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Institutional Ethics Committees: Should We Kill All the Lawyers? The Role of Lawyers on Hospital Ethics Committees

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I. INTRODUCTION

Lawyers who serve on hospital ethics committees frequently find themselves wondering what precisely the role of law is in resolving ethical dilemmas, how law affects the functioning of hospital ethics committees, and what non-lawyer colleagues on these committees think lawyers ought to be doing.

This article explores the role of lawyers on institutional ethics committees, and whether the presence of lawyers on institutional ethics committees affects the form or content of the committee's discourse or activities. This question, of course, immediately raises several normative questions: what is the purpose of institutional ethics committees, what do they do, where did they come from, and who selects the members?

The idea of asking a group of people not directly involved with a patient's care to advise the patient's physicians about ethical issues is a very recent phenomenon and is still in its adolescence.[1] But it is an awkward adolescence, without clear rules or direction. The "accepted wisdom" is that institutional ethics committees were established for the purpose of assisting physicians in resolving complicated ethical problems involving the care and treatment of patients within the healthcare institution.[2] Their decisions are, for the most part advisory. But despite the endorsement of the formal medical establishment,[3] they are frequently not welcomed within

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1. Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991).

2. AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, OPINION 9.11 - ETHICS COMMITTEES IN HEALTH CARE INSTITUTIONS (2010-2011), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion911.page.

3. *See, e.g.*, Sharon E. Caulfield, *Health Care Facility Ethics Committees New Issues In*

their own facilities. It is not clear why institutional ethics committees have evolved the way they have, as quasi-professional bodies composed chiefly of medically oriented members. An early example suggests what "might have been."

II. THE "BIRTH OF BIOETHICS": THE SEATTLE SWEDISH HOSPITAL "GOD COMMITTEE"

In 1961, Seattle Swedish Hospital's Artificial Kidney Center formed a proto-ethics committee, an Admissions and Policy Committee, to assist the medical staff make recommendations as to which patients should receive a then-new form of kidney dialysis which greatly expanded the number of patients who could benefit from receiving hemodialysis, far beyond the limited capacity of the hospital's center. The hospital created the committee in part to protect doctors from having to make these decisions about their own patients.

The committee, later termed the "God Committee," was composed of seven lay members – a lawyer, a minister, a housewife, a state government official, a banker, a labor leader, and a surgeon who served as a "doctor-citizen". It met every two weeks for four years. Journalist Shana Alexander received permission to attend some of the Committee's meetings and discussed their debates in a 1962 *Life* magazine article.[4] She said of the Committee "[t]hese seven citizens are in fact a Life or Death Committee. With no moral or ethical guidelines save their own individual consciences, they must decide, in the words of the Hebrew prayer, 'Who shall live and who shall die; who shall attain the measure of man's days and who shall not attain it; who shall be at ease and who shall be afflicted.' They do not much like the job."[5]

At the outset the Committee had to decide whether it should accept the recommendation of the kidney doctors at the hospital, that patients over forty-five and children should be excluded on the grounds that they were most likely to suffer other health problems that could compromise their dialysis – the committee did. Ultimately, the committee created its own list of criteria, an extensive list based upon age, sex, marital status and number of dependents, income, net worth, emotional stability, educational

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The Age Of Transparency, HUM. RTS., Fall 2007, at 10, 10 (citing the 1992 mandate of the Joint Commission – then the Joint Commission for the Accreditation of Healthcare Organizations ("JCAHO") – that healthcare facilities should have in place a mechanism for the consideration of ethical issues that arise in the course of patient care).

4. Shana Alexander, *Thirty Years Ago*, HASTINGS CTR. REP., Nov./Dec. 1993, at S5.

5. Shana Alexander, *They Decide Who Lives, Who Dies*, KIDNEY TIMES (Mar. 2011), http://kidneytimes.com/article_print.php?id=20110304143111.

background, occupation, past history and future potential, and names of people who could serve as references. The Committee also limited eligibility to residents of Washington State. Subsequent analysis of the Committee's selections over the four years showed that those with the best chance for acceptance by the committee were white middle aged, middle class men, not surprising since all members of the committee were middle class white men, with the exception of the "housewife" (who was married to a middle class white man).

The Committee struggled with how to determine the standards that should be employed in making its decisions.

