Golden Gate University Law Review

Volume 20 | Issue 2 Article 4

January 1990

Searching for Proper Judicial Recognition of Hospital Ethics Committees in Decisions to Forego Medical Treatment

Carol A. Murphy

Follow this and additional works at: http://digitalcommons.law.ggu.edu/ggulrev

Part of the Health Law and Policy Commons

Recommended Citation

Carol A. Murphy, *Searching for Proper Judicial Recognition of Hospital Ethics Committees in Decisions to Forego Medical Treatment*, 20 Golden Gate U. L. Rev. (1990).
http://digitalcommons.law.ggu.edu/ggulrev/vol20/iss2/4

This Comment is brought to you for free and open access by the Academic Journals at GGU Law Digital Commons. It has been accepted for inclusion in Golden Gate University Law Review by an authorized administrator of GGU Law Digital Commons. For more information, please contact jfischer@ggu.edu.

SEARCHING FOR PROPER JUDICIAL RECOGNITION OF HOSPITAL ETHICS COMMITTEES IN DECISIONS TO FOREGO MEDICAL TREATMENT

I. INTRODUCTION

The issue of withdrawing or withholding life-sustaining medical treatment arises with increasing regularity in the United States, prompted by a growing elderly population and constant technological advances.[1] A Hospital Ethics Committee (HEC)[2] may be utilized to assist in making treatment decisions for incompetent patients, but there is inconsistency in the deference given to HECs by courts. Neither federal nor state statutes have addressed the proper role of HECs in health care decisionmaking, and common law on the subject is conflicting.[3]

A competent patient has the right to make his or her own

1. Comment, *Recognizing the Value of Hospital Ethics Committees: Time for Judicial Reassessment*, 18 TOLEDO L. REV. 195, 198 (1989). The dilemma caused by advances in medical science is evident in a statement made by a prominent neurologist that "[o]n the one hand, many patients now survive and leave the hospital without brain damage; yet, as a necessary [consequence], we are producing patients with syndromes of severe, irreversible brain damage." Cranford, *Brain Death and the Persistent Vegetative State*, in LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS 62 (A.E. Doudera & J.D. Peters eds. 1982).

2. "True" Hospital Ethics Committees, sometimes called Institutional Ethics Committees, as addressed in this comment, are groups of people with diverse backgrounds which assist patients, their families, and medical practitioners in making medical decisions which involve moral issues. *See infra* notes 59-80 and accompanying text. Compare with Institutional Review Committees (IRCs), sometimes called Hospital Review Committees (HRCs) or Institutional Review Boards(IRBs), which review medical decisions, prognoses, and opinions. *See generally* Robertson, The Law of Institutional Review Boards, 26 UCLA L. REV. 484, 487-88 (1979). Ethics committees can also be found in nursing homes and dialysis centers. Cohen, *Ethics Committees*, 18 HASTINGS CENTER REPORT 11 (1988). The focus of this comment is ethics committees in hospitals, but the principles may be applied more broadly in most cases.

3. *See infra* notes 81-114 and accompanying text.

Published by GGU Law Digital Commons, 1990

treatment decisions.[4] This includes the initiation, withdrawal, and refusal of medical treatment.[5] Similarly, while competent[6], a patient may exercise his or her right of autonomy by executing a document[7] such as a living will,[8] durable power of attorney[9] or health care directive.[10] When the patient is incompetent and there is no directive, the decision is left to family members, doctors, and courts of law, with or without the input of an ethics committee.

Once it has been determined that the patient has the right to refuse treatment,[11] questions arise as to who will and who will

---

4. This doctrine is often traced to Schloendorff v. New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, in which Judge Cardozo wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Id.* at 129, 105 N.E. at 93. The right has been applied to recent cases involving the termination of treatment as well. In Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), a competent, seriously ill patient's desire to die naturally was frustrated by medical practitioners who refused his instructions to disconnect a mechanical respirator. The hospital and physicians also refused to honor instructions by the patient's wife, whom the patient had authorized with a durable power of attorney to make medical treatment decisions. The court found that the patient had the right to control his own medical treatment and held that the patient's wishes must be honored. *Id.* at 195, 209 Cal. Rptr. at 225. *See also In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987).

5. "The obvious corollary to [the principle that a doctor commits a battery by treating without consent] is that a competent adult patient has the legal right to refuse medical treatment." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983).

6. Competency, or having the appropriate legal standing, is often associated with capacity. However, these two terms are not identical.

7. Many state statutes now recognize the validity of certain health care directives. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (Deering 1987).

8. A living will has been defined as "a written statement that specifically explains the patient's preferences about life-sustaining treatment." *In re* Peter, 108 N.J. 365, 378, 529 A.2d 419, 426 (1987).

9. A durable power of attorney is defined as "an individual's written designation of another person to act on his behalf" which may be limited to action regarding health care decisions. THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 140.

10. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. AND BIOMED. AND BEHAVIORAL RES., MAKING HEALTH CARE DECISIONS 156-66 (1982) [hereinafter PRESIDENT'S COMM'N REPORT I] and PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. AND BIOMED. AND BEHAVIORAL RES., DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 5 (1983) [hereinafter PRESIDENT'S COMM'N REPORT II].

11. The issue of whether a patient has a right to decide whether to terminate or withhold life-sustaining medical treatment, often called the "right to die," is not directly addressed in this comment. That issue was recently addressed by the United States Supreme Court in Cruzan v. Missouri, 58 U.S.L.W. 4916 (1990). The Court simply held that a Missouri requirement that evidence of an incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence was constitutional. The majority

not be responsible for the decision. If a treatment decision involving an HEC is contested and must be decided by a court, the judge[12] will have to determine the appropriate level of deference to give the HEC determination.[13] This comment will explore the levels of judicial scrutiny applied to HEC decisions regarding life-sustaining medical treatment and explore the proper role of HECs within the American jurisprudential system.

II. HISTORICAL BACKGROUND OF HOSPITAL ETHICS COMMITTEES

Early "ethics committees" had clearly limited purposes and bear little resemblance to modern HECs. The first ethics committee is said to have originated in Seattle in 1960 in the wake of a medical breakthrough, the kidney dialysis machine.[14] A committee was established to aid in choosing the patients who would receive priority for kidney dialysis treatment. It was made up of a lawyer, a minister, a banker, a housewife, a government official, a labor leader, and a surgeon. Despite efforts to be fair,

---

decision did not state the circumstances under which a "right to die" exists, nor did any of the five opinions (including two concurring and two dissenting) mention the role of HECs in decisionmaking. The questions raised in this comment become relevant once it has been determined that there is a right to make such a decision.

12. Legal proceedings involving the question of medical treatment for an incompetent do not involve juries because relief is usually declaratory. The judge typically weighs the patient's right to privacy in making such a decision against the four "state interests": the preservation of life, the prevention of suicide, the integrity of the medical profession, and protection of innocent third parties. *See, e.g.* Rasmussen v. Fleming, 154 Ariz. 207, 216-18, 741 P.2d 674, 683-85 (1987); Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 741-45, 370 N.E.2d 417, 425-27 (1977); *In re Colyer*, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983), *overruled in part, In re Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984). Note, Balancing the Right to Die With Competing Interests: A Socio-Legal Enigma*, 13 PEPPERDINE L. REV. 109, 112-16 (1985).

13. The function of ethics committees in decisionmaking ranges from encouraging discussion to actually adopting recommendations or determinations for particular cases. The determinations are usually advisory and rarely binding. Wolf, *Ethics Committees In The Courts*, 16 HASTINGS CENTER REPORT 12 (1986). The determinations, also called decisions or recommendations, are often very persuasive. Gibson & Kushner, *Will the "Conscience of an Institution" Become Society's Servant?*, 16 HASTINGS CENTER REPORT 10 (1986). *See also* PRESIDENT'S COMM'N REPORT II at 162-63.

14. Dr. Belding Scribner of the University of Washington had just introduced long-term hemodialysis for the treatment of end-stage renal disease. Between 1960 and 1972, there were not enough dialysis machines for all chronic kidney patients, and screening by medical criteria still left too many candidates. The doctors involved decided to appoint an impartial body to choose the relatively few candidates who would receive dialysis treatment. The remaining patients were given little chance for survival. B. HOSFORD, BIOETHICS COMMITTEES, THE HEALTH CARE PROVIDER'S GUIDE 65-67 (1986).

the decisionmaking process drew quick and harsh criticism.[15]

Another early type of "ethics committee" was used by institutions to determine which pregnancies could be terminated through therapeutic abortions at a time when most abortions were illegal.[16] The decision was a medical one, as the only justification was endangerment to the pregnant woman.[17]

Legal recognition of hospital ethics committees traces back to the case of Karen Ann Quinlan.[18] In that landmark case, the court validated the recommendation by a hospital ethics committee to allow life support systems to be removed.[19] The patient was twenty-two years old and in a persistent vegetative state.[20] The court encouraged the formation of HECs by suggesting "that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared."[21] The opinion cited an article by Dr. Karen Teel revealing the dilemma doctors were facing in the treatment of terminally ill patients.[22] The court seemed sympathetic with the plight of a physician forced to make ethical judgments.[23]

---

15. The factors which the committee based its decisions upon were: patients' ages and sex, marital status and number of dependents, income, net worth, emotional stability, educational background, nature of occupation, and past performance and future potential. *Id.* One article, criticizing that unarticulated factors favored the "middle-class America social value system shared by the selection panel," noted "[a] candidate who plans to come before this committee would seem well-advised to father a great many children, then to throw away all his money." Alexander, *They decide Who Lives, Who Dies*, 53 LIFE 102 (1962).

