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HOSPITAL ETHICS COMMITTEES AS THE FORUM OF LAST RESORT: AN IDEA WHOSE TIME HAS NOT COME

ROBIN FRETWELL WILSON*

Hospital Ethics Committees have become a fixture in American medicine and are poised to become the forum of last resort for end-of-life decisions as a result of state statutes giving committees immunity and privilege. The effect of such legislation is to transform ethics committees from an adjunct to the courts into a substitute for them, without giving patients any of the process protections attendant to judicial decisionmaking. In this Article, Robin Fretwell Wilson provides a critical comparison of ethics committees to courts and concludes that contrary to the conventional wisdom of the ethics committee movement, it is unclear that hospital ethics committees are innately better suited to make end-of-life decisions than state and federal courts.

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In the twenty-one years since the New Jersey Supreme Court in *In re Quinlan*[1] seized upon medical ethics committees as a mechanism "to review the individual circumstances of ethical dilemma[s] and . . . provide[] . . . assistance and safeguards for patients and their medical

1. 355 A.2d 647 (N.J. 1976).

caretakers,"[2] ethics committees[3] have become a fixture in healthcare institutions in the United States.[4] Comprised of physicians, nurses, hospital administrators, ethicists, clergy members, lawyers, and community representatives,[5] ethics committees are charged, among

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2. *Id.* at 668 (citing Karen Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 9 (1975)).

3. An ethics committee is a "[c]onsultative committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients and families regarding difficult ethical decisions." OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY 444 (1987); *see also* Ronald E. Cranford & A. Edward Doudera, *The Emergence of Institutional Ethics Committees*, *in* INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 5, 6 (Ronald E. Cranford & A. Edward Doudera eds., 1984) [hereinafter INSTITUTIONAL ETHICS COMMITTEES] (defining an ethics committee as a "multidisciplinary group of health care professionals within a health care institution").

4. While this Article argues that perceived judicial shortcomings constitute the primary motivation for the adoption and use of ethics committees, *see infra* notes 59-76 and accompanying text, the exponential increase in ethics committees has been linked to a number of causes. Professor McCormick identifies eight cultural variables and social conditions as the impetus for establishing ethics committees, including the growing complexity of medical problems and the range of options available for treatment. *See* Richard A. McCormick, *Ethics Committees: Promise or Peril?*, 12 LAW, MED. & HEALTH CARE 150, 150-52 (1984). Professors Fletcher and Hoffmann trace the development of hospital ethics committees to federal laws mandating institutional review boards for the protection of human subjects in scientific research. *See* John C. Fletcher & Diane E. Hoffmann, *Ethics Committees: Time to Experiment with Standards*, 120 ANNALS INTERNAL MED. 335 (1994). Professor Capron traces the early growth in ethics committees to the 1984 Child Abuse Amendments, 42 U.S.C. §§ 5101-5106 (1994), known commonly as the "Baby Doe regulations." *See* Alexander Capron, *Legal Perspectives on Institutional Ethics Committees*, 11 J.C. & U.L. 417, 423 (1985). Professor Hoffmann identifies three external motivating factors for the development of ethics committees: the *Quinlan* case, the President's Commission Report, and the Baby Doe regulations, each of which is discussed more fully throughout this Article. *See* Diane E. Hoffmann, *Evaluating Ethics Committees: A View from the Outside*, 71 MILBANK Q. 677, 677-78 (1993); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) [hereinafter PRESIDENT'S COMM'N REP.]; Child Abuse Amendments, 42 U.S.C. §§ 5101-5106 (1994); *see also supra* notes 1-2 and accompanying text (discussing *In re* Quinlan); *infra* note 16 and accompanying text (discussing PRESIDENT'S COMM'N REP., *supra*); *infra* note 17 and accompanying text (discussing Baby Doe regulations).

5. The professional composition of a medical ethics committee may be prescribed by state law. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. II § 19-372(a) (1996) (requiring inclusion of a physician and nurse not directly involved in the care of the patient, a social worker, and a hospital representative, while also permitting community representatives, ethical advisers, and clergymen as committee members). Typically, ethics committees are composed of physicians, nurses, other healthcare professionals such as social workers, hospital administrators, attorneys, and community representatives. *See* Diane E. Hoffmann, *Regulating Ethics Committees in Health Care Institutions—Is It Time?*, 50 MD. L. REV. 746, 759 (1991) (reporting that 100% of ethics committees surveyed in Maryland contained at least one physician, 98% had at least one registered nurse, 96% included a social worker, and 86% included a hospital administrator or designee); Andrew L.

other tasks,[6] "with discussing or resolving ethical dilemmas" that arise in the healthcare context.[7] Such dilemmas may arise when a patient who is unable to express her wishes is terminally ill or permanently unconscious and a dispute arises about the continuation or termination of life-support.[8] Although less than one percent of

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Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1246 n.36 (1987) (citing survey finding 62% of ethics committees contained attorneys).

6. The functions of an ethics committee may be defined by state law. *See, e.g.*, HAW. REV. STAT. § 663-1.7 (1993) (designating the functions of an ethics committee to include consultation, education, review, and decisionmaking). The four most common tasks that ethics committees undertake are education of hospital staff and patients about medical ethics, providing a forum for the discussion of medical ethics issues, participating in institutional policy development on ethical issues, and case consultation. *See* Robin Fretwell Wilson et al., *Hospital Ethics Committees: Are They Evaluating Their Performance?*, 5 HOSP. ETHICS COMMITTEE F. 1, 4 (1993). This Article is concerned with the fourth task—the most controversial function—case consultation, which consists of ethics committee "participation in individual patient care decisions." Robert M. Veatch, *The Ethics of Institutional Ethics Committees*, *in* INSTITUTIONAL ETHICS COMMITTEES, *supra* note 3, at 35, 42; *see also* David C. Thomasma, *Hospital Ethics Committees and Hospital Policy*, QUALITY REV. BULL., July 1985, at 204, 204 ("[P]erhaps the most important and most problematic role of the hospital ethics committee is consultation.").

7. Randall B. Bateman, *Attorneys on Bioethics Committees: Unwelcome Menace or Valuable Asset?*, 9 J.L. & HEALTH 247, 248 (1995). An ongoing controversy exists over whether ethics committees act only in an advisory capacity or whether in fact they wield greater power. *See* Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 820 (1991); *see also infra* note 39 and accompanying text (reviewing arguments that ethics committees act as ultimate decisionmakers). The possibilities for committee participation in ethical dilemmas are fourfold, as indicated in the diagram below. In the optional consultation/optional (non-binding) recommendation and the mandatory consultation/optional (non-binding) recommendation categories, committees act in a purely advisory role. In contrast, in the optimal consultation/mandatory (binding) recommendation and the mandatory consultation/mandatory (binding) recommendation categories, committees act as final decisionmakers for treatment disputes.

Ethics Committees as Decisionmakers[a]		
Required review by ethics committee?	Weight accorded committee recommendation: Optional (non-binding)	Weight accorded committee recommendation: Mandatory (binding)
Optional	advisor	decisionmaker
Mandatory	advisor	decisionmaker

a. *See* John A. Robertson, *Committees as Decision Makers: Alternative Structures and Responsibilities*, *in* INSTITUTIONAL ETHICS COMMITTEES, *supra* note 3, at 85.

8. *See* Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 827-28 (1994). Other disputes that arise include disputes over whether a patient is brain dead and disputes over specific types of life-sustaining treatment, such as ventilatory support or artificial nutrition and hydration. *See id.* at 828.

hospitals in the United States had an ethics committee in 1983,[9] today eighty-four percent of large American hospitals have established such committees.[10] Indeed, hospital ethics committees are so ingrained in American medicine that they have become a part of popular culture. Ethics consultations, for example, are routinely depicted on popular television series such as "ER"[11] and "Chicago Hope"[12] and have figured prominently in the bestsellers *First, Do No Harm*[13] and *The Long Dying of Baby Andrew.*[14]

Fueling the acceptance of hospital ethics committees are numerous regulatory bodies and professional associations that have embraced ethics committees as a way to "avoid cumbersome court procedures and unwieldy litigation."[15] The President's Commission for the Study of Ethical Problems in Biomedical and Behavioral Research ("President's Commission") led the way in 1983 with its recommendation that healthcare institutions "explore and evaluate various ... administrative arrangements for review and consultation,

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9. *See* Stuart J. Youngner et al., *Patients' Attitudes Toward Hospital Ethics Committees*, *in* INSTITUTIONAL ETHICS COMMITTEES, *supra* note 3, at 73, 82.

10. *See* AMERICAN HOSP. ASS'N, HOSPITAL STATISTICS 212 (1994) (representing hospitals with at least 200 beds). The steady growth in the incidence of ethics committees is readily apparent. While ethics committees were almost non-existent in 1983, *see supra* text accompanying note 9, a 1985 survey found that 60% of large hospitals had institutional ethics committees, *see Ethics Committees Double Since '83: Survey*, HOSPITALS, Nov. 1, 1985, at 60, 64 (citing incidence of ethics committees in hospitals with at least 200 beds). As noted above, this figure increased to 84% by 1994.

Studies have found that 59% of nursing homes and long-term care institutions have an ethics committee. *See* American Ass'n of Homes & Servs. for the Aging, 1997 Ethics Involvement in Aging Servs. Survey 7 (unpublished results on file with the *North Carolina Law Review*) (finding that by 1997, 59% of nursing homes had established an ethics committee). The enormous growth in the number of ethics committees also occurred in long-term care institutions. Whereas 59% of such institutions now have an ethics committee, as recently as 1988 only 8% of long-term care facilities had an ethics committee. *See* Gary Glasser et al., *The Ethics Committee in the Nursing Home: Results of a National Survey*, 36 J. AM. GERIATRICS SOC'Y 150, 151 (1988) (finding that 8% of respondents had established a committee).

11. Telephone Interview with Brian Gabriel, Writer Assistant, *ER* (Sept. 23, 1997).

12. Telephone Interview with Dana Anderson, Researcher, *Chicago Hope* (Sept. 5, 1997).

13. LISA BELKIN, FIRST, DO NO HARM: A SUMMER OF LIFE AND DEATH DECISIONS AT A TEXAS HOSPITAL (1993) (chronicling the inner workings of the medical ethics committee at Hermann Hospital in Houston, Texas).

14. ROBERT STINSON & PEGGY STINSON, THE LONG DYING OF BABY ANDREW (1983) (describing ethics committee participation in parents' decision to withdraw life-sustaining care from their infant son).

15. Janet Fleetwood & Stephanie S. Unger, *Institutional Ethics Committees and the Shield of Immunity*, 120 ANNALS INTERNAL MED. 320, 320 (1994) (quoting from the abstract of the article).

such as 'ethics committees,' particularly for decisions that have life and death consequences."[16] The President's Commission's recommendation was quickly followed by endorsements by the Department of Health and Human Services,[17] the American Medical Association,[18] the American Nurses Association,[19] the American Hospital Association,[20] and other professional medical organizations.[21] Most significantly, the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO"), an accrediting organization that is influential in determining a hospital's ability to participate in Medicare,[22] mandated in 1992[23] that healthcare organizations address ethical issues in providing patient care.[24] This standard commonly is satisfied by a hospital ethics committee.[25]

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16. PRESIDENT'S COMM'N REP., *supra* note 4, at 5.

17. *See* Guidelines Relating to Health Care for Handicapped Infants, 45 C.F.R. § 84 app. C (1996) (encouraging hospitals to establish "infant care review committees" to review cases involving the withholding of life-sustaining treatment of newborns).

18. *See* Judicial Council, *Guidelines for Ethics Committees in Health Care Institutions*, 253 JAMA 2698-99 (1985) (suggesting procedures for ethics committee review).

19. *See* AMERICAN NURSES ASS'N, CODE FOR NURSES WITH INTERPRETATIVE STATEMENTS 7 (1985) (exhorting nurses to "participate in the ... establishment[,] ... of review mechanisms that serve to safeguard clients," such as duly established ethics committees).

20. *See* AMERICAN HOSP. ASS'N, GUIDELINES: HOSPITAL COMMITTEES ON BIOMEDICAL ETHICS, *reprinted in* JUDITH WILSON ROSS ET AL., HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 110, 110-11 (1986) (suggesting procedures for ethics committee review).

21. *See generally* James E. Strain, *The American Academy of Pediatrics Comments on the "Baby Doe II" Regulations*, 309 NEW ENG. J. MED. 443 (1983) (endorsing use of "infant care review committees" in medical decisionmaking for infants).

22. *See* 42 U.S.C. § 1395bb(a)(1) (1994) (establishing the effect of JCAHO accreditation). Medicare payments for inpatient hospital care totaled approximately $87 billion in fiscal year 1997 and are projected to climb to $94 billion in 2002. *See* Eric Weissenstein, *Budget Bill a Mixed Bag: Providers Criticize Spending Cuts, Back Medicare Reforms*, MOD. HEALTHCARE, Aug. 4, 1997, at 6, 6. Medicare and Medicaid payments accounted for 30.8% of the total healthcare spending in the United States in 1993, making Medicare participation critical for a hospital's fiscal solvency. *See* Mary Onnis Waid, *Health Care Financing Administration, Brief Summaries of Title XVIII of the Social Security Act* (last modified June 24, 1995) <http://www.netreach.net/~wmanning/medicare.htm#Background>.

23. *See* Matthew D. Jenkins, *Hospital Ethics Committees: Creation and Purposes*, *in* PRESENTATIONS OF THE 1992 CONFERENCE OF THE AMERICAN ACADEMY OF HOSPITAL ATTORNEYS 1 (1992) (describing the JCAHO requirement as a watershed in the development of hospital ethics committees).

24. *See* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., 1995 COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS 66 (1995) (discussing Standard RI.1 for accreditation, which requires a "functioning process to address ethical issues").

25. *See id.* (stating that "[p]atient rights mechanisms may include a variety of implementation strategies; for example, established ethics committees, the use of a

Also fueling the spread of ethics committees are various state statutes and regulations. Two states, Maryland[26] and New Jersey,[27] require healthcare institutions to establish ethics committees.[28] Arizona permits an attending physician in the absence of a surrogate to make healthcare decisions for a patient after she consults with an ethics committee,[29] while Hawaii grants full decisionmaking authority in patient care to an ethics committee.[30]

Courts also have welcomed the use of ethics committees. For example, Judge Miner, writing for the Second Circuit, suggested that a state might "require the establishment of local ethics committees as resources for physicians" in order to deal with such difficult questions as physician assisted suicide.[31] Similarly, the D.C. Court of Appeals has "urge[d] the establishment—through legislation or otherwise—of

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formalized ethics forum, ethics consultations, or any combination of these or other methods"). JCAHO's accreditation requirement may hasten the advent of an ethics committee in *every* hospital receiving federal funds. *See* Jenkins, *supra* note 23, at 1. Professors Fletcher and Hoffmann have observed, however, that JCAHO's " 'notably vague' requirement allows for vast diversity among institutions to address ethical issues in patient care." Fletcher & Hoffmann, *supra* note 4, at 335. By implication, the requirement may *not* give rise to an ethics committee or consulting service in *each* JCAHO-accredited institution. *See id.*

26. *See* MD. CODE ANN., HEALTH-GEN. II §§ 19-371 to -374 (1996) (requiring all licensed nursing homes and hospitals to have a "patient care advisory committee").

27. *See* N.J. ADMIN. CODE tit. 8, § 43G-5.1(h) (1997) (requiring licensed hospitals to have either an ethics committee or a "prognosis" committee). In contrast to a medical ethics committee, a prognosis committee fulfills an essentially medical function. A prognosis committee is assigned the task of agreeing or disagreeing with the responsible attending physician's determination "that there is not reasonable possibility of [a patient] ever emerging from ... [a] comatose condition to a cognitive, sapient state." *In re* Quinlan, 355 A.2d 647, 671 (N.J. 1976) (discussing the role of a "prognosis committee"); *cf.* notes 3 and 6 and accompanying text (discussing the purpose and functions of medical ethics committees).

28. A third state, New York, has considered legislation that would make ethics committees mandatory for healthcare institutions. *See* Fletcher & Hoffmann, *supra* note 4, at 335. On a national level, Senate Bill 1766 would have required all healthcare institutions or programs in the United States that received Medicare and Medicaid payments in the United States to establish an ethics committee. *See* S. 1766, 101st Cong. (1989).

29. *See* ARIZ. REV. STAT. ANN. § 36-3231 (West Supp. 1996) (permitting a healthcare provider to consult with and obtain the recommendations of an institutional ethics committee when a surrogate is unavailable).

30. *See* HAW. REV. STAT. § 663-1.7 (1993) (designating the functions of an ethics committee to include decisionmaking).

31. *See* Quill v. Vacco, 80 F.3d 716, 731 n.4 (2d Cir. 1996), *rev'd on other grounds*, 117 S. Ct. 2293, 2302 (1997); *see also* Severns v. Wilmington Med. Ctr., Inc., 421 A.2d 1334, 1349-50 (Del. 1980) (suggesting that ethics committees can assist in evidentiary hearings); *In re* Jobes, 529 A.2d 434, 463-64 (N.J. 1987) (Pollack, J., concurring) (arguing that ethics committees can assist family members and healthcare professionals in making end-of-life decisions for incapacitated patients).

another tribunal to make [life-and-death] decisions, with limited opportunity for judicial review."[32] Other courts have suggested that an affirmation by an ethics committee of a family's decision to withdraw life support would serve as persuasive evidence on certain legal questions[33] or, more dramatically, eliminate the need for judicial approval.[34]

The central driving force behind this wholehearted embrace of ethics committees by courts, legislators, and healthcare professionals is a single, fiercely held, but *untested* assumption: that the resolution of conflicts by ethics committees "avoid[s] cumbersome court procedures and unwieldy litigation."[35] According to conventional wisdom, 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."[36] Taking up this mantra, several commentators have asserted

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32. *In re* A.C., 573 A.2d 1235, 1237 n.2 (D.C. 1990).