> HOUSEWIFE: If we are still looking for the men with the highest potential of service to society, I think we must consider that the chemist and the accountant have the finest educational backgrounds of all five candidates.
> LAWYER: Both these men have made provisions so that their deaths will not force their families to become a burden on society.
> SURGEON: How do the rest of you feel about Number Three—the small businessman with three children? I am impressed that his doctor took special pains to mention that this man is active in church work. This is an indication to me of character and moral strength.
> HOUSEWIFE: Which certainly would help him conform to the demands of the treatment . . . .
> LAWYER: It would also help him endure a lingering death . . . .
> STATE OFFICIAL: But that would seem to be placing a penalty on the very people who have perhaps been most provident . . . .
> MINISTER: And both of these men have children too.
> LABOR LEADER: For the children's sake, we've got to reckon with the surviving parents opportunity to remarry, and a woman with three children has a better chance to find a new husband than a very young widow with six children.[6]

This is only a small fragment of the committee's deliberations, but it is unnerving. What was the committee's charge? Were they presented with a clear definition of ethical decision-making, or were they simply told to devise their own standards for determining eligibility? Were their recommendations advisory or determinative; in effect, did they have the authority of a jury? Was the patient or family involved in the committee's deliberations, and was there an opportunity for the patient or family to appeal the committee's decision, or to present evidence? Finally, it seems clear that only patients who had traditional support systems were considered; there were no patients who might need assistance from

6. *Id.*

surrogate or any form of long term care in order to continue their dialysis treatments.

What was the lawyer's role on this committee? He didn't "act like a lawyer;" he didn't raise issues one would expect a lawyer to raise. In fact, his comments might be said to have violated a lawyer's obligations as an officer of the courts, except that in this case the committee debates appear to have been more those like of a jury – confidential, only made public following the "verdict," due to the presence of a reporter.

The *Life* magazine article spawned an NBC television documentary, which highlighted the stories of some of the successful recipients.[7] A small town in Washington raised $30,000 for a young milkman. The "Bucks for Buddy" campaign included pancake breakfasts, bake sales, and a radio announcer's daily pitches for support. Another recipient, after discussing his dialysis, was asked if he knew what happened to the other applicants for the kidney machine. He replied, "'[O]nly two of us were accepted. . . . I don't know why [the others were rejected]—either for medical reasons or psychological reasons or [they] just didn't have the $30,000.'"[8] When asked if he knew what happened to the others, he replied, "They're dead."[9]

The "God Committee" has been disparaged; it was not really an ethics committee, but a rationing committee of laypersons, using social worth criteria to make its decisions. However, the outcome of the Seattle affair was not an immediate shift to institutional ethics committees, at least not with respect to disputes about end-of-life care and distribution of scarce medical resources. The outcome was a shift to rationing under a different guise. Perhaps in response to the negative reaction of the public, discussions about dialysis moved inside the institution to become less visible, often only among physicians, excluded laypersons (and lawyers) and became less specific about the process of and reasons for their decisions.[10] The facilities still considered personal details, but these became part of the medical judgment. The economically disadvantaged and those with an "unsavory" past were not considered a good risk for dialysis because they did not have the emotional support of stable families. Subsequent allocation methods included administration of IQ, personality, and vocational tests; lotteries (from a medically acceptable pool), and first-come first-served, premised upon the utilitarian principle of "maximizing outcome".[11]

The "God Committee" has frequently been cited as the case that led to

7. Sally T. Sanford, *What Scribner Wrought,* 13 RICH. J.L. & PUB. INT.337, 344 (2010).

8. *Id.* at 345.

9. *Id.*

10. Sally L. Satel & Benjamin E. Hippen, *When Altruism Is Not Enough: The Worsening Organ Shortage and What it Means for the Elderly*, 15 ELDER L.J. 153, 171 (2007).