16. B. HOSFORD, *supra* note 14, at 65.

17. *Id.*

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

19. *Id.*

20. *Id.* at 24, 355 A.2d at 654. A patient in a "chronic persistent vegetative state" was defined in *Quinlan* by Dr. Fred Plum as one "who remains with the capacity to maintain the vegetative parts of neurological function but who no longer has any cognitive function." *Id.* Although Karen Ann Quinlan was in a persistent vegetative state, it was pointed out that she was not "brain dead" as defined by the Ad Hoc Committee of Harvard Medical School. *Id.* The Ad Hoc standards include "absence of response to pain or other stimuli, pupilary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as 'flat' or isoelectric electroencephalograms and the like, with all tests repeated 'at least 24 hours later with no change.'" *Id.* at 27, 355 N.J. at 356.

21. *Id.* at 49, 355 A.2d at 668 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR LAW REV. 6, 8 (1975)).

22. Teel, *supra* note 21.

23. "Physicians, by virtue of their responsibility for medical judgments are, partly

The *Quinlan* opinion supported hospital ethics committees, but admitted "the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body."[24] The primary justification for reliance on such committees was the diffusion of responsibility, mainly for the benefit of the medical practitioner.[25]

The *Quinlan* case was a boost to the formation of HECs,[26] but has been criticized for several reasons. The recommendations of *Quinlan* actually had medical descriptions and definitions in mind, not moral dilemmas. The result was to offer medical "second opinions" to practitioners so that medical prognoses would be confirmed and responsibility of the decision was diffused. In this respect, the court was not suggesting an ethics committee, but rather a "risk management" or "liability control" committee whose main function was to disperse the responsibility of difficult medical decisions.[27] Currently, many hospitals utilize committees to confirm medical diagnoses which may be called "ethics committees", but function as Institutional Review Boards.[28]

The *Quinlan* opinion was broader than the facts warranted. It discussed hospital ethics committees as if they were common, referring to the number of hospitals which had established ethics committees as "many."[29] The idea of ethics committees in hospitals had not yet, in fact, gained wide acceptance.[30] The

---

by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make." *Quinlan* at 49, 355 A.2d at 668 (quoting Teel, *supra* note 21, at 8).

24. *Id.* (quoting Teel, *supra* note 21, at 9).

25. *Id.* at 50, 355 A.2d at 669. Diffusion of responsibility benefits the practitioner legally as well as psychologically.

26. *See infra* notes 47-51 and accompanying text.

27. The diffusion of responsibility for decisionmaking was an advantage of HECs suggested by Dr. Teel. Teel, *supra* note 21, at 9.

28. *See supra* note 2.

29. The court may have been misled by the Teel article from which it quoted, "[m]any hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians. . .which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers." *Quinlan* at 49, 355 A.2d at 668 (quoting Teel, *supra* note 21, at 9).

30. There were probably no ethics committees in 1975 which operated as Dr. Teel described. B. HOSFORD, *supra* note 14, at 69.

Quinlan court did not foresee the growth in both the issues faced by ethics committees and the liability questions involving HECs which later courts have been forced to confront.

The *Quinlan* court's sympathy for medical practitioners seemed to be based on an improper characterization of the doctor as the "decisionmaker".[31] Under the doctrine of informed consent, medical treatment decisions are made by the patient[32] or, if the patient is incompetent, by a surrogate. Physicians have a duty to inform decisionmakers of the patient's condition and treatment options.[33]

A significant development in the law was the articulation of two tests to determine the basis of the decision to forego medical treatment for incompetent patients. Following *Quinlan*, the New Jersey courts were forced to decide whether to withdraw life-sustaining procedures from several patients.[34] Most of the cases were decided in favor of withdrawal, allowing the patient to die without the treatment.[35] Although HECs were not involved in these decisions, the tests used are universally applicable once it has been determined that there is a right to make the decision.[36]

---

31. *See supra* note 27 and accompanying text.

32. [E]ach man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient. . . .

Natanson v. Kline, 186 Kan. 393, 406-407, 350 P.2d 1093, 1104 (1960). *See generally* KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

33. Professionals in both the medical and legal fields are still struggling with the scope of disclosure required by the doctor. Dilemmas include cases in which the practitioner may feel that disclosure may do more harm than good. *See* PRESIDENT'S COMM'N REPORT I at 70-102. *See also* KATZ, *supra* note 32, at 166-75.

34. Matter of Conroy, 98 N.J. 321, 486 A.2d 1209 (1985)(Removal of nasogastric tube from semi-vegetative woman with life expectancy of one year); Matter of Farrell, 108 N.J. 335, 529 A.2d 404 (1987)(Mentally competent woman with Arterial Lateral Scherosis requested that respirator be disconnected); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987)(Nursing home refused to remove tube from comatose, vegetative patient after request made by her power of attorney based on a "living will"); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987)(After surgery caused irreversible damage to pregnant woman, nursing home refused permission to remove tube from patient in persistent vegetative state).

35. The court in *Conroy* reversed a lower court ruling in favor of terminating treatment, but the case was not remanded in light of the patient's death. *Conroy*, 98 N.J. at 388, 486 A.2d at 1244.

36. *See supra* note 11.