33. *See, e.g., In re* Spring, 405 N.E.2d 115, 122 (Mass. 1980) (concluding that the opinion of ethics committee may be persuasive evidence of good faith and good medical practice); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 434-35 (Mass. 1977) (permitting court to consider findings of ethics committees on questions of foregoing life-sustaining treatment); *In re* Guardianship of L.W., 482 N.W.2d 60, 73-74 (Wis. 1992) (holding that a guardian should request review by an ethics committee and consider its opinion in determining the patient's best interest).

34. *See In re* Conservatorship of Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (discussing termination of life support from a patient in a persistent vegetative state). Legislation proposed in at least one state would have permitted ethics committee determinations to substitute for judicial review. *See* Hoffmann, *supra* note 5, at 750 & n.18 (citing Health Law Section of the Maryland State Bar Association, Proposed Amendments to the H.G. § 20-107: Individuals Who Are Terminally Ill or in a Persistent Vegetative State (Nov. 6, 1990)).

35. Fleetwood & Unger, *supra* note 15, at 320 (quoting from the abstract of the article).

36. Janet E. Fleetwood et al., *Giving Answers or Raising Questions?: The Problematic Role of Institutional Ethics Committees*, 15 J. MED. ETHICS 137, 138 (1989); *see also* American Acad. of Pediatrics, *Guidelines on Forgoing Life-Sustaining Medical Treatment*, 93 PEDIATRICS 532, 533 (1994) ("Recourse to the courts should be reserved for occasions when adjudication is clearly required by law or when concerned parties have disagreements that they cannot resolve, despite appropriate consultation, concerning matters of substantial importance."); Fleetwood & Unger, *supra* note 15, at 321 (stating that immunity statutes "support the public's interest in keeping personal, private decisions out of courts, which may be slow, expensive, and insensitive to the values at stake"); Jill Hollander, *Health Care Proxies: New York's Attempt to Resolve the Right to Die Dilemma*, 57 BROOK. L. REV. 145, 171 (1991) ("[T]he judiciary is not the proper forum for resolving these types of cases, as these cases necessarily have serious time-constraints, and involve complex issues, both medical and social, that are better left to those with more expertise in the area."); John J. Paris & Frank E. Reardon, *Ethics Committees in Critical Care*, 2 CRITICAL CARE CLINICS 111, 113 (1986) ("When asked to make actual treatment decisions, the courts are acutely aware of their limitations and lack

that committees are a viable alternative to inefficacious judicial involvement.[37]

Until recently, however, an essential corollary to this well-accepted assumption was that ethics committees properly function as an *adjunct* to the courts,[38] performing concurrent case review that

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of clinical experience."); Steven M. Richard, *Someone Make up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference*, 64 NOTRE DAME L. REV. 394, 414 (1989) ("Judicial review of cases involving the withholding of medical treatment has proven to be an expensive, time consuming, and indeterminate process."); Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Non-Autonomous Patients: Ethical Standards and Legal Liability for Physicians After* Cruzan, 264 JAMA 1846, 1848 (1990) ("The judicial system is too expensive, time consuming, and cumbersome for dealing with the personal matter of deciding whether to terminate life-sustaining treatment.").

37. Most notably, the President's Commission stated:

> The Commission believes that ethics committees ... can be more rapid and sensitive than judicial review: they are closer to the treatment setting, their deliberations are informal and typically private (and are usually regarded by their participants as falling within the general rules of medical confidentiality), and they are able to reconvene easily or delegate decisions to a separate group of members.

PRESIDENT'S COMM'N REP., *supra* note 4, at 168-69. Similarly, Professor Levine noted that "committees ... may avoid unnecessary recourse to litigation by aiding in the resolution of disagreements." Carol Levine, *Questions and (Some Very Tentative) Answers About Hospital Ethics Committees*, HASTINGS CTR. REP., June 1984, at 9, 10. Professors White and Fletcher concluded that "internal review [by an ethics committee or ethics consultation service] is preferable to judicial review." Margot L. White & John C. Fletcher, *The Patient Self-Determination Act: On Balance, More Help than Hindrance*, 266 JAMA 410, 411 (1991). Professor Scott found ethics committees particularly beneficial for patient's families, stating that "[a] less costly and less intrusive alternative [to judicial review] would be review by a committee modeled on a hospital ethics committee." Elizabeth S. Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L.J. 806, 852-53. According to Professor Scott, "[t]he rigorous procedural and substantive requirements under current law [which include mandatory judicial review] impose formidable costs on the family, in terms of money, time expended, and psychological stress." *Id.* at 855. In addition, "parents seeking sterilization will have to hire an attorney to pursue their objective. They have to pay for mental health evaluations and will often be forced to miss time from work." *Id.* at 856; *see also* DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE 255, 256 (1991) ("At the least, ethics committees may obviate the need to go to court .... [C]ommittees may also operate without paying scrupulous attention to the letter of the law or by finding a loophole that will sanction their recommendation."); Michael Vitiello, *On Letting Seriously Ill Minors Die: A Review of Louisiana's Natural Death Act*, 31 LOY. L. REV. 67, 82 (1985) (quoting President's Commission's statement that ethics committees can be more rapid and sensitive than judicial review, *see* PRESIDENT'S COMM'N REP., *supra* note 4, at 168-69).

38. *See, e.g.*, Hollander, *supra* note 36, at 171 (concluding that "the ultimate decision-making responsibility" should probably remain with the courts); Susan M. Wolf, *Toward a Theory of Process*, 20 LAW, MED. & HEALTH CARE 278, 286 (1992) ("One corollary of respect for patient autonomy will be that the ethics committee should remain entirely advisory.... At most, the committee should help trigger a judicial determination.").

may in turn be reviewed by a court.[39] As a result of legislation recently passed by a number of states granting privilege and immunity to ethics committee members and physicians who implement committee recommendations, the historical interrelationship between the courts and hospital ethics committees is beginning to change. In states such as Arizona,[40] Hawaii,[41]

39. An ongoing controversy exists over whether ethics committees do decide and should decide cases or merely act in an advisory capacity. One position is that "the use of [ethics] committees ... is purely optional and the role of committees is solely advisory." Hoffmann, *supra* note 5, at 746 n.1. A contrary position maintains that "[t]oday's ethics committees ... often command greater notice and their recommendations may be seen as more binding." Karen Ritchie, *When It's Not Really Optional*, HASTINGS CTR. REP., Aug.-Sept. 1988, at 25; *see also* Diane E. Hoffmann, *Does Legislating Hospital Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia*, 19 LAW, MED & HEALTH CARE 105, 115 (1991) (reporting that 42% of respondents in survey of hospital staff in five Maryland hospitals "thought that the role of the [hospital ethics] committee was to *decide* ethical issues"). Taking a middle ground, Professor Wolf suggests that "committees partake of both [consultation and actual adjudication], pursuing sometimes one and sometimes the other.... One minute the [committee] members will see the group as a committee advising caregivers; the next minute they will see it as a body for resolving or actually deciding treatment disputes." Wolf, *supra* note 7, at 820. This "double identity," Professor Wolf believes, arises from the fact that ethics committees "serve two masters"—patient and institution. *Id.*

Professor Wolf persuasively argues that the precise model under which a committee operates will vary from committee to committee and perhaps, for a given committee, from case to case, depending not only on the committee's changing understanding of its own role, but also on the weight accorded to the committee's recommendations by physicians, patients, and institutional actors. *See id. passim*; *see also* Robertson, *supra* note 7a., at 88 (discussing four different possibilities for committee participation in ethical dilemmas). Clearly, however, where a committee's recommendation is binding on healthcare providers and families that consult with the ethics committee (whether as a result of hospital policy or mutual agreement), the committee acts as the ultimate decisionmaker. *See* Wolf, *supra* note 7, at 821.

But even if a particular committee has authority only to give advice, the grant of statutory immunity for actions taken in reliance on committee advice may effectively make the committee the final decisionmaker. That is, if a healthcare professional would be subject to possible liability if she did not follow the committee's advice, but would be immune for following such advice, she would be very hesitant *not* to follow the committee's advice. Put another way, the healthcare professional will seek the comfort and security of the "safe harbor" created by the grant of immunity.

40. *See* ARIZ. REV. STAT. ANN. § 36-3231 (West Supp. 1996) (providing healthcare professionals immunity from criminal and civil liability, as well as professional discipline, if healthcare provider's actions or refusals to act are made in good faith reliance upon the advice of the committee).

41. *See* HAW. REV. STAT. § 663-1.7 (1993) (granting civil immunity for ethics committee members, for any person who files a complaint, and for any committee witness before the committee for any acts done in the furtherance of the committee's purpose, so long as the action is without malice). Professors Fleetwood and Unger contend that this statute provides broad legal protection for physicians who implement a committee's recommendations. *See* Fleetwood & Unger, *supra* note 15, at 320.

Maryland,[42] and Montana,[43] which now grant immunity from civil or criminal liability to members of ethics committees or healthcare providers who rely on committee advice,[44] disputes considered by an ethics committee are increasingly unlikely to be reviewed substantively by a court. As a result, ethics committees are transformed from an adjunct to the judiciary into a *forum of last resort.*[45] Also problematic are privilege statutes such as those in

42. *See* MD. CODE ANN., HEALTH-GEN. II § 19-374 (1996) (granting immunity to the committee, its members, and those who assisted in the committee's establishment from liability arising from advice given in good faith and providing that there will be no liability for the failure to carry out the advice of the committee if it is inconsistent with the hospital's written policies).

43. *See* MONT. CODE ANN. § 37-2-201 (1995) (granting immunity to medical ethics review committee members if their recommendation is made without malice and in the reasonable belief that the recommendation is warranted by the information known to them after a reasonable effort to obtain the necessary facts, and providing that the proceedings and records of the committee are not subject to discovery or introduction into evidence).

44. Significantly, immunity may be available to ethics committees and their members under state surrogate decisionmaking or advance directive statutes. *See, e.g.*, Kate McMillan, *Pre-Directives: Paper Swords and Shields*, ADVOCATE: IDAHO ST. B., May 1994, at 10, 10 (noting that Idaho's Medical Consent Act, IDAHO CODE §§ 39-4301 to -4306 (1993), "affords blanket civil immunity to surrogate decision makers").

A 1992 proposal of the New York State Task Force on Life and the Law would have given the advice of an ethics committee similar protection. *See* THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY app. at 266 (1992) ("No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring in good faith a health care decision made pursuant to this article ...."). The Model Bill to Establish Hospital Ethics Committees, presented in the President's Commission Report, *see* PRESIDENT'S COMM'N REP., *supra* note 4, at 439, also embraced a presumption in favor of immunity for doctors implementing difficult treatment decisions. *See id.* at 441. It provided that "[t]he hospital staff, administration, and the responsible physician shall have the benefit of a presumption of freedom from civil and criminal liability for their actions taken in accordance with the committee's recommendation. Proof of gross negligence or wilfull [sic] disregard of the patient's interests overcomes this presumption." *Id. But see* Fleetwood & Unger, *supra* note 15, at 320 (discussing New Jersey's Commission on Legal and Ethical Problems in the Delivery of Health Care that rejected statutory protection for individuals who follow a committee's advice, but which lost its funding before a legislative proposal could be drafted).

45. As Fleetwood & Unger explain, "[immunity statutes] provide that persons who comply with the legislation and carry out activities as mandated by the statute may not be found civilly or criminally liable for any breach of personal interests resulting from compliance." Fleetwood & Unger, *supra* note 15, at 321. Concededly, these immunity statutes do not grant absolute immunity. *See* 2 SHELDON H. NAHMOD, CIVIL RIGHTS AND CIVIL LIBERTIES LITIGATION: THE LAW OF SECTION 1983 § 7.01, at 3 (3d ed. 1991) (describing the grant of absolute immunity to judges, prosecutors, and legislators under 42 U.S.C. § 1983 (1994)). Qualified immunity nonetheless insulates committee proceedings from judicial oversight in three ways. First, if there is no question of fact regarding the good faith of the committee or healthcare provider, the committee or provider will prevail

Maryland[46] and Montana,[47] which insulate the records of ethics committees. In addition to these emerging statutes, existing state statutes designed to protect tissue utilization, peer review, and other healthcare committees have been interpreted to shield ethics committees.[48] Such statutes "protect [committee] proceedings against

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on summary judgment. *See* Bryan v. James E. Holmes Reg. Med. Ctr., 33 F.3d 1318, 1333-34 (11th Cir. 1994). Second, when there is a question of fact for the jury regarding good faith, the leeway granted by the defense of qualified immunity encompasses an enlarged realm of acceptability, insulating what may in hindsight be viewed as negligence. *See, e.g.*, 2 NAHMOD, *supra*, § 8.04, at 116 (noting a significant margin of error for defendants under § 1983, which imposes a good faith requirement upon governmental actors who receive qualified immunity). Third, the "most meaningful effect of the immunity provisions may be the allowance of attorney's fees in frivolous cases," which act as a "useful deterrent to cases that are filed merely to delay proceedings or to intimidate [committee] members." *The Problem of Good Faith* (visited Sept. 9, 1997) <http://plague.law.umkc.edu/xfiles/x531.htm> (making this observation about immunity for peer review committees); *see also* Clark C. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1161 (1986) (noting that statutory immunity for peer review activities under the Health Care Quality Improvement Act of 1986 "may serve to deter some lawsuits.... [Because] the statute raises the plaintiff's stakes in the litigation by a fee-shifting provision"). Further frustrating the plaintiff's likelihood of success is the grant of privilege to ethics committee records and proceedings. *See infra* notes 46-51, 196-99, and 208-13 and accompanying text (discussing impact of privilege statutes on judicial redress).

Of course, statutes providing privilege and immunity do not prohibit injunctive relief. Thus, patients or families who are unhappy with the decision made by their provider or the ethics committee could still go to court for injunctive relief mandating treatment or withdrawal of treatment. In this instance, the ethics committee, strictly speaking, is not a forum of last resort. Where, however, courts give deference to an ethics committee's determination, or permit the committee's determination to substitute for judicial review, the ethics committee will effectively be the final decisionmaker. *See supra* notes 31-34 and accompanying text (discussing limits on judicial review suggested by courts). Similarly, where patients and their families lack the time, financial resources, or sophistication to go to court for injunctive relief, the ethics committee will functionally be a court of last resort. *See supra* note 39 and accompanying text (reviewing arguments that ethics committees act as ultimate decisionmakers); *infra* note 73 and accompanying text (observing that patients frequently die before their rights to reject treatment are vindicated in court). I am indebted to Professor Peters of the University of Missouri - Columbia School of Law for pointing out the possibility of injunctive relief.

46. *See* MD. CODE ANN., HEALTH-GEN. II § 19-374(e) (1996) (extending to advisory committees the protections afforded medical review committees under another section of the Maryland Code, *see* MD. CODE ANN., HEALTH OCC. § 14-501 (1994), which makes the proceedings, records, and files of a medical review committee confidential and not admissible or discoverable).

47. *See* MONT. CODE ANN. § 37-2-201(2) (1995) (stating that "[t]he proceedings and records of ... medical ethics review ... committees are not subject to discovery or introduction into evidence in any proceeding").

48. *See, e.g.*, Dade County Med. Ass'n v. Hlis, 372 So. 2d 117, 119 (Fla. Dist. Ct. App. 1979) (holding reports of ethics committees protected, even though they would not be protected under a literal interpretation of the statute). Numerous commentators have suggested that medical ethics committees may fall within the ambit of state peer review statutes. *See, e.g.*, Marta Fisher Linenberger, *Hospital Ethics Committees in Kansas*, J.

discovery, prohibit disclosure of what transpired at committee meetings, and exclude testimony or documents relating to the committee's actions from evidence in court proceedings."[49] This "privilege" frustrates judicial review of committee actions, erecting "a major obstacle to patients' suits against doctors or hospitals"[50] by making a committee's wrongdoing or neglect unobservable and therefore nearly impossible to substantiate in litigation.[51]

By shutting off access to the courts, statutes that grant immunity or insulate against discovery effectively anoint the ethics committee (or healthcare provider who consults with the committee) as the final arbiter of the patient's fate.[52] This is not to say that state efforts to immunize and grant privilege to ethics committees are without their benefits. Indeed, the virtue is striking and obvious to any ethicist, healthcare provider, layperson, or attorney who has served—generally without pay—on an ethics committee or participated in an ethics committee consultation. The benefits do not alter, however, the fundamental effect of privilege and immunity statutes: to recast ethics committees as the final forum for end-of-life decisions.

This Article attempts to take a step backward and examine what

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KAN. B. ASS'N, Dec. 1994, at 43 (noting that if an ethics committee in Kansas is constituted as a committee of the medical staff, state law "may insulate the committee's actions provided the actions are in good faith and without malice"). *But see* B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 153 (1984) (suggesting that because "courts have been very literal in interpreting [existing] peer review statutes," new state or federal legislation may be necessary to protect ethics committees).

49. Merritt, *supra* note 5, at 1252.

50. Goldberg, *supra* note 48, at 155; *see also* Fleetwood & Unger, *supra* note 15, at 321 (stating that "immunity provisions for health care professionals who follow advice from ethics committees ... *support the public's interest in keeping personal, private decisions out of courts*" (emphasis added)).