11. *Id.*

the "birth" of ethics committees. It is also set off a chain of events that led to a significant advance in health law. The 1972 amendments to the Social Security Act created the End State Renal Disease Program, ending the need for decisions about allocation of dialysis technology and making dialysis universally available under Medicare, without consideration as to age, income or medical condition.[12]

With respect to the "birth" of "bioethics" and ethics committees, the credit falls somewhere between law, medicine and philosophy. Albert Jonsen suggests that it does not much matter, "[w]hether [the] birthday [of ethics committees] was November 9, 1962, the date of the *Life* article about the Seattle committee, or June 16, 1966, the day [Henry] Beecher's article on the ethics of research appeared in the [*New England Journal of Medicine*], or March, 31 1976, when the New Jersey Supreme Court rendered its decision *In the Matter of Karen Ann Quinlan*, all these events pushed medical ethics out of its past into its future."[13] Nor does it matter whether bioethics was conceived "in the inspiration that struck Dan Callahan and Will Gaylin in 1969 to start The Hastings Center and, almost simultaneously, struck Andre Hellegers to start the Kennedy Institute for Bioethics in Georgetown, the ideas for bioethics were waiting to be heard."[14]

III. FROM RATIONING COMMITTEES TO ETHICS COMMITTEES – NOT A GREAT LEAP

However, many people consider the New Jersey Supreme Court's decision in *In re Quinlan* to have given institutional ethics committees an official stamp of approval. Ethics committees began to move into the mainstream following that court's opinion. *Quinlan* involved a father's request to remove his daughter from life support, a young women whom all physicians agreed was in a permanent vegetative state following a drug overdose. The court held that Quinlan's father had the right to act as her surrogate decision maker and to direct the actions of her physicians. In its opinion, the court noted the years of contentious litigation and expressed its frustration at the lengthy adversarial process. It was "impossibly cumbersome" for the courts to be involved in patient care decision making, said the court, suggesting that an ethics committee within the health facility would more effectively and knowledgeably act as an alternative to the more

12. Social Security Amendment of 1972, Pub. L. No. 92-603, § 299I (1972).

13. Albert R. Jonsen, *The Birth of Bioethics*, HASTINGS CTR. REP., Nov./Dec., 1993, at S1, S3 (citing Henry Beecher, Special Article, Ethics and Clinical Research, N.Eng. J. Med., 24; 274, 1354-1360)

14. *Id.*

traditional probate court process.[15]

The *Quinlan* court recognized the failure of the adversarial process in ethical disputes over patient care. As courts often do, it is likely that the *Quinlan* court picked up on a nascent trend in medical society, a frustration with increasing disputes over medical decision-making, and the emergence of the field of medical ethics (the seminal work on the topic is *The Principles of Biomedical Ethics*[16] by Thomas Beauchamp and James Childress). As a result, institutional ethics committees have become nearly universal since *Quinlan*, and are now required by a number of official bodies.[17] The only membership requirement is diversity; members must come from a variety of disciplines and theoretical backgrounds, and must be representative of the local community.[18]

In 1998, over ninety percent of U.S. hospitals had ethics committees, compared to just one percent in 1983.[19] In many institutions, physicians have been unenthusiastic about the presence of ethics committees.[20] However, the American Medical Association Code of Ethics suggests that "[p]referably, a majority of the committee should consist of physicians, nurses, and other health care providers,"[21] and this is how most institutional ethics committees are composed at present, with most additional members also drawn from the facility – social workers, chaplains, and occasionally institution administrators.

Institutional ethics committees' duties have also evolved. Initially their duties primarily involved clinical consultation, advising treating physicians and families about treatment options and assisting in resolving disputes over patient treatment and care. Gradually they began to take on a policy function as well; to review and draft institutional policies that touch on issues of ethics, and more recently, to provide training in core ethics competencies to institutional committee members.[22] However, they struggle with somewhat incompatible goals – to make the process of consultation and consideration of ethical issues less adversarial and to bring tough

15. In re Quinlan, 355 A.2d 647 (N.J. 1976).

16. THOMAS BEAUCHAMP & JAMES CHILDRESS, THE PRINCIPLES OF BIOMEDICAL ETHICS (Oxford Univ. Press 2008) (1979).

17. PAT MILMOE MCCARRICK, ETHICS COMMITTEES IN HOSPITALS 1-2 (1992), *available at* http://bioethics.georgetown.edu/publications/scopenotes/sn3.pdf.

18. JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS 104 (1992).

19. Glenn McGhee et al., *A National Study of Ethics Committees*, AM. J. BIOETHICS, Fall 2011, at 60, 62.

20. Bernard Lo, *Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 N. ENG. J. MED. 46 (1987) ("The committee may feel attacked by various groups [including] attending physicians who fear that their power is being usurped.").

21. AMERICAN MED. ASS'N, *supra* note 2.

22. McGhee et al, *supra* note 19, at 60.

decisions into the open.

IV. THE ROLE OF LAWYERS

Lawyers have been members of institutional ethics committees from the beginning, although only a minority of institutional ethics committees has a lawyer as a member. Most are appointed as community members, although occasionally legal representatives of the institution or risk managers are members.

Despite the history, the role of law and lawyers on ethics committees has been controversial. Do (or should) lawyers bring a particular expertise to ethics committees, or should they behave like the lawyer on the Seattle "God Committee" – like just another member of the community? What role should lawyers play in the training of institutional ethics committee members?

For example, consider the following hypothetical dilemma. An institutional ethics committee in a community hospital was asked to give an advisory opinion about an experimental in vitro fertilization procedure proposed by a physician-owner of a local fertility clinic. The physician did not request the participation of the hospital; he simply wanted the input of the ethics committee as to what ethical issues he could expect. However, the description of the project was framed as a "proposal." The committee was composed of various members of the hospital staff including physicians, nurses, and a social worker, three community members, including a lawyer, and was chaired by two staff members – a physician and a hospital chaplain. It also had a paid ethics consultant. Prior to the meeting, the ethics consultant distributed a lengthy analysis of the fertility physician's proposal. The committee engaged in a lengthy discussion of the ethical issues, led by the ethics consultant, but the lawyer felt that there were significant legal issues as well, and wished to include those in the discussion.

What should the outcome be? The ethics consultant felt the purpose of the discussion was solely to address the ethical issues, and that the legal issues would divert attention from the serious ethical concerns. The lawyer felt that the committee needed to have all of the relevant information, legal as well as ethical, in order to address the issue in a coherent way.

This highlights a key conflict over how institutional ethics committees view their role in clinical ethics consultation – one that is exclusively ethical, regardless of individual members' disciplinary training, or one that draws on committee members' individual expertise as contributors to an ethical discourse and seeks multidisciplinary perspectives.

The emergence of professional bioethicists and ethics consultants have raised the bar for what constitutes training, as has the report defining the

Core Competencies for Health Care Ethics Consultation, initially adopted by the Association for Bioethics and Humanities in 2008 and revised in 2010.[23] The focus on core competencies shifted the direction of institutional ethics committee discourse in the direction of requiring that all members have formal training in ethics consultation. To its credit, the report does not take a position on whether professionally trained bioethics consultants, or institutional ethics committees should perform ethics consultations.[24]

The report defines the nature and goals of ethics consultation, the types of skills, knowledge and character traits important for conducting ethics consultations, and the special obligations of consultants.[25] Individuals engaged in healthcare ethics consultation ("HCEC") should be able to access, critically evaluate, and use relevant knowledge in the following concepts:

- Moral reasoning and ethical theory as it relates to HCEC
- Common bioethical issues and concepts that typically emerge in HCEC
- Health care systems
- Clinical context as it relates to HCEC
- The local health care institution in which the consultant (or committee member) works
- The local health care institution's policies relevant for HCEC
- The beliefs and practices of the local patient and staff population
- The relevant codes of ethics and professional conduct and guidelines of accrediting organizations; and
- Relevant health care law.[26]

There is little doubt that all, or at least most, institutional ethics committee members should have an effective grasp of the concepts contained in items two through eight. It is also likely that most institutional staff that serves on committees should receive basic training in these concepts, although many of them will already have a basic understanding. It is less clear whether the more esoteric concepts of moral reasoning and ethical theory require precise, explicit training, or whether patients and physicians may be better served when institutional committee members contribute the moral principles and ethical perspectives of their own

23. AM. SOC'Y FOR BIOETHICS & HUMANITIES, CORE COMPETENCIES FOR HEALTH CARE ETHICS CONSULTATION (2010).

24. Frederick Adolf Paola, *Law, Humanities and Equipoise in the Education of Physicians Assistants,* INTERNET J. ALLIED HEALTH SCI. & PRAC., Apr. 2006, at 1, 2, http://ijahsp.nova.edu/articles/vol4num2/paola.pdf.

25. AM. SOC'Y FOR BIOETHICS & HUMANITIES, *supra* note 23, at 22-33.

26. *Id.* at 27.

disciplines.

Looking at the three key functions of institutional ethics committees – clinical consultation, bioethics education, and policy development, lawyers have been involved in institutional policy development ever since institutions began to develop policies, since policies are generally reviewed by institutional legal staff before final approval. But does it make sense for lawyers to participate in policy-making or advising on policy through their participation on institutional ethics committees as well? All policies should comply with legal requirements relating to the topic under consideration, especially since many issues involve legislation, regulations, or official policies. If an institutional ethics committee is asked to assist the institution in drafting an institutional policy, for example a Physician Order for Life Sustaining Treatment ("POLST") form, what should be the role of a lawyer-member of the ethics committee? Institutional policies are generally reviewed by institution administration, often including an institution attorney, before final approval. What does the committee lawyer-member contribute that is different? Consider the other two functions of the institutional ethics committee – ethics consultation, and staff, and now, committee education. With respect to all three ethics committee functions, the lawyer-member can provide the basic knowledge of the law – one of the Core Competencies relevant to bioethics consultation (e.g., end-of life decision making, competency, informed consent, privacy).[27] Non-lawyers can acquire general legal knowledge; however, the lawyer-member has the advantage of recognizing that the law in its "black letter" context may interpret similar concepts differently.[28] Lawyers can explain how legal concerns might impact ethical analyses, not just "black-letter" law, but legal perspectives of ethical issues such as informed consent, confidentiality, and futility. The expanded framework can provide the committee with useful tools for ethical analysis.[29]

This argument frames the discourse in favor of including lawyers as community members on institutional ethics committees, and it suggests that it may not be wise to delegate all training of members of committee members to bioethics consultants, or to turn over all ethics consultation to professional ethics consultants. (Lawyers employed by the institution have different interests altogether).

The core competencies explicitly include education in relevant health care law as one of the competencies. Who should provide this education? Perhaps it is sufficient if some members of the committee (whether or not a

27. *Id.*

28. Amy L. McGuire et al., *The Ethics of Lawyer-Ethicists*, 33 J.L. MED & ETHICS 603, 605 (2005).

29. *Id.*

lawyer) take on this role. Or should only lawyers (whether committee members or not) be the "educator" whose role is to "teach" the non-lawyer members about the law and the legal issues involved in ethical decision-making? And it adds a further question – what should be the content of legal training?

The ethical principles of the Beauchamp and Childress trope are autonomy, nonmaleficence, beneficence, and justice.[30] The concept of "justice," for bioethicists, does not always mean due process for the patient, as that might create an adversarial relationship between patient and provider.[31] However, the point in the article cited above is not that the conflicting interpretations of due process (legal and ethical) are adversarial or that legal "due process" is not a "lawyerly enemy of the physician." The point is that legal and ethical due process, if it were possible to marry the two, are a tool to guarantee that the patient is heard.[32]

V. CONCLUSION

The above discussion suggests that lawyers are appointed to ethics committees to temper and to balance the tone of ethical discussions. Looking closely at the issues that ethics committees are struggling with today, ethical issues in health care have gradually been re-defined as legal issues. However, who is doing the defining? Does this make it easier or more difficult to make decisions about these controversies? And are these things that can be taught to non-lawyers? These questions affect both the design and functioning of ethics committees, as well how and who should train ethics committee members.

Institutional ethics committees have taken on a more significant role in the functioning of institutions since *Quinlan*, and have expanded to include, in addition to patient consultation, education – of institution staff and committee members, and institution policy development. Consultations are now a key component of bioethical issues in patient care, and the the Core Competencies have codified most of the skills necessary for a "good" ethicist." But not enough is known about what legal skills, or legal knowledge, are necessary, whether the skills can be taught, or whether a lawyer-ethicist can provide the training "on-site"? That is an issue crying out for research. In any event, the role of lawyers, still developing, will become more relevant, clear and important; ideally it will not be long before the "good" lawyer-ethicist will become widely accepted as an integral member of institutional ethics committees.

30. *See, e.g.*, BEAUCHAMP & CHILDRESS, *supra* note 16.
31. Wolf, *supra* note 1, at 858.
32. *Id.* at 806.