The first test is the "substituted judgment approach."[37] This method attempts to make the choice which the patient would have made had he or she been able.[38] The substituted judgment approach favors the person's right to privacy and considers the individual's attitudes and morals.[39] It is generally followed where the patient has made clear at least some basic preferences regarding the foregoing of medical treatment.[40] To consider these preferences in making the decision, the patient had to have been competent to make the decision for himself at the time the preference was made known.[41]

The second test utilizes the "best interests" standard,[42] which is typically applied where a lack of evidence about the patient's choice precludes the substituted judgment approach. The best interests test requires the surrogate decisionmaker to choose the course of treatment or non-treatment which best promotes the patient's well-being.[43] The standard is objective, with no reference to the patient's actual or supposed preferences.[44] Though it seems contradictory, courts have decided in favor of terminating life-sustaining treatment based on the best interest of the patient.[45] These tests often overlap, making it difficult to determine what approach was actually used.[46]

---

37. Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 758, 370 N.E.2d 417, 430 (1977); Brophy v. New England Sinai Hospital, 398 Mass. 417, 427, 497 N.E.2d 626, 636 (1986).

38. PRESIDENT'S COMM'N REPORT I at 178-179.

39. One court recognized the "unwritten constitutional right of privacy" which protects a patient against unwanted infringements of bodily integrity. *Saikewicz* at 739, 370 N.E.2d at 424.

40. In *In re* Eichner, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), Brother Fox, an 83-year-old member of a Catholic religious order called the Society of Mary, was being maintained in a permanent vegetative state by a respirator. Father Eichner, local director of the society, applied to have the respirator removed on the ground that it was against the patient's wishes as expressed prior to his becoming incompetent. This request was supported by the patient's 10 nieces and nephews, his only surviving relatives. The Appellate Division held that the patient's right to decline treatment was guaranteed by the common law as well as the Constitution. *Id.*

41. It is preferable, but not required, that the patient's preferences be incorporated into a written health care directive. *See supra* notes 8-11 and accompanying text.

42. *See* Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); *In re* Torres, 357 N.W.2d 332 (Minn. 1984).

43. PRESIDENT'S COMM'N REPORT I at 179-80.

44. *Id.*

45. *See, e.g., Rasmussen*, 154 Ariz. 207, 741 P.2d 674; *Torres*, 357 N.W.2d 332.

46. "At some point, as the evidence of the patient's subjective intent becomes less and less trustworthy, the exercise of substituted judgment shades into a best interests

The *Quinlan* court endorsed further study into hospital ethics committees,[47] but little research was published until 1983. In that year, HECs again gained attention when the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research reported on issues related to ethical problems in medicine.[48] At that time, attending physicians were primarily responsible for assuring high quality treatment decisions.[49] The President's Commission recognized that ethics committees could play a broader role than the narrow function embraced by *Quinlan.*[50] The Commission's report suggested that health care institutions "explore and evaluate various formal and informal administrative arrangements for review and consultation, such as 'ethics committees.' "[51] Although the focus of the report emphasized decisions to forego[52] life-sustaining treatment,[53] the discussion of the potential role of HECs included recognition of a greater need for research into the use of ethics committees in a variety of treatment decisions.[54]

Another impetus for the development of HECs was the dis-

---

analysis. . . ." Pollock, *Life and Death Decisions: Who Makes Them and by What Standards?*, 41 RUTGERS L. REV. 505, 515 (1989).

47. The opinion reiterated Dr. Teel's statement that "[t]he concept of an Ethics Committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point." *Quinlan* at 49, 355 A.2d at 668 (1976) (quoting Teel, *supra* note 21, at 9).

48. PRESIDENT'S COMM'N REPORT II. *See* pages 1-4 for general purposes and findings of the Commission. The Commission's earlier report dealt with forms of consent to medical treatment. *See* PRESIDENT'S COMM'N REPORT I. The first report mentioned HECs briefly in recommending that "[h]ealth care institutions should explore and evaluate various informal administrative arrangements, such as 'ethics committees,' for review and consultation in nonroutine matters involving health care decision-making for those who cannot decide." PRESIDENT'S COMM'N REPORT I at 6.

49. PRESIDENT'S COMM'N REPORT II at 153.

50. Beyond the diagnosis and prognosis confirmation role endorsed by *Quinlan*, the Commission suggests three additional functions which are now widely accepted: educating, formulating policies, and reviewing treatment decisions. *Id.* at 160-61. *See infra* notes 60-61 and accompanying text.

51. PRESIDENT'S COMM'N REPORT II at 5.

52. The term "forego", as used in the Commission's report, encompasses both noninitiation or the withholding of medical treatment and discontinuation of ongoing treatment or withdrawal. *Id.* at 2 n. 1.

53. The President's Commission defined "life sustaining" treatment as encompassing "all health care interventions that have the effect of increasing the lifespan of the patient," including respirators and kidney machines as well as more passive activities which have the effect of prolonging the patient's life. *Id.* at 3.

54. *Id.*

cussion surrounding the adoption of the "Baby Doe" regulations.[55] These regulations encouraged the formation of "infant bioethics committees" to review decisions against aggressive medical treatment for handicapped newborns to safeguard against discrimination on the basis of handicap.[56] Many hospitals realized the value of HECs after implementing procedures conforming to the "Baby Doe" regulations.[57] Whatever the reason for initiating the formation of an HEC, most hospitals now use ethics committees, and their numbers are growing.[58]

III. OPERATIONAL ASPECTS OF MODERN HECS

After considering the foundation and background of HECs, it is appropriate to analyze the operational and functional aspects of ethics committees before considering the proper role of HECs in decisionmaking. HECs can be characterized by function and composition.[59] The issues before an HEC and its procedural processes are often unique to the institution. Therefore, the goals of HECs are as varied as the institutions which they serve.

Generally, HECs serve four functions.[60] First, the HEC educates the entire medical staff at a hospital in an effort to improve communication. Second, it assists in drafting policies to be adopted by a hospital. Third, it consults with staff members, patients, and family members, usually by appointing one or two

---

55. *Ethics Committees Double Since '83: Survey*, HOSPITALS, Nov. 1, 1985, at 60, 64 (Attributed the increase in ethics committees to the Baby Doe regulations). *See also* Cranford & Doudera, *The Emergence of Institutional Ethics Committees*, 12 LAW, MEDICINE & HEALTH CARE 13.

56. *See* B. HOSFORD, *supra* note 14, at 53-60. The purpose of the legislation was to compel simple but lifesaving surgery to handicapped children such as Baby Jane Doe, who was born with Down's syndrome. *Id.* at 54-55.

57. *See supra* note 55.

58. A survey conducted by the American Hospital Association's National Society for Patient Representatives found that the number of respondents with ethics committees rose from 26 percent in 1983 to 60 percent in 1986. HOSPITALS, *supra* note 55, at 60. Additionally, The California Medical Association Council has advised acute care hospitals in California to establish and support an ethics committee. Cranford & Doudera, *supra* note 55, at 14.

59. PRES. COMM'N REPORT I at 187.

60. *See* Cranford & Doudera *supra* note 55, at 13; PRESIDENT'S COMM'N REPORT II at 160-161; Levine, *Questions and (Some Very Tentative) Answers about Hospital Ethics Committees*, 14 HASTINGS CENTER REPORT 10 (1984).

committee members to represent the HEC.[61] Fourth, the entire committee analyzes and reviews individual patient cases.

HECs sometimes play an integral part in educating and advising health care practitioners on ethical issues not involving the patient's life or death, but nonetheless controversial.[62] HECs provide a forum for increased communication between the parties who are making the decision and those providing medical care. Clarifying the facts and fostering communication may comprise up to 80 or 90 percent of the HEC's work.[63] Many professionals consider this the paramount function.[64] Even a "minor" decision between doctor and decisionmaker can lead to serious problems, if there is a failure in communication.[65]

Currently, the focus of ethics committees seems to be on recommendations[66] by the entire committee made on an individual case basis. This is the most controversial function of an HEC[67] and is not limited to decisions to withdraw treatment for an incompetent adult. Other medical/legal decisions involving HECs include the sterilization of a mentally incompetent person[68] and the withholding of treatment for a terminally ill infant.[69] There are many reasons to involve an HEC in the decisionmaking process. One purpose may be to ensure that all relevant medical and ethical aspects of the dilemma are disclosed to those who need the information.[70] Another may be to

61. This function is sometimes incorporated into the other three functions. *See* Cranford & Doudera, *supra* note 55, at 16; Gibson & Kushner, *supra* note 13, at 11.

62. An example of such a decision was the issue of whether an incompetent should be sterilized faced in *In re* Eberhardy, 102 Wis. 2d 539, 307 N.W.2d 881 (1981).

63. Murray, *Where are the Ethics in Ethics Committees?*, 8 HASTINGS CENTER REPORT 12 (1988).

64. "Some advocates of ethics committees as primarily consultive bodies have been adamant that such groups should not themselves make decisions." PRESIDENT'S COMM'N REPORT II at 162-63. *See also* Levine, *supra* note 60.

65. "Without conversation, individual self-determination can become compromised by condemning physicians and patients to the isolation of solitary decision making, which can only contribute to abandoning patients prematurely to an ill-considered fate." J. KATZ, *supra* note 32, at 128.

66. The decisions are usually not formal or final. *See supra* note 13.

67. Fost & Cranford, *Hospital Ethics Committees: Administrative Aspects*, 253 J. A.M.A. 2687-92 (1985).

68. *In re* Eberhardy, 102 Wis. 2d 539, 307 N.W.2d 881 (1981).

69. *In re* P.V.W., 424 So.2d 1015 (La. 1982); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984).

70. Levine, *supra* note 60, at 9-10.

resolve disagreements among the medical staff or family members about the proper method of treatment for the patient.

The specific function of the HEC often dictates its composition.[71] When the committee is simply used to confirm a medical diagnosis[72], its members would be mostly, if not entirely, medical practitioners.[73] When the HEC is used to aid family members to reach a treatment decision, the membership would probably include at least one social worker, ethicist or clergy member.[74] Similarly, if the HEC is designed as a risk management tool, then hospital administrators and attorneys would serve on the committee.[75]

By definition, a true HEC is multidisciplinary[76], allowing for differing points of view. This diversity is essential to address varied aspects of the issue before it, and allows HECs to "serve as a link between societal values and the actual developments occurring in the institutions that care for and treat the particular patients whose cases manifest these dilemmas."[77] Diversity in composition also makes uniform acceptance of HEC recommendations by courts difficult.

Consultation with an HEC is typically optional, although some have suggested that it be mandatory for certain particularly important questions.[78] Few determinations of HECs are mandatory.[79] It is more common for HECs to provide recom-

71. Comment, *supra* note 1, at 199.

72. This type of committee is not a "true" hospital ethics committee, although it follows the *Quinlan* model and provides a medical second opinion. *See supra* note 2; *see also* notes 24-28 and accompanying text.

73. PRESIDENT'S COMM'N REPORT II at 166.

74. *Id.*

75. *Id.* Minimizing legal liability is a common concern for medical practitioners and institutions. For additional information on the role of an HEC in legal protection, *See* Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239 (1987). *See also* J.W. ROSS, HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 93-95 (1986).

76. The *Quinlan* opinion endorsed "an Ethics Committee composed of physicians, social workers, attorneys, and theologians." *In re* Quinlan, 70 N.J. 10, 49, 355 A.2d 647, 668, *cert. denied*, 429 U.S. 922 (1976) (quoting Teel, *The Physician's Dilemma*, *supra* note 21, at 8). *See supra* note 2.

77. R. CRANFORD & A.E. DOUDERA, INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 10 (1984).

78. Merritt, *supra* note 75, at 1247-49.

79. *Id.* at 1249.

mendations to the decisionmakers.[80]

There is basic agreement on the functions of HECs, but their operational aspects differ according to the goals of the institution. Uniformity is lacking in several areas including procedures for advising decisionmakers, composition of HECs, and record-keeping for accountability. The formation of HECs is a positive start toward ensuring the privacy rights of patients, and development of HECs continues.

IV. JUDICIAL CONSIDERATION OF HEC DETERMINATIONS

Courts are divided on how to treat determinations made by ethics committees.[81] There are few reported cases that considered the determination of an HEC in evaluating a treatment decision. The decisions that have been rendered usually arise when there is a conflict between the patient's family and the attending physician or hospital.[82] Once the treatment decision reaches a court of law, a judge may treat the HEC determination as evidence or may not consider it at all when deciding the case.

A. HEC Determination Not Relevant to Court's Decision

An opinion which gave no deference to an ethics committee determination was *In re L.H.R.*.[83] The Supreme Court of Georgia decided whether a terminally ill infant in a chronic vegetative state, with no hope of developing cognitive functioning, could be removed from a respirator.[84] An *ad hoc* Infant Care Re-

80. *See* note 13.

81. *See supra* notes 83-114 and accompanying text.

82. The concern is usually legal liability. This is understandable considering the case of Barber v. Superior Ct., 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), where the court dismissed murder charges against two doctors who had removed life-support systems from a vegetative patient at the request of the patient's family. One judge who had to make a treatment decision for an incompetent feels that "the problem really would not prompt the public concern that it has if it were not for the fear of civil and criminal liability." Byrne, *Deciding for the Legally Incompetent: A View from the Bench*, in Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients 25 (A. E. Doudera and J. D. Peters eds. 1982).

83. 253 Ga. 439, 321 S.E.2d 716 (1984). *See* Wolf, *Ethics Committees In The Courts*, 16 Hastings center report 12-13 (1986).

84. *L.H.R.* at 439, 321 S.E.2d at 717-18.

view Committee[85] agreed with the infant's parents, physician, and guardian ad litem that life support systems should be removed.[86] The infant was removed from life support systems and died before the case got to the appellate court. The objective of the opinion was to establish guidelines for future cases.[87] The court apparently ignored the committee's recommendation, but did mention that an HEC concurred in the decision.[88] The opinion stated that there was no need to consult an HEC in this case.[89]

Although it considered the possibility of a distinct role of HECs in decisions to forego life-sustaining treatment,[90] the court did not adopt such a role. The court simply held that "the decision whether to end the dying process is a personal decision for family members or those who bear the responsibility for the patient."[91] The opinion acknowledged that this was a moral and ethical decision,[92] but it declined to take the opportunity to recognize the HEC determination as helpful and admissible evidence.

The court held that the family or legal guardian could decide to forego treatment in similar cases, whether the patient was an infant or an adult, without either ethics committee consultation or prior judicial approval.[93] However, the court allowed for committee consultation if the hospital, doctor or family so chose.[94] Thus, the proper time for consideration of an HEC determination was *before* the treatment decision got to the courtroom. According to the Supreme Court of Georgia, once the de-

85. This is the type of committee recommended by the Baby Doe Legislation. *See supra* notes 55-56 and accompanying text.

86. *Id.* at 439, 321 S.E.2d at 718.

87. The court stated "[t]he primary purpose for the appeal is to afford this court an opportunity to set forth guidelines for the future handling of this type situation." *Id.*

88. *Id.*

89. *Id.* at 446, 321 S.E.2d at 723.

90. The court considered the opinions of several professionals regarding how these decisions should be made, including one in which HECs played a central role. *Id.* at 442-44, 321 S.E. 2d at 720-21.

91. *Id.* at 446, 321 S.E.2d at 723.

92. *Id.*

93. *Id.* The court deemed the decision as declining to artificially extend the dying process which should not be left to the state as the state has no interest in the prolongation of dying. *Id.*

94. *Id.*

cision reaches the court, the HEC determination has no relevance.

B. HEC DETERMINATION USED AS EVIDENCE

The highest courts in Minnesota[95] and Massachusetts[96] have used HEC determinations as evidence to aid in decisionmaking. In addition, there are unreported cases in which judges sought the opinion of an HEC before deciding cases involving the withdrawal of life-sustaining medical treatment.[97]

The Supreme Court of Minnesota, in *In re Torres*,[98] allowed into evidence the reports of three area biomedical ethics committees.[99] The court stated that the committee reports outlined the procedures used to reach a decision.[100] This seemed to reassure the court that doctors had reached the "right answers." [101] In a footnote, the court remarked that hospital ethics committees are "uniquely suited to provide guidance to physicians, families, and guardians when ethical dilemmas arise." [102] The court also indicated that an HEC determination in favor of disconnecting life-support systems in agreement with doctors and family members would remove any necessity for a court order.[103] The *Torres* court clearly gave the highest deference to an HEC determination, admitting it into evidence because it added credibility to the decision of the patient's conservator and family.

The Supreme Judicial Court of Massachusetts, in the 1977 *Saikewicz* case, stated that a judge *may* consider the findings and advice of an ethics committee, but is not required to do

95. *In re* Torres, 357 N.W.2d 332 (Minn. 1984).

96. Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (Mass. 1980).

97. Wolf, *supra* note 83, at 15 n. 5.

98. 357 N.W.2d 332. In this case, the patient was a 57-year old man who was hospitalized after he suffered a fall in his home. *Id.* at 334.

99. The court was not considering a determination by the committee in Mr. Torres's hospital because the hospital's position was complicated by the fact that Torres became comatose due to an incident at the hospital. The reports came from HECs of three other hospitals. Wolf, *supra* note 83, at 13.

100. *Torres* at 335.

101. Wolf, *supra* note 83, at 13.

102. *Torres* at 335-36 n. 2.

103. *Id.* at 341 n. 4. Three justices concurred specially in order to disagree with this footnote. *Id.* at 341.

so.[104] The court recognized the difficulty in making a decision to forego medical treatment and welcomed the assistance of HECs.[105] The same court also approved of *Saikewicz* in the 1980 case of *In re Spring*.[106] The *Spring* court indicated that the concurrence of "qualified consultants" with medical professionals "may be highly persuasive" in determining the proper course of treatment.[107] The opinion implies, but does not state, that ethics committees are considered to be "consultants."[108]

Although both *Torres* and *Spring* seem to allow ethics committees to serve as experts, they disagree on the area of expertise. In Minnesota, ethics committees are given deference in "moral"[109] and procedural matters in resolving the issue. The Massachusetts court would probably use the HEC recommendation to determine whether proper medical procedure was utilized.[110]

C. Reluctance Toward HEC Determinations

Courts are divided over the issue of allowing HEC recommandations to be admitted into evidence, mainly for the lack of uniformity which exists.[111] The diversity of membership in HECs and differences in the function of each ethics committee make it difficult for courts to support a decision made by them. HECs are still a fairly new concept, and hopefully time will bring increased procedural similarity.

It may also be troublesome for courts to accept a decision in which an HEC concurred because the entire process may be confidential. Courts are used to making decisions based on all available facts, but they are justifiably reluctant to give any weight to a group of people who are unaccountable. For these reasons, HECs should provide some documentation supporting the rec-

---

104. *Saikewicz* at 758, 370 N.E.2d at 434.

105. *Id.*

106. 380 Mass. 629, 405 N.E.2d 115 (Mass. 1980)

107. *Id.* at 634, 405 N.E.2d at 122.

108. The court stated that it did not disapprove of committee review of decisions by members of the hospital staff, and that the "concurrence of qualified consultants may be highly persuasive on issues of good faith and good medical practice." *Id.*

109. *Torres*, at 335-36 n. 2.

110. *Spring*, at 634, 405 N.E.2d at 122.

111. *See supra* notes 71-80 and accompanying text.

ommendation.[112] To alleviate the conflict which arises between accountability and the patient's confidentiality, it has been suggested that HECs should make notes on the patient's medical file, so that the actions of an HEC would be subject to "limited judicial review."[113]

There is no agreement on the issues of confidentiality[114], so HECs continue to operate with no legal guidance. Though some courts may follow the example of *Torres* and *Saikewicz* by allowing HEC determinations to be considered, it would be better if courts first considered the membership, procedure, and accountability of the HEC in the particular case. Judges will likely continue their reluctance to treat all HEC recommendations as evidence when making the treatment decision until uniformity exists.

V. THE ROLE OF HECS IN MAKING TREATMENT DECISIONS

Those courts which allow an HEC determination to be used as evidence recognize a role for HECs in decisionmaking. The question of judicial deference, however, is different than the issue of the appropriate decisionmaking process because the appropriate procedure determines whether the decision should be made by courts at all. The question then becomes: who should be responsible for making decisions to forego life-sustaining treatment for incompetent patients? The spectrum of answers to that question ranges from requiring all decisions to be made by a court of law to allowing the patient's family alone to decide.

The role of ethics committees in decisionmaking is not settled. In light of the varied nature of the composition and processes of HECs, it is understandable that their determina-

---

112. The court in *Torres* stated that the HECs involved explained their procedures to the court. Although the procedures were not divulged in the opinion, the documentation evidently added to the court's acceptance of the HEC determination. *Torres* at 335.

113. Cranford, Hester, & Ashley, 13 LAW, MEDICINE & HEALTH CARE 54 (1985). "The notation in the patient's records should disclose, for example, what information was provided to the [HEC], who was involved (e.g., relatives, guardian, patient advocate), and what significant issues were considered." *Id.* The medical records are admissible in court, allowing for some judicial review while retaining the confidentiality of the committee's deliberations or discussions. *Id.*

114. *Id.* at 59.

tions are treated with differing degrees of court involvement. There has been much discussion but little practice of vesting HECs with decisionmaking capabilities.[115] At the other extreme, some experts believe that HECs should not be involved in treatment decisions at all.[116] The recognized roles of HECs in decisionmaking outside the courtroom generally fall into three categories.

A. PROGNOSIS CONFIRMATION

In *Quinlan* the court allowed the removal of life-support systems without liability in favor of her guardian who sought declaratory relief in concurrence with the attending physicians and a hospital ethics committee.[117] However, the court added "[b]y the above ruling we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice."[118] This suggests that judicial intervention is not necessary when there is a concurrence among the patient's family, attending physicians, and the ethics committee. Because the ethics committees referred to in the *Quinlan* opinion actually only inquired into medical issues, this view has been called prognosis confirmation or "medical paternalism."[119]

The prognosis confirmation function of HECs was followed by the Supreme Court of Washington.[120] The court mandated a "prognosis board" made up of the attending physician and at least two other physicians and required a unanimous concurrence to make treatment decisions without court intervention.[121] The purpose of the prognosis board was specifically limited to determining whether "there is no reasonable medical probability

115. Fost & Cranford, *supra* note 67, at 2681-92.

116. Siegler, *Ethics Committees: Decision by Bureaucracy*, 16 HASTINGS CENTER REPORT 22-24.

117. 70 N.J. at 55, 355 A.2d at 672.

118. *Id.*

119. Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases*, 5 AMERICAN JOURNAL OF LAW & MEDICINE 97 (1979).

120. *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983) *overruled in part*, *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

121. *Id.* at 134-35, 660 P.2d 738 at 749.

that the patient will return to a sapient state."[122]

Although New Jersey seemed to favor ethics committees only to offer medical second opinions where the decision was made by the court, as in *Quinlan*, the New Jersey Supreme Court apparently has been willing to relinquish some of its decisionmaking power and allow flexibility. In *In re Jobes* the court found that "[j]udicial review is not required for the decision to forego the life-sustaining treatment; it may be used only in special circumstances which may occur where there is a conflict among the family, the guardian, or the physician."[123] In this less rigid interpretation, decisionmaking by medical practitioners in conjunction with family members is routine; resort to judicial review is made only in unusual, undefined circumstances. Under either the strict or flexible position, the role of HECs remains that of offering second opinions to the decisionmaker on issues of medical diagnosis and prognosis.

B. JUDICIALIZATION APPROACH

The Supreme Judicial Court of Massachusetts made its position clear in *Saikewicz*:

> We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc, or permanent. Thus, we reject the New Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors and hospital 'ethics committee.'[124]

Massachusetts apparently reserves for the judiciary decisions to forego life-sustaining treatment. In New Jersey, this method would only be used in exceptional circumstances.[125] The *Saikewicz* decision noted that the particular case at hand did

122. *Id.* at 135, 660 P.2d at 749-50.

123. *Jobes* at 423, 529 A.2d at 449.

124. *Saikewicz* at 758, 370 N.E.2d at 434. This appears to be the clearest statement in favor of judicial decisionmaking. *Cf.* Severns v. Wilmington Med. Ctr. