medical consequence for a patient, or any other health care practitioner directly involved in the care of the patient.¹⁰

Second, the committee must consist of at least four members, including a physician not directly involved with the care of the patient in question, a registered nurse not directly involved, a social worker, and the hospital's chief executive officer or a designee.¹¹ The advisory committee may consist of as many other individuals as the hospital chooses,¹² and each committee must have a written procedure by which it is convened.¹³

In addition to any other duties or responsibilities, and on the request of the petitioner, the advisory committee shall offer advice in cases involving individuals with life threatening conditions.¹⁴ The committee may also educate hospital personnel, patients, and

6. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976) (holding against judicial review of cases involving termination of life support from patients in persistent vegetative states if multidisciplinary ethics committees confirm the patients' prognoses).

7. 357 N.W.2d 332 (Minn. 1984).

8. See *id.* at 335-36.

9. See *id.* at 341. The court held that the patient's due process rights were not violated by the decision to terminate life support, noting that (1) a full evidentiary hearing on the recommended care of the patient was held; (2) full and complete notice was given to all concerned; (3) all interests were represented at the hearing; (4) the testimony of the conservator, the examining physician, and the patient's friends and family were heard; and (5) the presiding judge was satisfied that the patient would have chosen to forego life-sustaining treatment if he were able to speak. See *id.* at 340.

10. See MD. HEALTH-GEN. CODE ANN. § 19-370(d) (1990).

11. *Id.* § 19-372(a)(1).

12. *Id.* § 19-372(a)(2).

13. *Id.* § 19-371(2).

14. *Id.* § 19-373(a).

patients' families concerning medical decisionmaking;¹⁵ and review and recommend institutional policies and guidelines concerning the withholding of medical treatment.¹⁶

The committee may not be held liable in court for advice given in good faith, and all proceedings and deliberations are confidential.¹⁷ The advice of the committee becomes part of the patient's record.¹⁸

The Maryland legislature amended the law in 1990 to include related institutions engaged in the nursing home care of individuals who, because of advanced age or physical or mental disability, require domiciliary care or personal care in a protective, institutional environment.¹⁹ This includes nursing homes, convalescent homes, and nursing facilities for the handicapped.²⁰ The related institutions may operate their committee jointly with a hospital advisory committee or jointly with an advisory committee representing no more than thirty other related institutions.²¹

Beginning with the *Quinlan* case over ten years ago, and continuing through the recent *Cruzan* decision,²² families, patients, and health professionals have become increasingly concerned with life and death decisions complicated by evolving medical technology and the recent onset of rationing health care. Patient care advisory committees are the most appropriate mechanisms to offer necessary advice and information upon which families, patients, and health professionals can make informed, rational judgments. Evidence of their value may be found not only in their growth over the past decade, but also in the serious attention they have received from leading scholars in medical ethics.

I witnessed this attention when I was invited in June 1990 to address an interdisciplinary conference on hospital ethics committees and the law, sponsored by the Health Law Program at the University of Maryland School of Law. Although my own experience as

15. *Id.* § 19-373(b)(1).

16. *Id.* § 19-373(b)(2).

17. *Id.* § 19-374(c).

18. *Id.* § 19-374(e)(2).

19. See Act of May 29, 1990, ch. 545, 1990 Md. Laws 2376 (codified at MD. HEALTH-GEN. CODE ANN. § 19-370(e) (1990)).

20. MD. HEALTH-GEN. CODE ANN. § 19-370(e) (1990).

21. See *id.* § 19-371(b).

22. *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841, 2851, 2854 (1990) (recognizing the constitutional right of a competent person to refuse life-sustaining treatment; holding that a state may require clear and convincing evidence of an incompetent patient's wish to refuse the same).

a legislator led me to disagree with some of the positions taken there, the conference resulted in valuable contributions to the ongoing discussion of ethics committees, as the following articles and essays make clear, and in particular, shed new light on legal issues surrounding the committees.

The Symposium begins with a very useful article by Diane Hoffmann, a faculty member at this law school, in which she summarizes the results of her recent study of ethics committees in Maryland, the District of Columbia, and Virginia. Professor Hoffmann argues that rather than legislatively mandating ethics committees in hospitals, policy makers should simply regulate those ethics committees that emerge voluntarily in response to institutional needs. The Symposium continues with a commentary by Susan Wolf of the Hastings Center, in which she identifies conflicting functions of ethics committees and discusses the need for due process protections for patients' rights in ethics committee case consultations. Dr. John Fletcher of the University of Virginia Health Sciences Center, responding to Ms. Wolf's argument, agrees substantially but distinguishes between ethics committees and ethics programs. The ethics program is more broadly based within the institution and Dr. Fletcher argues that it could help prevent difficult consultations. Dr. Fletcher also places the ethics committee movement in its historical context and sketches a broad medical ethics policy agenda for the future. The Symposium closes with essays by Jonathan Moreno, who focuses on sources of trouble for ethics committees and concludes that legislatively mandating ethics committees is unwise, and by Dr. Gail Povar, who draws on her considerable experience teaching and as chairperson of the George Washington University Medical Center's ethics committee to confront the difficult question of how to gauge the success of an individual ethics committee.