51. *See* Goldberg, *supra* note 48, at 166 & n.84 (citing Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1462-63 (1980)); *see also* Merritt, *supra* note 5, at 1253 ("Without evidence, a plaintiff has no case. These evidentiary statutes, therefore, may as a practical matter also lead to immunity for the covered hospital committee.").

52. It is difficult to conceive of a cause of action against an ethics committee because the committee's procedural duties and responsibilities remain largely undefined. *See* Wolf, *supra* note 38, at 278 ("[W]e see no systematic effort to study process itself, yoke it to appropriate values, and demand that process do right by the patient. It is a gaping hole in medical ethics."). At a minimum, however, it must be assumed that an ethics committee has a duty to give ethical advice within the limits of the law. While one might argue that there are no right answers in the realm of ethics, some legal responsibilities and obligations can be clear-cut. An example of negligent advice by a committee would be a recommendation of assisted suicide in a state that has made such an action illegal. Such advice might well be "ethically" sound, but still would be negligent based upon its illegality.

heretofore has been untested: the basic tenet of the ethics committee movement that the committees are better suited to end-of-life decisionmaking than the courts.[53] Part I reviews the pervasive endorsement of ethics committees as a "good way to resolve complex ethical issues in patient care [without resorting to] the costly, often adversarial, legal system."[54] Part II examines arguments for and against a court's competence to render decisions in refusal of treatment and other cases involving medical ethics issues.[55] Part III then considers advantages and disadvantages of using ethics committees as a substitute for judicial resolution of troubling medical ethics cases.[56] Part IV considers the impact of privilege and immunity statutes on judicial review and questions whether such legislation is appropriate in a legal system that couples responsibility with accountability.[57] Finally, Part V concludes that courts should bear the *final authority* for patient care decisions.[58]

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53. Although this Article is concerned with choosing the best decisionmaker when a patient lacks capacity to direct his own treatment, both committees and courts, albeit by necessity, are substituting their judgment for that of the patient. Thus, "[p]atients might wonder what they can hope to gain when judicial orders 'substitute bureaucratic authority for professional authority.' From the patient's point of view, there is only paternalism, with the legal system engaging medicine in a struggle over which ought to fill the role of father." Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1132 (1991) (quoting JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 228 (1984)).

54. Fleetwood & Unger, *supra* note 15, at 320; *see infra* notes 59-76 and accompanying text.

55. *See infra* notes 82-155 and accompanying text.

56. *See infra* notes 160-207 and accompanying text. Importantly, ethics committees are by no means the only mechanisms developed as alternatives to the courts. Professors White and Fletcher note that "[o]ne purpose of advance directives [or "living wills"] is to avoid recourse to the courts to resolve difficulties associated with decision making for incapacitated patients." White & Fletcher, *supra* note 37, at 411 (discussing advantages of advance directives or "living wills," which are written expressions of a patient's preferences for the provision or withholding of medical treatment that operate when the patient lacks capacity to express her wishes). The significant distinction between statutes authorizing advance directives and the use of hospital ethics committees, however, is that advance directives avoid court oversight *while giving voice to the wishes of the patient.* The use of an ethics committee as a substitute for judicial review cannot make such a claim and must ground its authority in efficiency, expertise, and other justifications. *See infra* notes 82-155 and accompanying text.

57. *See infra* notes 208-257 and accompanying text.

58. *See infra* notes 258-64 and accompanying text. Of course, society can designate other bodies to bear the responsibility for final patient care decisions. Sigrid Fry-Revere suggests the following approaches: (1) professional self-regulation through such mechanisms as accreditation or certification; (2) regulation by state and local government in the form of licensure or professional discipline; (3) federal government regulation through peer review organizations or other mechanisms; (4) court-enforced accountability; (5) the creation of a government commission to build consensus about the appropriate use of ethics committees; and (6) institutional self-regulation through such

I. THE UNDERLYING PRINCIPLE OF THE ETHICS COMMITTEE MOVEMENT: COMMITTEES ARE BETTER FORUMS FOR RESOLUTION OF ETHICAL ISSUES THAN COURTS

Hospital ethics committees have been touted as an excellent means of resolving complex medical ethics issues without resort to the costly, adversarial legal system.[59] The President's Commission encouraged the development of ethics committees that "do not supplant the principal decisionmakers [i.e., the patients, families, and healthcare providers,] but [that] provide for efficient review *without regularly incurring the liabilities of judicial review*."[60] The Commission identified four principal shortcomings of judicial review:

> [It] is costly in terms of time and expense; it can disrupt the process of providing care for the patient, since medical decisionmaking is evolutionary rather than static; it can create unnecessary strains in the relationship between the surrogate decisionmaker and others, such as the health care providers, who may be forced into the role of formal adversaries in the litigation; and it exposes ordinarily quite private matters to the scrutiny of the courtroom and sometimes even to the glare of the public communications media.[61]

Commentators and scholars have taken up this mantra and embraced committees as a viable alternative to judicial involvement.[62] In so doing, they have identified three additional limitations to court authority for end-of-life decisionmaking: that courts lack the technical, medical, and ethical expertise necessary to make such decisions;[63] that courts "may be insensitive to the values at stake" in

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mechanisms as institutional review boards or peer review committees. *See* SIGRID FRY-REVERE, THE ACCOUNTABILITY OF BIOETHICS COMMITTEES AND CONSULTANTS 78-92 (1992). Because regulation, whether governmental control or self-regulation, does not seem to be on the immediate horizon, *see* Fletcher & Hoffmann, *supra* note 4, at 335 (discussing absence of standards to evaluate the performance of hospital ethics committees), consideration of the relative capacities of the courts and ethics committees to make patient care decisions is appropriate, *see* Wilson et al., *supra* note 6, at 1 (discussing results of national study that found rudimentary self-evaluation of performance by hospital ethics committees).

59. *See* Fleetwood & Unger, *supra* note 15, at 320. While this section attempts to establish perceived judicial incompetence as the overarching factor in the adoption and use of ethics committees, the growth of the ethics committee movement has been linked to a number of causes. *See supra* note 4 and accompanying text.

60. PRESIDENT'S COMM'N REP., *supra* note 4, at 164 (emphasis added).

61. *Id.* at 159.

62. *See supra* notes 36-37 (cataloguing articles endorsing the use of ethics committees).

63. *See* Hollander, *supra* note 36, at 171 ("[T]hese cases ... involve complex issues,

these cases;[64] and that judicial involvement increases stress on the family unit, disrupts family functioning, and discourages family involvement.[65]

Echoing these concerns, many courts have recognized the limits of judicial review.[66] The New Jersey Supreme Court, which first advocated in *Quinlan* the establishment of ethics committees as a way to improve medical decisionmaking,[67] reasoned that "a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."[68] Similarly, in *Cruzan v. Director, Missouri Department of Health*,[69] Justice Scalia scolded that "[t]his Court need not, and has no authority to, inject itself into

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both medical and social, that are better left to those with more expertise in the area."); *see also* Michael L. Perlin, *Are Courts Competent to Decide Competency Questions?: Stripping the Facade from* United States v. Charters, 38 U. KAN. L. REV. 957, 968 (1990) (noting concerns about "judges' abilities to interpret social science data"). Judges also may lack the expertise to make good ethical decisions. *See, e.g.*, Perlin, *supra*, at 968 (stating that competency questions include concerns about "judges' ... capacity to ... 'unpack' their own decision-making processes").

64. Fleetwood & Unger, *supra* note 15, at 321; *see* Perlin, *supra* note 63, at 968 (noting concerns about "judges' abilities ... to render thoughtful decisions in areas that cause them a significant amount of personal discomfort").

65. *See* Parham v. J.R., 442 U.S. 584, 605 (1979) (finding a requirement of a formal adversary hearing prior to hospitalization of minor children disruptive to the family and a deterrent to seeking needed treatment); Richard, *supra* note 36, at 414 ("Judicial involvement may suppress familial evaluation of the patient's needs, as it tends to suggest that the family has no control over the loved one's destiny."); Scott, *supra* note 37, at 856 (stating that mandatory judicial review of sterilization of retarded individuals "predictably create[s] greater tension within a family unit already subject to considerable stress," which in turn can "have a disruptive effect on [parents'] ability to care for the child").

66. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 293 (1990) (Scalia, J., concurring); Rasmussen v. Fleming, 741 P.2d 667, 674 (Ariz. 1986); *In re* Longeway, 549 N.E.2d 292, 295 (Ill. 1989); *In re* Jobes, 529 A.2d 434, 449 (N.J. 1987); *see also* Hollander, *supra* note 36, at 171 & nn.112, 113 ("[C]ourts realize that the judiciary is not the proper forum for resolving these types of cases, as these cases necessarily have serious time-constraints, and involve complex issues, both medical and social, that are better left to those with more expertise in the area."); Weir & Gostin, *supra* note 36, at 1848 ("Most courts have consequently concluded that such judicial intervention [in life-sustaining treatment cases] is both unnecessary and counterproductive except to protect the lives of nonautonomous patients who have no surrogate.").

67. *See In re* Quinlan, 355 A.2d 647, 668 (N.J. 1976). The majority of commentators agree that while the *Quinlan* court contemplated a prognosis committee—charged with the task of confirming the medical diagnosis—it intended future ethics committees to have more "multidisciplinary" tasks. *See* Capron, *supra* note 4, at 422-23; *see also* note 27 and accompanying text (describing function of a prognosis committee).

68. *Quinlan*, 355 A.2d at 669.

69. 497 U.S. 261 (1990).

every field of human activity where irrationality and oppression may theoretically occur, and if it tries to do so it will destroy itself."[70] In *Parham v. J.R.*,[71] the United States Supreme Court characterized formal adversary pre-admission hearings as "time-consuming procedural minuets."[72] A lower court similarly remarked that "[t]oo many patients have died before their right to reject treatment was vindicated in court."[73] And the Minnesota Supreme Court observed in *In re Conservatorship of Torres*[74] that judicial review of situations involving termination of medical treatment would inundate the trial courts.[75] These advocates, though, appear to have assumed an underlying premise: that ethics committees are better equipped than the courts to make the final decisions on medical ethics issues.[76] Parts II and III examine this assumption.

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70. *Id.* at 300-01 (Scalia, J., concurring). Similarly, writing for the majority, Chief Justice Rehnquist noted that "we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself." *Id.* at 286. Lower courts have also expressed no wish to wrench private decisions away from the parties in interest. *See, e.g.*, Bartling v. Superior Court, 209 Cal. Rptr. 220, 226 (Cal. Ct. App. 1984) (There is "no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made"); Barber v. Superior Court, 195 Cal. Rptr. 484, 493 (Cal. Ct. App. 1983) ("[R]equiring judicial intervention in all cases is unnecessary and may be unwise."); *In re* Browning, 568 So. 2d 4, 15 (Fla. 1990) ("[W]e are loath to impose a cumbersome legal proceeding at such a delicate time in those many cases where the patient neither needs not desires additional protection.").

71. 442 U.S. 584 (1979).

72. *Id.* at 605 (upholding a Georgia statute that authorized parents to place their minor children in psychiatric hospitals).

73. *In re* Farrell, 529 A.2d 404, 415 (N.J. 1987). Patients' deaths occurred during the judicial proceedings in *Corbett v. D'Alessandro*, 487 So. 2d 368, 369 (Fla. Dist. Ct. App. 1986), and *In re Conroy*, 486 A.2d 1209, 1219 (N.J. 1985).

74. 357 N.W.2d 332 (Minn. 1984) (en banc).

75. *See id.* at 341 n.4 (estimating ten patients per week removed from life support in Minnesota alone). The American Hospital Association estimates that 4200 end-of-life choices need to be made each day in the United States. *See* Andrew H. Malcolm, *Judge Allows Feeding Tube Removal*, N.Y. TIMES, Dec. 15, 1990, at A10.

76. *See supra* notes 61-65 and accompanying text (cataloging the putative advantages of participation by ethics committees in end-of-life decisionmaking). In addition to describing the limitations of judicial review, the President's Commission identified a number of advantages of court proceedings. First, "the judicial process is a public one." PRESIDENT'S COMM'N REP., *supra* note 4, at 159. Second, adjudication by the courts should lead to principled and impartial decisions. *See id.* Third, the adversarial process encourages full exposition of the issues. *See id.* Although recognizing these advantages of courts, the President's Commission concluded that the benefits of ethics committees on the whole outweigh their drawbacks if judicial review is available when necessary. *See id.* at 160.

II. EXAMINING THE UNDERLYING PREMISE: COURTS AS DECISIONMAKERS

We can assess the relative ability of courts and ethics committees to resolve medical ethics controversies by looking at the medical and "ethical" expertise of each body;[77] the cost, timeliness, and ability to preserve privacy offered by courts and ethics committees;[78] the objectivity of courts and ethics committees;[79] the error costs associated with court and committee decisions;[80] and the capacity of each to treat like cases alike.[81] This analysis will look first at the courts and then at ethics committees, beginning with the technical expertise of the courts.

A. The Courts' Expertise

Criticism of the courts' expertise may be divided into two separate claims: first, that courts lack the medical expertise necessary to make treatment withdrawal decisions, and, indeed, have made grave mistakes; and second, that courts lack the requisite ethical expertise.

1. Medical Expertise

Many commentators have criticized courts as lacking sufficient medical expertise to decide medical ethics issues.[82] Examining these criticisms, former D.C. Circuit Judge David Bazelon stated that

> [v]ery few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject similar scrutiny of the effect of psychiatric treatment on human lives.... [I]t

77. *See infra* notes 82-116 and accompanying text (analyzing capacity of courts); *infra* notes 160-69 and accompanying text (analyzing capacity of ethics committees).

78. *See infra* notes 117-28 and accompanying text (analyzing capacity of courts); *infra* notes 170-80 and accompanying text (analyzing capacity of ethics committees).

79. *See infra* notes 129-42 and accompanying text (analyzing capacity of courts); *infra* notes 181-99 and accompanying text (analyzing capacity of ethics committees).

80. *See infra* notes 143-45 and accompanying text (analyzing capacity of courts); *infra* notes 200-05 and accompanying text (analyzing capacity of ethics committees).

81. *See infra* notes 146-55 and accompanying text (analyzing capacity of courts); *infra* notes 206-07 and accompanying text (analyzing capacity of ethics committees).

82. *See In re* Quinlan, 355 A.2d 647, 669 (N.J. 1996) (discussing judicial review as "a gratuitous encroachment upon the medical profession's field of competence"); Hollander, *supra* note 36, at 171 (noting that treatment disputes "involve complex [medical] issues ... that are better left to those with more expertise in the area").

> can hardly be said that we are more concerned for the salmon than the schizophrenic . . . .[83]

Judges have, however, sometimes reached mistaken factual conclusions regarding technical expert testimony.[84] In end-of-life decisions, judges appear to have difficulty assimilating and weighing complex medical information.[85] Moreover, as Michael Flick points out, "[j]udges know less than doctors or patients about th[e] uncertainty" surrounding death and the implications this has for the decisions to be made.[86] Finally, few state court judges encounter end-of-life decisions, and for those judges who do, such cases arise only once every six and a half years.[87] Consequently, courts have little

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83. David L. Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 743 (1969).

84. *See, e.g.*, Smith v. State, 355 A.2d 527 (Md. Ct. Spec. App. 1976); *see also* E. Donald Elliott, *Toward Incentive-Based Procedure: Three Approaches for Regulating Scientific Evidence*, 69 B.U. L. REV. 487, 495 (1989) (commenting that judges "are not known for their scientific literacy"); John W. Osborne, Note, *Judicial/Technical Assessment of Novel Scientific Evidence*, 1990 U. ILL. L. REV. 497, 524 (arguing that "a lay judge may be in no better position than a lay juror to evaluate" scientific testimony); John W. Wesley, Note, *Scientific Evidence and the Question of Judicial Capacity*, 25 WM. & MARY L. REV. 675, 683, 685-86 (1984) (questioning ability of judges and juries to comprehend and evaluate complex scientific evidence). The *Smith* opinion held that since the psychological stress evaluator ("PSE") was equivalent to a polygraph, and since Maryland courts do not admit polygraph evidence, evidence of a PSE test was also inadmissible. *See Smith*, 355 A.2d at 535-36. In fact, PSE is technologically distinct from the polygraph. *See* Ching Wah Chin, Note, *Protecting Employees and Neglecting Technology Assessment: The Employee Polygraph Protection Act of 1988*, 55 BROOK. L. REV. 1315, 1332 (1990) (observing that "PSE is very different from a polygraph because a person can be tested by the PSE without that person's knowledge" and because "the PSE only measures one physiological response while the polygraph measures three").

85. *See* Tom Hafemeister, *Helping the Courts Decide: Decision-Making Regarding Life-Sustaining Treatment Project of the National Center for State Courts (1989-1991)*, *in* PROCEEDINGS OF THE PEW CHARITABLE TRUSTS' COLLOQUY FOR STATE APPELLATE COURT JUDGES: LIFE AND DEATH DECISIONS: STATE JURISPRUDENCE AFTER *CRUZAN* AND *WEBSTER* 67, 67-68 (Margot L. White ed., 1992) [hereinafter COLLOQUY PROCEEDINGS]. Professor Hafemeister discussed the results of a survey of state court judges' experience with life-sustaining medical treatment cases conducted by the National Center for State Courts. Interpreting the survey results, he found that judges had difficulty with these cases because they "often rais[e] factual questions about which the judge has limited knowledge," *id.* at 67, and "many of the judges had difficulty evaluating the medical testimony they received," *id.* at 68; *see also* Bernard Lo et al., *Family Decisionmaking on Trial: Who Decides for Incompetent Patients?*, 322 NEW ENG. J. MED. 1228, 1229 (1990) (questioning whether judicial rulings are based on sound clinical information).

86. Flick, *supra* note 53, at 1164. Presumably, ethics committee members—as professionals intimately close to the clinical context—will have a better understanding of the uncertainty of clinical prognosis.

87. *See* Hafemeister, *supra* note 85, at 67 (reporting results of survey of state court judges).

opportunity to accumulate expertise in such matters.[88]

Although widespread, these criticisms prove fundamentally unfounded. First, courts have in fact confronted complex technical evidence in cases concerning computer technology,[89] environmental science,[90] epidemiology,[91] psychology,[92] and economics.[93] Indeed, if lack of medical expertise is sufficient to defeat court jurisdiction over end-of-life decisions, then it seems equally likely to defeat jurisdiction over *every* dispute requiring assessment of scientific or economic data. Such wholesale disqualification would leave the courts with very little to do.[94]

Second, counterbalancing the judiciary's limitations is an array of tools that courts have to help them amass and assimilate technical information. The most common source of specialized knowledge in American trials is expert testimony.[95] Under the Federal Rules of

88. *See id.* at 68 ("[A]lthough one in five [state court] judges hear these cases, they do not hear very many and as a result, there appears to be a lack of procedures and expertise for resolving them."). Professors Hafemeister and Robinson's study of the judiciary estimates, however, that more than 7000 cases involving end-of-life decisions have been heard by state courts. *See* Thomas L. Hafemeister & Donna M. Robinson, *The Views of the Judiciary Regarding Life-Sustaining Medical Treatment Decisions*, 18 LAW & PSYCHOL. REV. 189, 190 n.8 (1994).

89. *See* Apple Computer, Inc. v. Franklin Computer Corp., 714 F.2d 1240, 1242-45 (3d Cir. 1983).

90. *See, e.g.*, Natural Resources Defense Council v. Thomas, 805 F.2d 410 (D.C. Cir. 1986) (considering validity of EPA emissions standards for diesel engines); Weyerhaeuser Co. v. Costle, 590 F.2d 1011 (D.C. Cir. 1978) (considering a challenge by the pulp paper mill industry to EPA Clean Water Act regulations).

91. *See Developments in the Law—Toxic Waste Litigation*, 99 HARV. L. REV. 1458, 1618-24 (1986); *see also In re* "Agent Orange" Prod. Liab. Litig., 611 F. Supp. 1223, 1231 (E.D.N.Y. 1985) (finding that epidemiology studies are "the only useful studies having any bearing on causation"), *aff'd*, 818 F.2d 187 (2d Cir. 1987).

92. *See* James M. Doyle, *Applying Lawyers' Expertise to Scientific Experts: Some Thoughts About Trial Court Analysis of the Prejudicial Effects of Admitting and Excluding Expert Scientific Testimony*, 25 WM. & MARY L. REV. 619, 623-27 (1984).

93. *See* Eymard v. Pan Am. World Airways, 795 F.2d 1230, 1233-35 (5th Cir. 1986); Reilly v. United States, 682 F. Supp. 150, 152 (D.R.I. 1988) (stating that "this court found itself confronted ... with issues of profound economic complexity" that warranted court appointment of an economist as an expert), *aff'd in relevant part*, 863 F.2d 149 (1st Cir. 1988).

94. *See* MICHAEL P. DOOLEY, FUNDAMENTALS OF CORPORATION LAW 207 (1995) ("Conceding that [while] judges are not 'business experts,' neither are they experts in medicine, engineering, product design or other areas of specialized knowledge that may give rise to cognizable claims of negligence.").

95. *See* Edward V. DiLello, Note, *Fighting Fire with Firefighters: A Proposal for Expert Judges at the Trial Level*, 93 COLUM. L. REV. 473, 474 (1993). In some cases expert testimony has been criticized as far-fetched, unreliable, and lacking in objectivity. *See* United States v. Wilson, 361 F. Supp. 510, 512 (D. Md. 1973) (discussing unreliability of expert testimony regarding polygraph tests); LEE COLEMAN, THE REIGN OF ERROR:

Evidence, for example, courts may appoint their own experts.[96] In recent years, court-appointed experts have been used advantageously in a range of cases involving technical testimony.[97] In addition, courts may utilize special masters when "exceptional conditions" warrant use of such individuals.[98] Masters, who are usually practicing lawyers or other professionals with special expertise in the subject matter of the dispute, have appeared in virtually every type of dispute[99] and perform a variety of tasks ranging from simple case management to performing substantive judicial duties.[100] Where a "trial judge is unfamiliar with the basic issues raised by a case," the court may invite and consider amicus curiae briefs.[101] And finally, state court judges

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PSYCHIATRY, AUTHORITY, AND LAW 45 (1984) (criticizing expert testimony as far-fetched); FRANKLIN M. FISCHER ET AL., FOLDED, SPINDLED AND MUTILATED: ECONOMIC ANALYSIS AND *U.S. V. IBM* 351 (1983) (suggesting that expert witnesses may take on the point of view of attorneys with whom they work); Barry Tarlow, *Admissibility of Polygraph Evidence in 1975: An Aid in Determining Credibility in a Perjury-Plagued System*, 26 HASTINGS L.J. 917, 924, 960-69, 974 (1975) (discussing unreliability of expert testimony regarding polygraph tests).

96. *See* FED. R. EVID. 706.

97. *See, e.g.*, Syntex Opthalmics, Inc. v. Tsuetaki, 701 F.2d 677, 679-80, 684 (7th Cir. 1983) (finding that testimony by the court-appointed expert obviated the need for testimony from the parties' experts).

98. *See* FED. R. CIV. P. 53(b). Although many of these cases will be heard in state rather than federal court, most jurisdictions provide for a similar judicial option. *See, e.g.*, TEX. R. CIV. P. 171 ("The court may ... appoint a master in chancery ...."). In *Bouvia v. County of Los Angeles*, 241 Cal. Rptr. 239 (Cal. Ct. App. 1987), for instance, the trial court appointed two independent physicians as special masters to assist in evaluating the medical needs of a plaintiff suffering from severe cerebral palsy who sought to prohibit county hospital physicians from withdrawing her morphine without her consent. *See id.* at 242.

99. *See* Vincent M. Nathan, *The Use of Masters in Institutional Reform Litigation*, 10 U. TOL. L. REV. 419, 421 (1979) (noting that special masters have been appointed in actions involving antitrust violations, patent infringement, and eminent domain; and recognizing that referrals have been made to masters in suits involving habeas corpus and bankruptcy). In a recent example, eight special masters served in the Agent Orange litigation. *See* Linda Silberman, *Judicial Adjuncts Revisited: The Proliferation of Ad Hoc Procedure*, 137 U. PA. L. REV. 2131, 2147 n.89 (1989).

100. *See* DiLello, *supra* note 95, at 486. In addition to court-appointed experts and special masters, one reform proposal would provide for the creation of a new federal office of judicial adjuncts who are specialists in technical fields, in order to facilitate faster, more efficient, and less expensive adjudication of factual issues involving technical evidence. *See id.* at 473-74.

101. Hafemeister, *supra* note 85, at 69. Professor Hafemeister cautioned that

> the court should balance its informational needs against the need to arrive at a prompt and decisive resolution of the matter, the need for a balanced presentation of the issues, the need to maintain the integrity of the courtroom and conformity to judicial procedures, and perhaps most importantly, the need to respect the privacy and minimize the anguish of the parties who are directly involved.

Id.

may consult guidelines prepared by the National Center for State Courts and the Coordinating Council on Life Sustaining Medical Treatment Decision Making by the Courts (the "Court Guidelines"),[102] which "identify and describe relevant issues ... and serve as an information resource" in withdrawal of treatment cases.[103] Significantly, each of these methods provides the court with accumulated expertise in medicine and end-of-life decisionmaking.[104]

Third, and most important, many medical ethics issues are not primarily issues of pure science, but rather involve normative decisions in which medical science offers little help.[105]

2. Ethical Expertise

Courts have also been criticized because they are not ethical experts.[106] This criticism, too, is weak. Foremost, it is far from self-evident what qualities contribute to good ethical decisionmaking. Some of the strengths that philosophers identify as providing ethics committees with a claim to special competence[107]—for example, that committees have training in "understanding logical arguments and detecting fallacies"[108]—are skills at which judges would appear

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102. *See* NATIONAL CTR. FOR ST. CTS., GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES (2d ed. 1993).

103. Hafemeister, *supra* note 85, at 68.

104. Another possible tool for courts to use is full-time judicial adjuncts. However, because end-of-life decisions occur infrequently and do not involve protracted litigation, as in *Agent Orange*, there are fewer economies of scale to be achieved through the use of a full-time judicial adjunct (unless of course the adjunct was given exclusive jurisdiction over such decisions, much as the Court of Customs and Patent Disputes is given jurisdiction over patent disputes). A clearinghouse approach, however, has practical disadvantages. For example, it would increase the burden on families and health professionals by requiring litigation of the dispute at some location other than the local courthouse. As such, courts are more likely to rely on expert testimony or appoint a special master or court-appointed expert in such cases.

105. As Dr. Avorn explained, when we consider ethical issues, "we have left the domain of physiology and entered the realm of values." Jerry Avorn, *A Physician's Perspective*, HASTINGS CTR. REP., June 1982, at 11, 12.

106. *See, e.g.*, *In re* A.C., 573 A.2d 1235, 1237 n.2 (D.C. 1990) ("Because judgment in ... [life and death cases] involves complex ... ethical issues ..., we would urge the establishment of another tribunal to make these decisions ...."); Hollander, *supra* note 36, at 171 (observing that medical ethics cases "involve complex issues, both medical and social, that are better left to those with more expertise in the area").

107. Even assuming that moral philosophers and theologians may have a deeper appreciation of the "leading [moral] theories and ... their bearing on specific issues," committees rarely are comprised entirely of such morally astute members. *See* Daniel Wikler, *Ethicists, Critics, and Expertise*, HASTINGS CTR. REP., June 1982, at 12, 13; *infra* note 166 and accompanying text.

108. Peter Singer, *Ethics and Experts*, HASTINGS CTR. REP., June 1982, at 9, 9.

equally adept. Moreover, because so much of evaluating the ethics of a particular action entails "examin[ing] the legally possible options" and "knowing when existing law needs to be determinative,"[109] judges would also appear to be inherently skilled at making these determinations.[110]

More importantly, treatment decisions for incapacitated patients rest not so much on particular reasoning abilities as they do on normative judgments and assessments of factors not involved in professional ethics training.[111] The normative judgments to be made—primarily, what kind of life is worth living and from whose perspective is the quality of life decision to be made—entail philosophical and personal considerations that do not fall within the sole province of those trained in ethics.[112] Many committee members, moreover, have engaged in little or no formal study of clinical ethics and maintain largely unexamined personal conceptions of medical ethics.[113] Most judges can easily match this level of expertise.[114]

Similarly, there is nothing about committees that makes them singularly suited to making the factual assessments required in such cases. For example, a treatment decision for a newborn with permanent physical or mental handicaps requires assessment of the infant's

> adaptability to his social environment, [which] depends not only on what the child can do but on what others are willing to do to adapt the environment to the child. This in turn depends on intangibles, such as the acceptance of a child in his home as well as on the quality of community resources

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109. Russell L. McIntyre, *The Legitimation of Ethics Consultation*, TRENDS IN HEALTH CARE, LAW & ETHICS, Fall 1993, at 7, 9.

110. *But see* Wolf, *supra* note 38, at 287 ("[T]he committee operates in the domain of morality, where 'rights' are only part of a complex vocabulary that includes 'needs' and 'wants,' where virtues exist besides rules, and theoretical controversy abounds.").

111. *See* Patrick A. Malone, *Medical Authority and Infanticide*, 1 J.L. & HEALTH 77, 105 (1985-86); *see also* Perlin, *supra* note 63, at 970 ("Because treatment choices are 'individualized,' physicians have no particular ability to determine whether, from the *patient's* perspective, a treatment's hazards outweigh its benefits.").

112. In fact, these cases largely raise questions about whose values, and which values, will enter into a determination of quality of life. *See* James F. Childress, *Ethical Issues in Jurisprudence—Ways to Analyze Them*, *in* COLLOQUY PROCEEDINGS, *supra* note 85, at 7, 13 (making the same observation about optional versus obligatory treatment standards).

113. *See* Fletcher & Hoffmann, *supra* note 4, at 336; *see also infra* notes 161-69 and accompanying text (discussing ethics committees' ethical expertise).

114. Indeed, ethicists concede that "the skills that philosophers have are not especially esoteric. Anyone with reasonable intelligence and the time to read a few books and think a bit can acquire them." Peter Singer, *How Do We Decide?* HASTINGS CTR. REP., June 1982, at 9, 10.

such as schools, physical therapy, and live-in institutions.[115] A court may address each of these matters by taking expert testimony, appointing a special master or expert in rehabilitative care, inviting amicus briefs on the salient factual and ethical questions, or consulting the Court Guidelines for assistance in extrapolating and addressing the relevant factual and ethical issues.[116] These treatment decisions, then, require factual assessments that a court has the necessary resources and expertise to make. Moreover, the decisions stand on normative assessments of what is valuable for a particular patient, judgments for which neither a court nor a committee is singularly qualified.

B. Cost, Timeliness, and Ability to Preserve Privacy

In addition to attacks on expertise, courts have been indicted for "impos[ing] formidable costs on the family, in terms of money, time expended, and psychological stress."[117] Upon closer examination, these charges, too, appear exaggerated. We begin with an analysis of the cost of litigating medical treatment disputes.

1. Cost

Without a doubt, representation in court by an attorney will require greater expenditure of resources by the parties than dispute resolution at the institutional level. However, most of the added cost of court proceedings consists of attorney fees. This represents a fixed additional cost over the cost of ethics-committee-dispute-resolution *only if* one assumes that court proceedings require representation while dispute resolutions by committees do not.[118]

Even where a cost differential exists, several devices exist to ease the monetary burden on individual adjudicants. For example, court-appointed counsel may be available to indigent patients. Alternatively, the court may appoint a guardian ad litem or a

115. Malone, *supra* note 111, at 106.

116. *See supra* notes 95-104 and accompanying text (outlining tools available to courts to amass and assimilate technical information).

117. Scott, *supra* note 37, at 855.

118. The cost differential does not reflect the different cost of these proceedings, but rather the cost of being represented versus not being represented. Conceivably, one could retain and use an attorney to advocate one's interests before a committee—indeed, this may be advisable where committees are granted immunity and privilege and thus become, in most instances, the forum of last resort. Equally likely, an individual may appear in court without representation, or may have counsel or a guardian appointed on his behalf. *See* Hoffmann, *supra* note 8, at 839 n.78 (listing cases in which court appointed a guardian for incapacitated patient).

guardian for the patient when such an appointment is necessary to protect the patient's interests.[119]

Notably, the cost differential may be more perceived than real. In the related context of mandatory judicial review prior to forcible medication in psychiatric hospitals, empirical studies have shown that few patients actually refuse medication and, as a result, court involvement does not unduly impair institutional resources.[120] Because only a fraction of end-of-treatment cases will require judicial review,[121] one can expect that court hearings for these cases will require only a small outlay of money and court resources over time.

A less obvious disadvantage of judicial review is that the public bears the cost of the proceeding in the form of taxes to maintain courts.[122] Such cases "often entail a sizeable outlay of judicial resources ... [as they] often require[] emergency hearings, expedited proceedings, [and] attempts to appoint a guardian ad litem."[123] In contrast, when institutions resolve these cases through the use of ethics committees, the institution, not taxpayers, supports the cost of dispute resolution.

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119. *See* Hafemeister, *supra* note 85, at 70. In a recent survey, 70.8% of judges indicated that none of the parties in life-sustaining decisionmaking cases had been financially burdened. *See* Hafemeister & Robinson, *supra* note 88, at 202.

120. *See* Perlin, *supra* note 63, at 973. Empirical studies of judicial review prior to forced medication have found that only a tiny percentage went to court: 1.3% of the involuntary patients and 0.6% of the total population. *See* Julie Magno Zito et al., *One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility*, 12 INT'L J.L. & PSYCHIATRY 295, 298, 302 (1989); *see also* Donald J. Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. LEGAL MED. 107, 119 (1985) (finding that implementation of due process procedures has cost little and has resulted in unexpected savings). Concededly, these data are not definitive: it may be that few patients refuse medications *precisely* because of the prohibitive cost of litigating the need for medication.

121. *See* Hafemeister, *supra* note 85, at 67 (observing that legal disputes involving end-of-life decisions arise on average only once every 6 1/2 years). In contrast, a survey commissioned by the American Association of Critical-Care Nurses ("AACN") found that 65% of critical care nurses "participate in decisions about withdrawing or withholding life support at least several times each month, with 24 percent taking part in such discussions at least several times each week." AACN, Frequent Life Support Decisions Confirm Expertise of Critical Care Nursing, Survey Reveals 1 (May 23, 1990) (press release) (on file with the *North Carolina Law Review*).

122. Sigrid Fry-Revere identifies this public burden as a disadvantage to any form of government regulation that is to be carried out effectively. *See* FRY-REVERE, *supra* note 58, at 45; *cf.* Hafemeister & Robinson, *supra*, note 88, at 202 (reporting that a minority of judges found medical ethics proceedings expensive only for the state rather than the parties).

123. Hafemeister, *supra* note 85, at 68.

2. Timeliness

The Court Guidelines noted above recognize that "unnecessary delay . . . engender[s] injustice and hardship" and therefore the court response to a life sustaining medical treatment question must be "timely and expeditious."[124] To accommodate the need for a timely response, the Court Guidelines suggest that judges "establish early control over an [end-of-treatment] case . . . and . . . tak[e] appropriate steps to expedite the case."[125] Moreover, a court should retain jurisdiction over a case following the issuance of its orders so that it may respond quickly if a disgruntled party takes steps to block or delay implementation of the court's order.[126] Collectively, these mechanisms provide some comfort that end-of-treatment decisions can be adjudicated in a timely fashion.

3. Ability to Preserve Privacy

While the ability to preserve privacy may appear to be a genuine drawback of judicial proceedings, the problem is easily solved. As one federal judge noted in the context of peer review litigation, disclosure of committee records need not intrude on patient privacy since anonymity can be preserved through protective orders.[127] A recent survey of the judiciary indicates that in rare situations judges have closed hearings to the public, sealed records of the court proceedings, taken testimony in camera, and referred to parties by initials or pseudonyms.[128]

C. Objectivity

Added to criticisms of the courts as unwieldy, intrusive, and costly are charges that some bias exists in judicial review of end-of-life cases. As before, a principled examination of this charge suggests, on balance, otherwise. This Article begins an examination of the objectivity of courts by canvassing studies asserting that

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124. *Id.* at 69 (discussing the Court Guidelines for medical ethics disputes).

125. *Id.* at 68-69. Judges have used a number of unusual procedures to expedite these sorts of cases—ex parte hearings, hearings via conference call, bedside visits, after-hours sessions, and out-of-court hearings, as well as accelerated scheduling and decisionmaking. *See* Hafemeister & Robinson, *supra* note 88, at 209. Few judges have found expeditiousness to be a problem. *See id.* at 207. *But see id.* at 210 (providing anecdotal evidence that parties may find a delay of *hours* excessive and painful).

126. *See* Hafemeister, *supra* note 85, at 73.

127. *See* Robinson v. McGovern, 83 F.R.D. 79, 89-92 (W.D. Pa. 1979) (discussing confidentiality of peer review records).

128. *See* Hafemeister & Robinson, *supra* note 88, at 203-04, 212.

judicial decisions in medical ethics cases are biased.

A study by Professors Miles and August of twenty-two state appellate court decisions concerning withholding or withdrawal of treatment for incompetent patients observed asymmetric gender-patterned reasoning within the cases.[129] Specifically, courts tended to view a man's prior wishes as rational and a woman's prior remarks as unreflective, emotional, childlike, and immature when the same evidence existed in both cases for the rationality of the decision.[130] As a result of this gender-based treatment by courts, "women are disadvantaged in having their moral agency taken less seriously than that of men."[131]

Equally disturbing, courts considering end-of-life treatments almost invariably authorize decisions resulting in death rather than sustaining life.[132] Demonstrating this, Justice Stevens in his *Cruzan* dissent laid out an "unbroken stream of cases" authorizing cessation of treatment when the patient was in a vegetative state.[133] While distressing, these studies fail to tell the whole story. Balanced against these shortcomings, court proceedings promote objectivity by ensuring that *all* relevant parties have notice and an opportunity to be heard.[134] The Court Guidelines described earlier stress that the court's primary concern is to "ensure that the patient's views are heard, if at all possible."[135] This may be accomplished by allowing the patient "to testify in chambers ... [or] from his or her hospital bed via telephone, ... holding court in settings other than the courthouse or taking steps to insure the proceedings are recorded so that they can be subsequently reviewed by a non-attending patient."[136] Other individuals who should be joined as parties or subpoenaed as witnesses include anyone with a direct familiarity with (a) the patient's wishes, (b) the care or treatment provided, or (c) the

129. *See* Steven H. Miles & Allison August, *Courts, Gender and the "Right to Die,"* 18 LAW, MED. & HEALTH CARE 85, 88, 92 (1990).

130. *See id.* at 88.

131. *Id.* at 92.

132. *See* Flick, *supra* note 53, at 1132 n.42, 1166 n.164.

133. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 348 & n.21 (1990) (Stevens, J., dissenting) (dissenting from majority opinion holding that Nancy Cruzan's parents lacked decisionmaking authority to have life-sustaining treatment withdrawn). As Justice Stevens noted, *Cruzan* is an exception to this pattern. *See id.* at 349 (Stevens, J., dissenting).

134. *See* Hollander, *supra* note 36, at 170-71 ("Arguably, the ultimate decision-making responsibility should not be shifted away from the courts, which presumably provide a detached but searching investigation in deciding such questions of life and death.").

135. Hafemeister, *supra* note 85, at 69.

136. *Id.* at 70.

qualifications of the patient's putative representative.[137] This list is exhaustive and one that clearly exceeds that used by the majority of ethics committees.[138] Beyond mere notice and an opportunity to be heard, the judicial system offers parties the opportunity to appeal a decision to a second neutral body for reconsideration.

More importantly, the court can—and should—hold formal adversarial hearings to resolve the matter before it. Although the antagonistic nature of court proceedings heightens participants' discomfort, such a "hearing should ... allow the court to reach an independent determination and not merely to ratify a decision reached by others."[139] Thus, the adversarial process itself, together with the procedural protections described above, should lead to principled and impartial decisions reflecting a full exposition of the issues.[140]

Finally, court proceedings promote objectivity simply because the decisions are "made by an independent arbitrator such as a federal court (aided by an impartial guardian or custodian)."[141] This allows courts to "stand guard against treatment decisions improperly motivated by the financial concerns of a family or institution, disagreements between family members or family and physicians, or medical professionals acting in their own interest, rather than the patient's [interest]."[142]

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137. *See id.* at 69.

138. *See infra* notes 196-97 and accompanying text (explaining that committees often make decisions behind closed doors without providing notice to patient or decisionmaker or following standards of due process).

139. Hafemeister, *supra* note 85, at 70; *cf.* PRESIDENT'S COMM'N REP., *supra* note 4, at 159 (stating that the adversarial process encourages full exposition of the issues). *But see* Parham v. J.R., 442 U.S. 584, 609 (1979) ("Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.").

140. *See* PRESIDENT'S COMM'N REP., *supra* note 4, at 159 (reviewing the positives and negatives of judicial review); *cf.* Hollander, *supra* note 36, at 171 (maintaining that courts are able to provide an impartial decisionmaking process but questioning whether courts are the proper forum).

141. United States v. Charters, 829 F.2d 479, 499 (4th Cir. 1987), *on reh'g*, 863 F.2d 302 (4th Cir. 1988) (en banc).

142. Beth Schermer, *A Practical Guide for Hospital Counsel in Decisions to Withhold or Withdraw Medical Treatment*, 23 J. HEALTH & HOSP. L. 264, 264 (1990); *see also Charters*, 829 F.2d at 499 & n.28 (noting that mandatory judicial review prior to forcible medication in psychiatric hospitals circumvents decisions designed to benefit an institution, such as those easing its institutional budget).

D. *Error Costs Associated with Court Decisions*

Courts have rejected mandatory judicial review in a number of contexts, stressing that institutional review incurs fewer error costs than judicial decisionmaking by non-expert judges. For example, the Court of Appeals for the Fourth Circuit rejected a mental patient's claim that his competency to make an informed judgment to accept or reject medication must be determined by a neutral fact-finder because the court was not convinced that giving this determination to "non-specialist judges . . . offers a better protection against error than would leaving it . . . to responsible medical professionals."[143]

This conclusion that courts do not add to the diagnostic work of mental health professionals has been roundly criticized, largely on the grounds that a significant number of mental hospitals, unpoliced, have engaged in patterns and practices of serious misuse of psychotropic drugs.[144] Error costs, then, are a function of the relative expertise of courts and ethics committees to make end-of-treatment decisions, and the ability of each to decide impartially and without a conflict of interest. These matters are addressed in other sections.[145]

E. *Capacity to Treat Like Cases Alike*

Several features of the legal system promote fundamental fairness and equality in treatment among cases. First, courts must respect the principle of stare decisis, which places a high burden on

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143. *Charters*, 863 F.2d at 311. The Fourth Circuit also concluded that the threat of side effects "can better be assessed and reviewed [intra-institutionally] than by an adversarial adjudicative process." *Id.*; *see also In re* A.C., 573 A.2d 1235, 1237 n.2 (D.C. App. 1990) ("Because judgment in . . . [life and death cases] involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment . . . of another tribunal to make these decisions. . . .").

144. *See, e.g.*, Rennie v. Klein, 476 F. Supp. 1294, 1299-1302 (D.N.J. 1979), *modified*, 635 F.2d 836 (3d Cir. 1981) (en banc), *vacated*, 458 U.S. 1119 (1982). At trial, one expert testified that psychotropic drugs were the "be all and end all" of state psychiatric hospitals, and in an office memo the defendant-state-hospital-medical-director conceded that medication was used "as a form of control and as a substitute for treatment." *Id.* at 1299. The record also established that hospital physicians regularly failed to diagnose tardive dyskinesia and other neurological side effects present in one third to one half of all state hospital patients, and "unjustified polypharmacy" was common. *Id.*; *see also* Davis v. Hubbard, 506 F. Supp. 915, 926 (N.D. Ohio 1980) ("[T]estimony at trial established that the prevalent use of psychotropic drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of staff and for punishment.").

145. *See supra* notes 82-116 and 129-42 and accompanying text (discussing capacity of courts to decide cases correctly and impartially); *infra* notes 160-69 and 181-99 and accompanying text (discussing capacity of committees to decide cases correctly and impartially).

courts to justify their departure from existing case law.[146] Second, because decisions have precedential value and bind courts within a single jurisdiction, different courts in that jurisdiction handle substantially similar cases in a roughly uniform manner. Third, Supreme Court review resolves some conflicts in treatment among jurisdictions, introducing horizontal uniformity among the federal circuits or the state courts.

Of course, our federalist system tolerates some inconsistency in state law on many fundamental issues, such as the death penalty and abortion, a phenomenon Professor Dworkin labels "checkerboard justice."[147] For example, the Supreme Court rested its decision on federalism concerns in affirming the Missouri Supreme Court's decision that Nancy Cruzan's parents lacked authority to effectuate a request to withdraw life support.[148] As Justice O'Connor explained, because "no national consensus has yet emerged on the best solution for this difficult and sensitive problem [of the right to refuse medical treatment,] ... the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States."[149]

As Professor Dworkin observes, it is constitutionally acceptable *and inherently fair* for individual states to provide different degrees of protection for individual rights *as long as* the states do not make arbitrary distinctions among their citizens as to who will have their rights protected.[150] Professor Dworkin explains society's acceptance of some degree of inconsistency among states by pointing to the importance we place on political integrity—our sense that citizens of a given community should share rights and obligations equally:[151]

> "[Integrity] requires government to speak with one voice, to act in a principled and coherent manner toward all its citizens, to extend to everyone the substantive standards of justice or fairness it uses for some.... [Integrity requires a]

146. *See* Planned Parenthood v. Casey, 505 U.S. 833, 854-69 (1992); Helvering v. Hallock, 309 U.S. 106, 119 (1940); Burnet v. Coronado Oil & Gas Co., 285 U.S. 393, 406 (1932) (Brandeis, J., dissenting); BLACK'S LAW DICTIONARY 978 (6th ed. 1991) (establishing stare decisis as a court policy to follow precedent and not disturb settled law).

147. RONALD DWORKIN, LAW'S EMPIRE 184-86 (1986). Difference among state laws is not the only inconsistency tolerated in the United States. Differences occur from municipality to municipality as well.

148. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 285-87 (1990).

149. *Id.* at 292 (O'Connor, J., concurring).

150. *See* DWORKIN, *supra* note 147, at 164-65; FRY-REVERE, *supra* note 58, at 19-23.

151. *See* DWORKIN, *supra* note 147, at 164-65; FRY-REVERE, *supra* note 58, at 19-23.

> state to act on a single, coherent set of principles even when its citizens are divided about what the right principles of justice and fairness really are . . . ."[152]

Consequently, legal scholars are not disturbed that Mississippi makes different evidentiary requirements of surrogate decisionmakers than, say, Virginia. Scholars *would oppose*, however, Mississippi judges' requiring one Mississippi citizen to demonstrate with clear and convincing evidence the wishes of a patient, while allowing a second Mississippian to act as surrogate by showing only that a patient's wishes more probably than not included the desire to withdraw treatment.[153] According to Professor Dworkin, then, a federal system can be fair without requiring all states to treat their citizens as every other state does, as long as each state treats each of its similarly situated citizens equally.[154]

Notwithstanding the prevailing acceptance of a federalist system, to the extent that end-of-life cases involve decisions that skilled judges are unable, among themselves, to make with consistent outcomes, judicial review of these cases may undermine public confidence in the courts. As the Fourth Circuit Court of Appeals explained with respect to determinations of mental competence:

> To suppose that [the difference in two mental states] is a distinction that can be fairly discerned and applied by even the most skilled judges on the basis of an adversarial fact-finding proceeding taxes credulity. The resulting threat of wholly inconsistent or highly anomalous adjudications is palpable, and *poses high risks to the integrity and trustworthiness* of the courts' already perilous involvement—out of necessity—in the adjudication of complex states of mental pathology.[155]

However, to emphasize the risks of flatly inconsistent determinations by different judicial tribunals is, to some extent, to beg the question. The relevant determination is whether such risks

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152. FRY-REVERE, *supra* note 58, at 20 (quoting DWORKIN, *supra* note 147, at 165-66, but omitting paragraph break between sentences and brackets around "to" in "state to act").

153. *See* DWORKIN, *supra* note 147. at 185. Another example of a conceivably fair, but nevertheless unacceptable, practice is a proposal allowing abortions only for women born in even years. *See id.* Fry-Revere suggests that handing out alternating life imprisonment and death sentences to persons guilty of the same crime would be another example. *See* FRY-REVERE, *supra* note 58, at 20.

154. *See* DWORKIN, *supra* note 147, at 185.

155. United States v. Charters, 863 F.2d 302, 310 (4th Cir. 1988) (en banc) (emphasis added).

are unavoidable, an inference that is affected in part by the comparative ability of ethics committees to make consistent decisions without sacrificing the protections afforded patients through judicial review. We turn now to this question.

III. EXAMINING THE UNDERLYING PREMISE: ETHICS COMMITTEES AS DECISIONMAKERS

Having examined the ability of the courts to comprehend the medical and ethical complexity of treatment controversies[156] and to dispatch these cases in a timely fashion,[157] at a bearable cost,[158] and in an objective, fair manner,[159] we now measure ethics committees against these same yardsticks. As before, we begin this exploration with the expertise of ethics committees.

A. The Committees' Expertise

Like the technical expertise of the judiciary, we can dissect an ethics committee's decisionmaking ability into medical expertise and ethical expertise. As with examination of the judiciary's expertise, we begin first with a look at the medical expertise of ethics committees.

1. Medical Expertise

With respect to clinical knowledge, committee members may be at no more advantage than the judiciary. Professor Ross notes that "clinical ethics consultants (usually neither physicians nor nurses) ... may ultimately become very knowledgeable about medicine, but they are always dependent upon their 'students' [the institution's healthcare personnel] to provide and assess the medical facts that must be judged before ethical analysis can proceed."[160] Unlike courts, however, committees do not command the resources to procure an extra-institutional professional appraisal of the medical facts.

2. Ethical Expertise

The ethical expertise ascribed to ethics committees[161] hinges

156. *See supra* notes 82-116 and accompanying text.

157. *See supra* notes 124-26 and accompanying text.

158. *See supra* notes 118-23 and accompanying text.

159. *See supra* notes 129-55 and accompanying text.

160. Judith Wilson Ross, *Commentary: Why Clinical Ethics Consultants Might Not Want to Be Educators*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 445, 446 (1993).

161. *See* Hollander, *supra* note 36, at 171 (arguing that treatment disputes "involve

largely on the expertise that member ethicists can bring to an ethical dilemma. "The ethicist brings knowledge of a process of moral reasoning and relevant literature which he or she is now asked to use to analyze a case and to recommend an appropriate course of action.... [The ethicist can] guid[e] the discussion and thereby instruct[] those involved concerning the values of the case and the justification of various courses of action...."[162] Although individual ethicists indeed may possess developed moral reasoning skills, "the 'expertise' of *ethics committees* is far from obvious."[163] As a threshold matter, ethicists are included in the ranks of less than one half of ethics committees.[164] Moreover, on those committees where ethicists serve, they "are not thought to be very influential, especially by physicians."[165] It may be expected, then, that any moral expertise ethicists bring to committee proceedings may be dampened by a credibility gap among physicians and other committee members.

Moreover, Professors Fletcher and Hoffmann note that "most members of ethics committees engage in little or no serious study of clinical ethics or related topics. In practice, each member tends to maintain his or her own personal concept of ethics, which is rarely examined in serious debate."[166] Experience aside, Professor Ross emphasizes that the notion of the ethics committee as an ethics expert may be incompatible with and may misrepresent the role of the committee in the patient care context.[167] Scholars have not even agreed on the appropriate qualifications that committee members

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complex [ethical] issues... that are better left to... [ethics committees which have] more expertise in the area" than the courts).

162. Jacqueline Glover et al., *Teaching Ethics on Rounds: The Ethicist as Teacher, Consultant, and Decision Maker*, 7 THEORETICAL MED. 13, 15-16 (1986); *see also* Wikler, *supra* note 107, at 12, 13 ("Knowledge of the leading theories and skill in determining their bearing on specific issues is one basis for claims of expertise in applied ethics....").

163. Fleetwood & Unger, *supra* note 15, at 323 (emphasis added).

164. *See* Hoffman, *supra* note 39, at 108 (reporting results of regional study of medical ethics committees).

165. *Id.* at 117.

166. Fletcher & Hoffmann, *supra* note 4, at 336; *see also* Susan M. Wolf, *Ethics Committees in the Courts*, HASTINGS CTR. REP., June 1986, at 12, 14 ("[E]thics committees should not be presumed to have [moral] expertise meriting deference.... [M]ost members probably have had no formal training in moral reasoning. Their collective opinion adds only the element of consensus. Yet consensus does not mean that the group has reasoned rigorously or well; it simply means that the members agree."). Admittedly, the same may be said of individual members of the judiciary.

167. *See* ROSS ET AL., *supra* note 20, at 32-33 (noting the possible use of ethics committees for issues involving impaired staff members and conflicts caused by religious philosophy or physician's joint ventures). Ross also emphasizes that ethics committee members are not ethical specialists but should be "thoughtful, reflective, critical thinkers." *Id.* at 37.

should possess.[168] And, to the extent that committee consult services reflect traditional medical decisionmaking, the "individualized, ad hoc character [of individual case resolution may be] ... ill-suited to address the broader ethical issues implicated in modern medicine."[169]

B. Cost, Timeliness, and Ability to Preserve Privacy

The second measure of ethics committees as decisionmakers is their ability to resolve treatment controversies in a cost-effective, timely fashion while preserving the privacy of the proceeding.[170] As with this Article's analysis of the judicial proceedings, this study begins with a review of the costs of ethics committee decisionmaking.

1. Cost

It is likely that review by an ethics committee of individual cases will cost less than judicial review, incurring neither court costs nor attorneys fees.[171] The cost of review per case is only part of the picture, however. We must also look at the propensity for the volume of such cases to grow as the bureaucracy to accommodate it—ethics committees—is put in place. Thus, if the use of ethics committees results in the routine review of " 'an even larger number and wider range of medical decisions' than would have been reviewed in court proceedings,"[172] this mechanism of review may be more costly in the aggregate.[173]

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168. *See* Fletcher & Hoffmann, *supra* note 4, at 336 ("[L]ittle consensus exists about standards for education and skills necessary for membership on a committee, or for the internal operations of committees, for providing consultation as a committee member, or for procedural guidelines for the conduct of consultations."); Giles R. Scofield, *Ethics Consultation: The Least Dangerous Profession?*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 419 (1993) ("Ethicists themselves do not agree on how ethics should be taught or on whether [ethicists] should reason analytically, causistically [sic], or phenomenologically."); *see also* Wolf, *supra* note 38, at 287 (noting that committees have enormous variation in ethical expertise).

169. *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1523-24 (1990).

170. For analysis of the courts' ability to meet these needs, see *supra* notes 117-28 and accompanying text.

171. *See* Scott, *supra* note 37, at 855-56 (noting that judicial review imposes formidable costs, including attorneys fees, court costs, and time away from work).

172. Mary Layne Ahern, *Biomedical Ethics Committees Confront Prickly Issues*, HOSPITALS, Aug. 1, 1984, at 66, 68 (1984) (quoting PRESIDENT'S COMM'N REP., *supra* note 4, at 165).

173. As noted above, very few end-of-life treatment decisions require judicial review. *See supra* notes 87-88 and accompanying text (reporting that state court judges encounter treatment disputes only once every six or more years). In contrast, many ethics committees hear a dozen or more cases per month. *See* Wilson et al., *supra* note 6

Moreover, per capita cost of ethics committee deliberations is misleading not only because it fails to account for volume increases, but also because it fails to account for duplication of efforts and costs. If judicial oversight of treatment controversies occurs as frequently *when there has been prior institutional review as when there has not*, then the tab for ethics committee review does not substitute for court costs but is tacked onto those costs. The President's Commission acknowledged this risk in strong cautionary language:

> If the existing process of decision-making, which is largely private and unreviewed, has been appropriate and has resulted in good 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.[174]

Notwithstanding the foregoing, a significant advantage of using ethics committees to resolve disputes is that the institution bears the cost of the proceeding, rather than taxpayers.[175]

2. Timeliness

Timeliness of dispute resolution is one area in which ethics committees, as institutional actors functioning at the bedside, have the clear advantage over redress to the courts. In a two-year study of an ethics consultation service in a community teaching hospital, "[a]ll respondents found that the consultation was provided quickly enough."[176] The ethics consultation service at a large tertiary care hospital, for instance, experienced average initial response time of two to three minutes for a request for consultation and several hours to a couple of days or longer for a formal consultation.[177] Few courts, if any, can boast such prompt turn-around times.

The superiority of committees in preserving patient confidentiality is less clear, an issue to which we turn now.

3. Ability to Preserve Privacy

Several problems raise serious doubts about a committee's

(unpublished data on file with the author).

174. PRESIDENT'S COMM'N REP., *supra* note 4, at 165.

175. *See supra* notes 122-23 and accompanying text (discussing costs to the public of judicial proceedings).

176. John LaPuma et al., *Community Hospital Ethics Consultation: Evaluation and Comparison with a University Hospital Service*, 92 AM. J. MED. 346, 348 (1992).

177. Telephone Interview with John C. Fletcher, Ph.D., Former Director, Center for Biomedical Ethics, University of Virginia Medical Center Bioethics Committee (Oct. 16, 1997).

capacity to preserve privacy. First, a "patient's charts are easily obtained by consultants whose participation in care is unknown to the patient."[178] Second, studies have shown that more than eighty individuals can make credible claims of access to a patient's clinical chart during an average stay.[179] Third, a committee, unlike a court, has no legal authority to direct either its own members or those caretakers utilizing committee services to maintain a patient's confidentiality.[180]

C. *Objectivity*

While an ethics committee, as an institutional player in the treatment setting, may be better able to gauge its impact on family members and proceed in a fashion that causes the least amount of strain,[181] the advantages of such proximity are not without their costs. Several aspects of committee performance suggest that one such cost is compromised objectivity.[182] First, ethics committees wholly or in part may conceive of their role as serving physicians,[183] suggesting that objectivity is an unrealistic expectation. Even when the committee sees its purpose as being an impartial arbiter, the committee may be concerned about preserving its place in the institution by decreasing physician anxiety about its role and authority.[184]

Second, an ethics committee may internalize and perpetuate its parent hospital's dominant institutional biases.[185] This risk seems real

178. Fletcher & Hoffmann, *supra* note 4, at 336.

179. *See id.* Of course, this jeopardizes a person's privacy with respect to ethical matters only if the committee or consultant records notes of the ethics consultation in the patient's chart.

180. *See supra* notes 127-28 and accompanying text for a discussion of protective orders issued by courts.

181. *See* Scott, *supra* note 37, at 855 (observing that mandatory judicial review "impose[s] formidable costs on the family, in terms of money, time expended, and psychological stress").

182. It is critical to any examination of objectivity that we decide from whose perspective a proceeding must be objective. Because fundamental liberty interests are often involved in medical ethical questions, *see* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278-79, 292 (1990), the patient's interest should be our starting point. As Professor Merritt points out, such a presumption "accords with the overriding goal of medicine—to further the patient's interest—and with the role that most advocates of ethics committees envision the committee as serving." Merritt, *supra* note 5, at 1273.

183. *See infra* notes 194-95 and accompanying text.

184. *See* Cranford & Doudera, *supra* note 3, at 11 ("A multidisciplinary ethics committee could help health care practitioners feel more secure about the appropriateness of their decisions and help assure patients of their rights.").

185. *See* Leslie Steven Rothenberg, *Clinical Ethicists and Hospital Ethics Consultants:*

given that most ethics committee members are institutional actors,[186] the majority of committees are chaired by physician-members,[187] the ethics committee literature is replete with advice to committees not to be reformers,[188] and the dynamics of group decisionmaking may inadvertently cause committees to avoid controversial issues or alternatives that prevent quick agreement.[189] As Professor Scofield tersely points out, "[o]ne need only ask who hires them, who they are accountable to, and what group they wish least to offend to appreciate how easily ethics consultants can lose the critical distance needed to exercise ... independent, objective judgment."[190] Indeed, extensive patient involvement in committee deliberations "may not reassure patients that their wishes and interests are represented.... Patients or surrogates who disagree with the committee's

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The Nature of Their "Clinical" Role, in ETHICS CONSULTATION IN HEALTH CARE 19, 27 (John C. Fletcher et al. eds., 1989) [hereinafter ETHICS CONSULTATION IN HEALTH CARE] (suggesting that "hospital-based philosophers might become absorbed 'into the medical center ethos and become collaborators in a flawed system' " (quoting William Ruddick, *Can Doctors and Philosophers Work Together?*, HASTINGS CTR. REP., Apr. 1981, at 12, 17)). An institutional bias that may be perpetuated by ethics committees may be the desire by "[d]octors ... to make all the choices." ROTHMAN, *supra* note 37, at 209; *see also* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984) (describing physicians' ambivalence about surrendering their traditional domination of the decisional process). An ethics committee may perpetuate this bias by giving greater deference to physicians than other healthcare professionals. *See* ROTHMAN, *supra* note 37, at 256 ("To the degree that ... [ethics committees] are doctor-convened, they may be doctor-dominated."); Hoffmann, *supra* note 39, at 111 (reporting that 60% of survey respondents in a regional ethics committee study found physicians most likely to influence the outcome of an ethics committee's recommendation). Concededly, the judiciary also runs the risk of perpetuating institutional biases. *See supra* notes 129-33 (discussing possible biases in judicial decisionmaking in the healthcare context).

186. *See supra* note 5 and accompanying text; *see also* ROTHMAN, *supra* note 37, at 255 ("Membership [on medical ethics committees] is heavily weighted to clinical personnel ...."); Hoffmann, *supra* note 39, at 108, 116-17 (reporting that a regional descriptive study of ethics committees in Maryland, the District of Columbia, and Virginia found 100% of committees contained at least one physician, 98% contained at least one nurse, 90% contained at least one social worker, and 80% contained at least one hospital administrator, with physician representation on such committees far outstripping representation by any other group).

187. *See* Hoffmann, *supra* note 39, at 108 (reporting that in the majority of jurisdictions surveyed physicians most often chaired the committees).

188. *See* Mark Siegler, *Cautionary Advice for Humanists*, HASTINGS CTR. REP., Apr. 1981, at 19, 19-20; *see also* Ronald E. Cranford & David L. Jackson, *Neurologists and the Hospital Ethics Committee*, 4 SEMINARS NEUROLOGY 15, 19 (1984) (assuaging doctors' fears that ethics committees will infringe on the "traditional decision-making prerogative of physicians" by emphasizing the limited powers of ethics committees to act in a "consultative, informative, and advisory capacity").

189. *See* Bernard Lo, *Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 NEW ENG. J. MED. 46, 48 (1987).

190. Scofield, *supra* note 168, at 420.

recommendations may say that the composition of the committee was biased against them."[191]

Compounding this risk of capture by the institution is the prevalent confusion about the proper purpose of an ethics committee.[192] While numerous authors argue that patient protection should be the primary purpose of ethics committees,[193] others at least conceive of risk management or the protection of institutional interests as a valid committee objective.[194] Equally as troubling as

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191. *See* Lo, *supra* note 189, at 47.

192. This confusion over purpose continues to dominate the discussion of medical ethics issues. *See* Judith Wilson Ross, *The AMA Talks Medical Ethics*, VITAL SIGNS: BIOETHICS NEWS & REVS., May 1997 (visited Oct. 2, 1997) <http://www.chce.org/vital.htm> (discussing positions taken in panel discussion by philosopher Robert Veatch, attorney Alex Capron, and physician Mark Siegler on the question of: "Who Should Control the Scope and Nature of Medical Ethics?").

193. *See* Capron, *supra* note 4, at 429; Ruth Macklin, *Consultative Roles and Responsibilities*, *in* INSTITUTIONAL ETHICS COMMITTEES, *supra* note 3, at 157; Veatch, *supra* note 6, at 35; *see also* George J. Annas, *Ethics Committees in Neonatal Care: Substantive Protection or Procedural Diversion?*, 74 AM. J. PUB. HEALTH 843, 843-44 (1984) (stating that although institutions often see the primary function of ethics committees as protecting their legal liability, "[t]he much more important potential function of ethics committees is the protection of the autonomy and dignity of individual patients"); Mila Ann Aroskar, *Considerations in Establishing an Ethics Committee*, 40 ASS'N OPERATING ROOM NURSES J. 88, 92 (1984) ("Institutional ethics committees have the potential for protecting patients' interests and welfare and assuring that reasoned, fair decisions are made for those unable to decide for themselves."); Robert M. Kliegman et al., *In Our Best Interests: Experience and Workings of an Ethics Review Committee*, 108 J. PEDIATRICS 178, 186 (1986) (noting that committees' goals should be "to promote the best interests of patients"); Judith Randal, *Are Ethics Committees Alive and Well?*, HASTINGS CTR. REP., Dec. 1983, at 10, 12 (characterizing the role of ethics committees as that of patient advocate).

194. *See* John A. Robertson, *Committees as Decision Makers: Alternative Structures and Responsibilities*, *in* INSTITUTIONAL ETHICS COMMITTEES, *supra* note 3, at 85, 88-89 (noting the potential use of an ethics committee as an "ethical risk management team"); Annas, *supra* note 193, at 843-44 ("Institutions and their staffs often see the primary function of ethics committees as protecting them against potential legal liability for treating or not treating particular patients.... This is a legitimate institutional goal, but such committees should probably be termed 'risk management' or 'liability control' committees instead of ethics committees."); Capron, *supra* note 4, at 429 ("[S]ome people ... favor ethics committees in the belief that they will protect physicians or hospitals."); Norman Fost & Ronald E. Cranford, *Hospital Ethics Committees*, 253 JAMA 2687, 2689 (1985) ("If the primary function of the group is to be advisory to the attending physician, apologies should not be needed for the physician's desire to have a free and uninhibited consultation.").

This concern that the ethics committee will act as a risk management team is heightened by the inclusion on nearly all committees of hospital administrators and in-house counsel, both of whom have probable conflicts of interest. *See* ROSS ET AL., *supra* note 20, at 39 (observing that "insofar as, in some cases, the hospital's interests (in avoiding possible law suits, for example) may not in the short run be consistent with the patient's desires or interests, the hospital lawyer should not to [sic] be placed in a position

committees that openly serve institutional interests are ethics committees that possess a "double identity," in which they advise patients *and* serve caregivers.[195] Such a conflicting role robs patients of the ability to know "precisely where they stand" vis-a-vis the committee.

Third, few committees have put in place the process protections that would help to combat institutional bias. As Professors Fletcher and Hoffmann note:

> [C]ommittees, which are confused about their advisory role, make decisions "behind closed doors" at the request of clinicians who approach the committee without notifying the patient or surrogate decision makers. Standards of due process are not followed and may even be unknown to the committee. Inattention to procedural due process raises concerns that the rights of caregivers, patients, and patients' families are possibly being compromised or violated.[196]

The due process protections afforded by judicial review but lacking in committee proceedings include uniform procedural guidelines, notification to all involved parties of a hearing, an appeal process, and the mandatory inclusion of an advocate for the patient's

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of possible conflict of interest"); Daniel Wikler, *Institutional Agendas and Ethics Committees*, HASTINGS CTR. REP., Sept.-Oct. 1989, at 21, 22 (asserting that administrators may "loo[k] to avoid ... fight[s]" and seek "narrow institutional gains, rather than success in meeting community needs"). A 1992 national survey, conducted with the assistance of the American Hospital Association, found that 96.2% of all ethics committees contain at least one administrator. *See* Wilson et al., *supra* note 6 (unpublished data on file with the author). This figure has almost doubled since the mid-1980s. *See* Gregory A. Jaffe, *Institutional Ethics Committees: Legitimate and Impartial Review of Ethical Health Care Decisions*, 10 J. LEGAL MED. 393, 413 (1989).

Professor Ackerman identifies a third conception of the committee's role that rejects a patient-centered focus for "an impartial analysis of the competing moral interests of other relevant parties." Terrence F. Ackerman, *Conceptualizing the Role of the Ethics Consultant: Some Theoretical Issues*, *in* ETHICS CONSULTATION IN HEALTH CARE, *supra* note 185, at 37, 42. This, too, greatly impacts the ability of a committee to act objectively on the patient's behalf.

195. *See* Wolf, *supra* note 7, at 820-31. This duality of purpose largely arises from the failure to articulate clearly a committee's mission and goals. As Merritt points out, "[i]t is unlikely that many committees identify whether their primary constituency is doctors or patients. Indeed, few of the participants may consciously think in advance of defining their roles in these terms." Merritt, *supra* note 5, at 1292. Physician committee members and physicians who consult with a committee, moreover, may be hobbled in achieving a "shared [decisionmaking] process [with the patient] marked by conversation and patient choice" by the "profound ambivalence among physicians about surrendering their traditional domination of the decisional process." Wolf, *supra* note 8, at 829-30 (citing JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 98-100 (1984)).

196. Fletcher & Hoffmann, *supra* note 4, at 336 (footnote omitted).

interests.[197] Until committees institute minimal process protections for patients and users, committee functions lack even a semblance of order and fairness and threaten to reach arbitrary and disparate outcomes.

Lastly, feminist scholars have argued that ethicists, like courts, may have integrated stereotypical perspectives into their work, perpetuating gender bias.[198] Other scholars suggest that "ethics [may] perpetuate the domination of some groups and individuals by others."[199]

D. Error Costs Associated with Committee Decisions

As late as 1991, some two decades into the ethics committee movement, ethics committee "insiders" first began to give serious consideration "to develop[ing] a common understanding of success—of defensible results—if we are to judge whether our assumptions about [ethics committee] processes and structures are correct."[200] Impeding the development of uniform standards, however, is the fear that such standards, like standards for physicians and other healthcare professionals, may expose committees and their members to liability.[201] Although a lack of agreed-upon standards may be expected in a movement still in its infancy, without even rudimentary agreement on the recommendations committees should make in particular situations, it should also be expected that recommendations will vary widely, and perhaps materially, from committee to committee.

Compounding the lack of uniform standards is the dramatically uneven professional qualifications of ethics committee members.[202]

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197. *See* Hoffmann, *supra* note 5, at 779-80 (citing PRESIDENT'S COMM'N REP., *supra* note 4, at 446); Lo, *supra* note 189, at 47; Wolf, *supra* note 7, at 803.

198. *See generally* ELIZABETH V. SPELMAN, INESSENTIAL WOMAN: PROBLEMS OF EXCLUSION IN FEMINIST THOUGHT (1988) (arguing that the caring perspective attributed to women fails to represent the diverse experiential perspectives of women); María C. Lugones & Elizabeth V. Spelman, *Have We Got a Theory for You! Feminist Theory, Cultural Imperialism and the Demand for 'The Woman's Voice,'* 6 WOMEN'S STUD. INT'L F. 573 (1983) (arguing that gender and race are pervasive elements in every individual's thinking and outlook).

199. Scofield, *supra* note 168, at 419 (citing SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE (1992)).

200. Gail M. Povar, *Evaluating Ethics Committees: What Do We Mean by Success?*, 50 MD. L. REV. 904, 907 (1991).

201. *See* Carol Levine, *Hospital Ethics Committees: A Guarded Prognosis*, HASTINGS CTR. REP., June 1977, at 26, 26.

202. *See* Wolf, *supra* note 38, at 287 (noting that committee members have enormous variation in ethical expertise).

Calling for an end to the "era of laissez-faire in ethics consultation," Professor Fletcher has chided hospitals to "exercise more control over who is authorized to provide ethics consultation."[203] The lack of control over professional qualifications and accountability standards, Professor Fletcher argues, "encourage[s] ethics disasters. It is surprising that in only the *Bouvia* case was a committee ... accused of 'ethics malpractice' and sued."[204] As Professor Jim Ellis observed in his testimony on ethics committees before the United States Civil Rights Commission in its hearings on the 1984 Child Abuse Amendments, "to place all of our civil rights enforcement resources [or more broadly, patient protection resources] in such a hit-or-miss mechanism when the stakes are so high for the [patients] involved is distressing."[205]

E. Capacity to Treat Like Cases Alike

As noted above, the movement's near utter lack of process protections for patients and users suggests that committees cannot guarantee fundamental fairness and equality in treatment among cases within an institution.[206] More importantly, even if due process protections were instituted and followed by hospital ethics, without judicial review or some other external regulatory mechanism, patients in one hospital have no guarantee of being treated in a similar fashion as patients at another hospital.[207] This violates our

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203. John C. Fletcher, *Commentary: Constructiveness Where It Counts*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 426, 432 (1993).

204. *Id.* (referring to *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal Ct. App. 1986)).

205. 2 *Protection of Handicapped Newborns: Hearing Before the United States Comm'n on Civil Rights* 35-36 (Vol. II) (1986) (testimony of Prof. James W. Ellis, School of Law, University of New Mexico), *quoted in* U.S. COMM'N ON CIVIL RIGHTS, MEDICAL DISCRIMINATION AGAINST CHILDREN WITH DISABILITIES 118 (1989) [hereinafter MEDICAL DISCRIMINATION].

206. *See supra* notes 196-97 (discussing lack of due process protections in ethics committee deliberation).

207. This argument assumes that process protections are *not* outcome-determinative. In order for process protections alone to secure inter-institutional equality of treatment, *as judged by substantive outcomes*, one would have to show both: (1) that Hospital A and Hospital B each followed the process protections; and (2) that a given set of process protections always leads to a defined substantive outcome. For example, one would need to show that notice and hearing would always lead to the substantive conclusion that a surrogate may make a decision for an incompetent patient.

Because privilege and immunity frustrate and even destroy the opportunity for matters initially resolved at the institutional level to be adjudicated at the societal level, *see supra* note 45 and accompanying text, the judicial mechanisms for guaranteeing that like cases will be treated alike cannot come substantively into play.

fundamental concern for integrity and fairness, a violation that occurs when people are most vulnerable—when they struggle at death's door.

F. Conclusion

The geometric increase in hospital ethics committees, together with more than two decades of experience, permits us to test the claim that recourse to the courts is vastly more expensive, unwieldy, and insensitive than decisions made at the institutional level with the input of hospital ethics committees. As the foregoing comparison demonstrates, the data trickling in on the performance of hospital ethics committees reveal a quirky mechanism that cannot sustain its claim of singular competence in resolving controversies over medical ethics issues.

In addition to the relative competence of courts and committees to make end-of-treatment decisions, legislative grants of privilege and immunity raise other questions that should be addressed: What advantages does liability offer in the context of medical-ethical decisionmaking? What policy arguments underpin the grant of privilege and immunity in related contexts, such as peer review, and do they apply with equal force to the ethics committee movement? And, are there certain matters that universally warrant judicial review, and do the cases with which ethics committees routinely deal fall within this category? We explore each of these questions in Part IV.

IV. THE IMPLICATIONS OF PRIVILEGE AND IMMUNITY STATUTES

We begin our investigation of the implications of grants of privilege and immunity for medical ethics decisions by looking at the role liability plays in the healthcare context.

A. Advantages of Liability

Liability affords four principal advantages: it encourages good decisionmaking, compensates persons who have been wrongfully harmed, promotes social dialogue on questions of withdrawal and withholding of treatment, and serves to guide the conduct of third parties.

1. Liability Promotes Good Decisions

As Professor Capron notes, "[a] certain amount of concern for legal risk serves as a healthy reminder of the weighty nature of the

decisions one is making."[208] In addition to underscoring a decision's gravity, liability serves a critical signaling function by informing providers how much to invest to avoid mishaps in patient care.[209] Privilege and immunity statutes may attenuate or abolish this deterrence signal[210] and therefore can be expected to result in poorer decisionmaking.[211] Poor decisions may arise for another reason as well. Specifically, providing immunity to professionals who rely on committee recommendations may compel caretakers to follow misguided committee recommendations in order to secure protection.[212] Furthermore, such immunity departs from society's

208. Capron, *supra* note 4, at 429; *see also* Flick, *supra* note 53, at 1165 ("In every medical decision, doctors basically gamble that their patient, and if need be a court, will later find their behavior reasonable. The fundamental uncertainty of the risks is part of *the insurance that decisions are carefully made.*" (emphasis added)).

209. *See* William B. Schwartz & Neil K. Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282, 1283 (1978) (applying Judge Learned Hand's formula: "litigation ... signals potentially negligent people that it will cost them more to be careless than to invest in an appropriate level of prevention," so "[d]amages awarded to a victim induce potentially negligent people to compare the cost of avoiding an injury with the cost of paying for it"); *see also* Edward P. Richards & Abraham Silvers, *Risk Management Theory: Reducing Liability in Corporate and Medical Environments*, 19 HOUS. L. REV. 251, 259 (1982) ("The riskor will best balance its needs against those of the individual workers, and of society as a whole, when the [victim/worker] receives enough to be made whole, and the cost of the occurrence of the risk is greater than the cost of preventing the risk.").

210. The effect of privilege and immunity statutes on the deterrence signal necessarily depends on the degree of protection provided under the statute. For example, if a state patterns its immunity statute after the Health Care Quality Improvement Act, 42 U.S.C. § 11101-52 (1994), which affords limited immunity, then the deterrent signal will be merely attenuated. That is, a deterrence signal will be sent in cases involving violations of a patient's civil rights, which are not protected by the Act, but may not be sent in cases of negligence, which fall within the Act's protective shield when certain due process protections have been provided. *See* Havighurst, *supra* note 45, at 1164 ("Although it may seem desirable to reduce the ability of marginal practitioners to retaliate for legitimate actions taken against them, the other horn of the legal system's dilemma is the risk that abusive conduct will be inadequately policed if statutory immunities reduce the threat of suit."); *cf.* Ira P. Robbins, *The Legal Dimensions of Private Incarceration*, 38 AM. U. L. REV. 531, 784 (1989) (arguing in a related context that state laws prohibiting state contractors from claiming sovereign immunity create "a self-enforcing accountability system in which the private contractor is required ... to exercise the necessary degree of care to ensure compliance with the contract," and that "[p]ermitting the contractor to escape liability through the use of a sovereign immunity defense would undermine the goal of accountability"). Stated differently, the strength of the deterrence signal varies with the "margin of error" created by the particular grant of immunity. *See supra* note 45 and accompanying text (discussing the enlarged realm of acceptability resulting from a grant of qualified immunity).

211. *Cf.* Richards & Silvers, *supra* note 209, at 258-59 (predicting poorer decisionmaking in situations where compensation is limited by law in order to protect the risk-taker from financial loss).

212. *See* Fleetwood & Unger, *supra* note 15, at 324. Professor Flick makes a similar

refusal to shield primary care physicians who follow a clinical consultant's advice.[213]

2. Liability Compensates Plaintiffs Who Have Been Wrongfully Harmed

In addition to deterrence, a second function of litigation is to compensate plaintiffs who have been harmed by others.[214] Unfortunately, the cost of a committee's protective shield is borne by plaintiffs who may have injuries for which society otherwise would provide a remedy. As the District Court for the Eastern District of Kentucky explained:

> [E]ven though some injury might inure to the functioning of the peer review committee by denying the privilege, plaintiff's ability to proceed with the litigation is totally thwarted by granting it. The benefit gained for the correct disposal of litigation by denying the privilege is overwhelming, because this court's ability to evaluate plaintiff's constitutional claims would be totally negated if the privilege is recognized.[215]

As Merritt says, "[i]n a legal system that couples responsibility with liability, immunity for ethics committees would be inappropriate."[216]

3. Adjudication Promotes Social Dialogue on Significant Issues

Court proceedings generally are marked by open hearings and public records, although courts often take steps to protect the privacy of the individuals involved.[217] Intra-institutional resolution of troubling life and death issues by an ethics committee, coupled with

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point, arguing that uncertainty about the locus of decisionmaking in medical ethics cases serves an insurance function, which is undermined by privilege and immunity statutes. *See* Flick, *supra* note 53, at 1165 ("Doctors must be held accountable for their personal involvement in healing.... Cementing the locus of medical decisionmaking power in any party abrogates the insurance [created by not knowing who may legally decide] by allowing the people involved to assign responsibility for their actions to someone else ....").

213. *See* Fleetwood & Unger, *supra* note 15, at 323 ("[I]mplementing advice from an ethics committee should provide no more immunity from liability than does following the recommendation of an expert clinical consultant.").

214. *See* Schwartz & Komesar, *supra* note 209, at 1282.

215. Ott v. St. Luke Hosp., 522 F. Supp. 706, 711 (E.D. Ky. 1981). Courts grant protection only when the " '*injury* [from] disclosure [is] *greater than the benefit* thereby gained for the correct disposal of litigation.' " *Id.* at 710 (quoting ACLU v. Finch, 638 F.2d 1336, 1344 (5th Cir. 1981)).

216. Merritt, *supra* note 5, at 1297.

217. *See* Hafemeister, *supra* note 85, at 70; *see also supra* notes 127-28 and accompanying text (discussing privacy measures applied by courts).

immunity for professionals making these decisions, constructs a cloak of secrecy around end-of-life decisionmaking. Keeping such matters from public view "may contribute to misunderstanding, frustration and lack of public confidence" in the decisionmakers.[218] It also undermines the "valuable education function [provided by public access, especially] since such cases are often of great interest to the public."[219]

Certainly such a result would be ironic. Ethics committees were intended to provide valuable input and dialogue on ethical issues surrounding treatment decisions,[220] not to be instruments for shrouding decisions. As Professor Bok points out, secrecy itself cannot be justified when it "undermine[s] and contradict[s] the very respect for persons and human bonds that confidentiality was meant to protect."[221] Thus, the strong societal interest in open proceedings militates against shielding such decisions from public view by granting protection to committees.

4. Adjudication Is Essential to the "Guidance Function of Law"

Of greater concern than muffled ethical dialogue, intra-institutional resolution of medical ethics issues threatens to erode an indispensible function of judicial resolution, the "guidance function of law":[222]

> Litigation guides third parties. Litigation results in written opinions that apply necessarily vague positive law to concrete fact situations. Those opinions are expository—they refine and elaborate ambiguous norms and "give operation[al] meaning to principles that would otherwise remain abstract, rhetorical and elusive."[223]

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218. Hafemeister, *supra* note 85, at 71 (making this observation about closed court proceedings).

219. *Id.*; *see also* United States v. Bryan, 339 U.S. 323, 331 (1950) (noting that evidentiary privileges contravene the fundamental principle that " 'the public . . . has a right to every man's evidence' " (quoting JOHN HENRY WIGMORE, A TREATISE ON THE ANGLO-AMERICAN SYSTEM OF EVIDENCE IN TRIALS AT COMMON LAW § 2192 (3d ed. 1940))).

220. *See* Teel, *supra* note 2, at 8-9.

221. SISSELA BOK, SECRETS: ON THE ETHICS OF CONCEALMENT AND REVELATION 135 (1982).

222. Edward Brunet, *Questioning the Quality of Alternate Dispute Resolution*, 62 TUL. L. REV. 1, 23-24 (1987) (asserting that alternative dispute resolution threatens to undermine the "guidance function of law").

223. *Id.* at 20 (quoting Girardeau A. Spann, *Expository Justice*, 131 U. PA. L. REV. 585, 592 (1983) (discussing alternate dispute resolution), but changing "operational" to "operation").

> As ... [alternative dispute resolution] receive[s] a larger market share of disputes, we can anticipate additional "disputes" arising as law loses its ability to lead or influence societal behavior.[224]

Where resolution of treatment disputes by ethics committees supplants judicial review, a significant opportunity to articulate substantive law to govern conduct is lost.

B. Policy Justification for Privilege and Immunity

As Professor Capron notes, "the law [generally] looks with disfavor on privileges that make unavailable material that might be helpful to fact-finders in resolving an issue."[225] Privilege and immunity are granted, however, when societal interests in having an activity performed outweigh the costs associated with the loss of access to judicial redress.[226] For example, the Health Care Quality Improvement Act[227] (the "Act") grants privilege[228] to "peer review" records in order to combat the threat of liability.[229] This liability

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224. *Id.* at 23-24.

225. Capron, *supra* note 4, at 430; *see also* United States v. Bryan, 339 U.S. 323, 331 (1950) ("Evidentiary privileges contravene the fundamental principle that 'the public ... has a right to every man's evidence.' " (quoting 8 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2185 (McNaughton rev. 1961) [hereinafter WIGMORE, EVIDENCE])).

226. *See* Ott v. St. Luke Hosp., 522 F. Supp. 706, 710 (E.D. Ky. 1981) (stating that the " '*injury* ... [from] disclosure ... must be *greater than the benefit* thereby gained for the correct disposal of litigation' " (quoting *ACLU v. Finch*, 638 F.2d 1336, 1344 (1981), which quotes other cases quoting 8 WIGMORE, EVIDENCE, *supra* note 225, § 2285)). In effect, privilege and immunity statutes are a subsidy of the activity that is granted protection. *See, e.g.*, Merritt, *supra* note 5, at 1258 ("[I]nterpretation of the protective statutes to apply to ethics committees would be a means of *nurturing* their growth." (emphasis added)).

227. Health Care Quality Improvement Act, 42 U.S.C. § 11101-52 (1994).

228. The Act affords physicians participating in peer review both privilege and immunity protection. With respect to privilege, the Act provides a very limited form of privilege. Specifically, § 11137(b)(1) provides for confidentiality only of information provided to the national repository pursuant to the Act. *See* Pagano v. Oroville Hosp., 145 F.R.D. 683, 694 (E.D. Cal. 1993). The Act does not protect reports remaining within the hospital's peer review file. *See* Manthe v. VanBolden, 133 F.R.D. 497, 500-01 (N.D. Tex. 1991). With respect to immunity,

> [t]he Act affords hospitals, physicians, and other entities engaged in peer review protection from monetary damages under all federal and state actions except those relating to civil rights and due process denials. Immunities are conditioned upon a series of reasonableness standards, including due process guidelines, that must be adhered to in the review process.

John D. Blum, *Medical Peer Review*, 38 J. LEGAL EDUC. 525, 528 (1988).

229. The legislative history to the Act states:

> The purpose of this legislation is to improve the quality of medical care by

unreasonably discourages physicians from participating in effective professional review and, therefore, undermines society's ability to protect the public from harm by incompetent doctors.[230]

Significantly, the policy arguments underlying the grant of privilege and immunity to peer review committees simply do not pertain here. First, there is no evidence that healthcare professionals

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> encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior. Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill.

H.R. REP. NO. 99-5540, at 6 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6384; *see also* Blum, *supra* note 228, at 528 ("The most compelling of the factors that led to the enactment of the Health Care Quality Improvement Act was the continued fear on the part of organized medicine that those engaged in peer review were legally vulnerable, regardless of state law protections."); Capron, *supra* note 4, at 430 ("The rationale for confidentiality of 'peer review' records ... is [that it is] necessary for candid evaluation of professionals' performance, which in turn leads to better internal discipline and correction of problems ...."); Havighurst, *supra* note 45, at 1160-61 ("One purpose of this act is to combat 'the threat of private money damage liability under Federal laws ... [which] unreasonably discourages physicians from participating in effective professional peer review.' " (quoting Pub. L. No. 99-660, §§ 401-32, 100 Stat. 3784 (1986))); Louise M. Joy, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection*, 20 ST. MARY'S L.J. 955, 962-63 (1989) ("Congress passed the [Act] to encourage good faith peer review of physicians practicing in hospitals ...."); Kym Oltrooge, *An Ounce of Prevention Is Worth a Pound of Cure: The Need for States to Legislate in the Area of Hospital Professional Review Committee Proceedings*, 46 WASH. & LEE L. REV. 961, 966-67 (1989) ("Through the protection the [Act] accords to physicians engaged in professional review actions, Congress attempted to encourage physicians to participate in the professional review process, and thus maintain a high standard of quality for medical care in the country."); Jacqueline Oliverio, Note, *Hospital Liability for Defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, but Words May Cost Me My Job*, 92 W. VA. L. REV. 739, 754 (1990) ("Congress recognized that [the] goal [of restricting the ability of incompetent physicians to continue to practice and deliver poor care] could be accomplished through effective ... peer review, only if the threat of liability for physicians participating in the ... review process was eliminated." (citing 42 U.S.C. § 11101(4) (1994))).

State immunity and privilege statutes grant protection for similar reasons. *See* Merritt, *supra* note 5, at 1257 ("The protective statutes are an acknowledgement that some special protections [to doctors from damage awards] may be necessary to encourage the effective use of such committees, which ultimately benefit the public."); Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 179 (1988) (citing the desire to combat physician "reluctance to participate in peer review" due to liability concerns and the need "to enhance the improvement of medical care services" as motivating factors for state protection of peer review committee work).

230. Admittedly, the threat of liability is significant, as liability consists not only of damages for defamation, slander, and other common law and statutory causes of action, but also includes treble damages under federal antitrust law. *See* AMERICAN MED. ASS'N, COLLECTIVE NEGOTIATION AND ANTITRUST: A GUIDE FOR PHYSICIANS 4 (1997).

and laypersons in the community have chosen not to serve on ethics committees out of concern for their potential liability. Indeed, the dramatic growth in the number of institutions with such committees suggests that recalcitrance to serve has not been an issue.[231] Nor is there evidence that healthcare professionals and others are not using ethics committees out of fear of liability—in fact, some professionals may seek ethics committee input precisely to shield themselves from liability.[232] Second, because the creation of an ethics committee or similar "mechanism" is tied to accreditation and thus to participation in Medicare,[233] hospitals have sufficient incentive to provide ethics committee services without an additional societal subsidy in the form of protective statutes.[234] Third, immunity undermines an institution's "incentive to supervise [committee] operations and implement steps essential to the protection of [patients]."[235] Lastly, given the lack of policy justifications for immunity, society should provide no more immunity from liability than it does to primary care physicians who

231. *See supra* note 10 and accompanying text.

232. *See supra* notes 39, 212 and accompanying text (explaining "safe harbor" effect of immunity for relying on an ethics committee recommendation).

233. *See supra* note 22 and accompanying text.

234. Arguably, increased risk of liability itself should not merit a subsidy (i.e., immunity) in the peer review context, either. That is, peer review is a prerequisite to hospital accreditation, *see* Goldberg, *supra* note 48, at 151, and is a cost that can be internalized by the hospital through indemnification of the physicians participating in the peer review process, *see* KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 60 (1990) (explaining indemnification); Charles M. Pisano, Comment, *Judicial Interpretation of Indemnity Clauses*, 48 LA. L. REV. 169, 169 (1987) (noting that indemnity clauses are "used primarily as a means of allocating the risks of a project among the parties involved"). Denying doctors immunity would force hospitals and physicians to allocate this risk between themselves, rather than externalizing it to potential plaintiffs.

In addition to accreditation as a motivating factor, Professor Goldberg identifies the improvement of patient care and the ensuing decrease in legal liability as further incentives for hospitals to provide professional peer review *without a subsidy*. *See* Goldberg, *supra* note 48, at 155. To the extent that ethics committees are perceived to improve patient care or decrease litigation, hospitals have these additional incentives to provide committee services without a subsidy.

235. John A. Robertson, *The Law of Institutional Review Boards*, 26 UCLA L. REV. 484, 535 (1979) (making this observation about immunity for institutional review boards and advocating instead that institutions carry insurance on board members); *see also* PRESIDENT'S COMM'N REP., *supra* note 4, at 168 ("Although they should be protected while acting with due care and diligence, primary decisionmakers and those who review their actions should not be entirely relieved of legal responsibility."); George J. Annas, In Re Quinlan: *Legal Comfort for Doctors*, HASTINGS CTR. REP., June 1976, at 29, 30-31 (raising a question of how "dangerous and inappropriate is it to diffuse responsibility and simultaneously grant complete immunity from the consequences of any decision so reached").

follow the advice of a clinical consultant.[236]

C. *Cases Meriting Mandatory Judicial Review*

Significantly, early endorsements of ethics committees as alternatives to judicial resolution gave committees only a qualified endorsement.[237] The President's Commission Report, for example, concluded that "[r]ecourse to the courts should be reserved for the occasions when adjudication is clearly required by state law or when concerned parties have disagreements that they cannot resolve over matters of substantial import."[238] Likewise, the Court Guidelines prepared by the National Center for State Courts require judicial involvement in two types of disputes: those involving "unresolvable disagreements among the primary decision makers, or [those that raise] serious grounds for believing there is a need for protective services."[239] These characterizations of the role of courts implicitly contemplate a two-tiered review consisting of the ethics committee and the court, a structure that is threatened, if not severed, once ethics committees are granted privilege and immunity.

In two related contexts—sterilization decisions for mentally retarded children and treatment decisions for severely disabled infants—the law allows fewer opportunities for ad hoc decisionmaking rather than permitting greater discretion.[240] For

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236. *See* Fleetwood & Unger, *supra* note 15, at 323 ("[I]mplementing advice from an ethics committee should provide no more immunity from liability than does following the recommendation of an expert clinical consultant.").

237. *See* Vitiello, *supra* note 37, at 82.

238. PRESIDENT'S COMM'N REP., *supra* note 4, at 6. A number of courts also seem to have contemplated a two-tier level of review. *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 493 (Cal. Ct. App. 1983) ("[R]equiring judicial intervention in *all* cases is unnecessary and may be unwise." (emphasis added)); Custody of a Minor, 434 N.E.2d 601, 607-08 (Mass. 1982) (listing factors making judicial intervention appropriate in some cases only); *In re* Quinlan, 355 A.2d 647, 669 (N.J. 1976) (stating that "a practice of applying to a court to confirm such decisions would *generally* be inappropriate" (emphasis added)). *See also generally* Weir & Gostin, *supra* note 36, at 1848 ("Most courts have consequently concluded that . . . judicial intervention [in life-sustaining treatment cases] is both unnecessary and counterproductive *except* to protect the lives of nonautonomous patients who have no surrogate." (emphasis added)). *But see In re* Conservatorship of Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (stating that an affirmation by an ethics committee of a family's decision to withdraw life support from a patient in persistent vegetative state would eliminate the need for judicial approval).

239. Hafemeister, *supra* note 85, at 74.

240. In a third setting—on therapeutic research with incompetents and children—the vulnerable subject is simply not permitted to participate. *See* 45 C.F.R. § 46.401-409 (1996) (governing use of children as subjects in clinical research); ROBERT J. LEVINE, ETHICS AND REGULATION OF CLINICAL RESEARCH 236 (2d ed. 1986) (noting that federal regulations provide that "we should generally refrain from involving . . . [children

example, society "protects the mentally disabled person by establishing a heavy presumption against sterilization and by requiring a judicial decisionmaker."[241] Such procedural safeguards presume "a conflict of interest between the child and the parent" seeking sterilization, and "consequently exclude parents from any role in the decision."[242] In addition to the foregoing procedural safeguards, the law prohibits the decisionmaker—the court—from considering certain variables when making a sterilization decision.[243] A court may not, for instance, consider a parent's interest in "avoiding the inconvenience associated with menstrual hygiene" or the state's interest in preventing the financial burden associated with children of retarded persons.[244]

The law is equally protective of medically fragile infants.[245] Sparked by the desperate and ultimately unsuccessful efforts of a guardian ad litem in Bloomington, Indiana, to secure life-saving medical treatment against parental wishes for a Down Syndrome infant known only as Baby Doe,[246] Congress passed the 1984 Amendments to the Child Abuse Prevention and Treatment Act[247]

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and incompetent individuals] in research that is irrelevant to their conditions or at least as a class of persons"). This, of course, is even more protective of research subjects than mandatory judicial review would be. *See, e.g.*, Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063 (Mich. Cir. Ct. 1973) (finding that involuntarily committed patient cannot consent to experimental "high risk-low benefit" psychosurgery).

241. Scott, *supra* note 37, at 824.

242. *Id.* at 818; *see In re* Grady, 426 A.2d 467, 475 (N.J. 1981) (determining that incompetents are best protected by independent judicial decisionmaking, not parents' good faith decision); *In re* Guardianship of Hayes, 608 P.2d 635, 640 (Wash. 1980) (determining that parents' interests cannot be presumed to be identical to those of the child).

243. *See* Scott, *supra* note 37, at 821-22 & n.51.

244. *Id.* at 822.

245. *See* Phoebe A. Haddon, *Baby Doe Cases: Compromise and Moral Dilemma*, 34 EMORY L.J. 545, 584 n.133 (1985) (" 'It is clear that a primary purpose of the regulation is to require physicians treating newborns to take into account only wholly medical risk-benefit considerations and to prevent parents from having any influence upon decisions as to whether further medical treatment is desirable.' " (quoting American Academy of Pediatrics v. Heckler, 561 F. Supp. 395, 400 (D.D.C. 1983))).

246. Born with Down's Syndrome, Baby Doe had a tracheoesophageal fistula, a surgically correctable failure of the esophagus and trachea to properly connect. Baby Doe's parents refused to consent to intravenous feeding or to routine corrective surgery of the blocked digestive tract. The Monroe County (Indiana) Circuit Court and the Indiana Supreme Court upheld their refusal, and Baby Doe died of starvation six days later. *See In re* Infant Doe, No. 608 204-004A (Monroe County Cir., Apr. 1982) (declaratory judgment), *writ of mandamus dismissed sub nom.* State *ex rel.* Infant Doe v. Bloomington Hosp., *cert. denied*, 464 U.S. 961 (1983); LORI B. ANDREWS, MEDICAL GENETICS: A LEGAL FRONTIER 244 (1987).

247. Child Abuse Amendments of 1984, 42 U.S.C. §§ 5101-5106 (1994).

(the "Amendments"), which regulate nationally all medical treatment decisions for infants with life-threatening conditions.[248] The Amendments set forth a standard of care designed to eliminate the discriminatory denial of medical treatment to handicapped infants.[249] Principal enforcement of the Amendments resides with the Child Protective Services ("CPS") agencies that administer each state's child abuse and neglect laws.[250] Every state receiving federal child abuse grants must establish programs and procedures ("Baby Doe programs") within its CPS unit to respond to reports of "medical neglect."[251] As with sterilization, lawmakers were motivated in part by parents who were incapable of making rational, infant-focused judgments during their time of grief for their disabled infant.[252] The result was sharply circumscribed discretion by the decisionmakers and the insertion of an impartial party—the State CPS unit—into the decisionmaking process.[253]

Thus, in situations distinguished by a vulnerable patient and a suspect decisionmaker, ad hoc decisionmaking has been severely limited. Because many of the end-of-life treatment decisions ethics committees will be called on to make involve persons largely unable

248. *See id.* For information on Congress's inspiration, see the remarks of Senator Hatch in 130 CONG. REC. 27,774 (1984).

249. *See* 42 U.S.C. §§ 5101-5106. The Amendments characterize medical neglect as including the withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from impaired infants with life-threatening conditions. *See id.* § 5106(g)(10). Medically indicated treatment is the treatment that, in the treating physician's "reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions." *Id.*

The only exceptions to the requirement that doctors always treat imperiled infants are when (i) "the infant is chronically and irreversibly comatose"; (ii) the treatments would only prolong dying or would be futile or ineffective in helping the infant survive; or (iii) when the treatment would be virtually futile in helping the infant survive and would itself be inhumane. *Id.*

Even when an infant meets a treatment exception, the infant must always receive "appropriate nutrition, hydration, and medication." *Id.* Anticipated quality of life is not a factor to be weighed in a treatment decision. *See* 45 C.F.R. pt. 1340, app. at 329 (1996) ("[T]he definition's focus on the potential effectiveness of treatment in ameliorating or correcting life-threatening conditions makes clear that it does not sanction decisions based on subjective opinions about the future 'quality of life' of a . . . disabled person.").

250. *See* MEDICAL DISCRIMINATION, *supra* note 205, at 111.

251. *See* 42 U.S.C. § 5106a(b)(10)(B).

252. *See* 130 CONG. REC. 27,774 (remarks of Sen. Hatch); *accord id.* at 27,319-20 (remarks of Rep. Murphy); *id.* at 26,110-22 (conference report); *id.* at 26,122-23 (Appendix: Joint Explanatory Statement by Principal Sponsors of Compromise Amendment Regarding Services and Treatment for Disabled Infants).

253. *See* MEDICAL DISCRIMINATION, *supra* note 205, at 111.

to protect themselves,[254] are conducted through procedures that fail to guarantee the minimal process protections that would alert a family member or other surrogate to the need to advocate the patient's interests,[255] and because the ethics committee itself may have conflicting duties to the institution or caregiver,[256] we should reject any legislative efforts to maximize the authority of committees while minimizing their accountability.[257]

V. CONCLUSION

In a field as intellectually new as medical ethics, it is hardly surprising that the assumptions driving the establishment of ethics committees are only now beginning to be examined. Nevertheless, with more than two decades of experience a sufficient track record now exists to permit a comparative analysis of courts and ethics committees as competing end-of-life decisionmakers. Parts II and III suggest, I believe, that the sundry advantages ascribed to ethics committees by scholars, regulators, and the judiciary are more illusory than real. Under careful scrutiny, the claim that committees singularly possess the ethical and technical expertise, responsiveness, and sensitivity to make treatment decisions is equivocal at best.

The comparative analysis of courts and ethics committees has implications, too, for the functioning of ethics committees. Plainly, ethics committees have much to learn from the courts in constructing procedures to accord due process to patients, who, after all, are the largest stakeholders in treatment decisions.[258] While committees need not become "quasi-courts,"[259] a greater dialogue regarding the minimal process protections due to patients is warranted.

Finally, the comparison of courts and ethics committees sheds light on the proper relationship between the two institutions. For the reasons discussed in Part III—permitting ethics committees to operate outside the view of the courts—by giving committees privilege and immunity—may have the unfortunate and unintended effect of exposing patients to an unregulated, ad hoc decisionmaking process with little or no guarantee that the patient's interests alone

254. *See supra* note 3 and accompanying text.

255. *See supra* notes 196-97 and accompanying text.

256. See *supra* notes 185-91 and accompanying text discussing institutional biases. At the very least, few committees have a clearly articulated commitment to the patient's interests. *See supra* notes 193-95 and accompanying text.

257. *See* Scofield, *supra* note 168, at 421.

258. *See* Wolf, *supra* note 38, at 283.

259. *See id.* at 287.

will be the paramount consideration. Moreover, even if committees adopted perfect process protections, committees lack the legal expertise, commitment to precedent, and public accountability to adjudicate legal rights.[260]

Beyond the relationship between courts and ethics committees, there is reason to be concerned about the legislative grants of privilege and immunity for ethics committee actions emerging in state legislatures. As I argue in Part IV, this is because privilege and immunity statutes maximize the authority of ethics committees while minimizing their accountability.[261] Moreover, caution is warranted anytime a strong policy justification has not been demonstrated. Here, no wholesale revolt by healthcare providers—such as that which plagued peer review—has occurred or is even anticipated.[262]

This is not to say that privilege and immunity statutes are without justification. They are justified. Statutes granting privilege and immunity to ethics committees embody a desire to leave painful treatment decisions as much as reasonably possible to patients, family members, and their physicians. On balance, however, these statutes may abdicate too much. Each of the statutes considered in this Article insulates ethics committee members and healthcare professionals who participate in treatment decisions without setting the terms for such participation. This is ironic given that an analogous statute, the Health Care Qualified Immunity Act, exacts a price for the immunity it affords—notice and opportunity to be heard, representation by an attorney and written determination, among others.[263] The failure to place a "due process pricetag" on privilege and immunity is a critical omission because "the procedures elaborated in bioethical discourse have themselves been thin, minimal, and almost exclusively attentive to encounters between lone individuals such as doctor and patient."[264]

In summary, the grant of privilege and immunity to institutional ethics committees and those who rely on their recommendations constitutes an unusual transfer of power from the courts to institutional decisionmakers, for which society has exacted very little in exchange. Such a transfer of regulatory authority substantially weakens society's ability to exercise oversight in an area of

260. *See id.*
261. *See* Scofield, *supra* note 168, at 421.
262. *See supra* notes 231-36 and accompanying text.
263. *See* 42 U.S.C. § 11112(b) (1994).
264. Wolf, *supra* note 38, at 281.

fundamental interest to each of us—the time and manner in which we die. With issues as important as life and death in the balance, we should hesitate to forfeit to institutional ethics committees the authority to act as the forum of last resort.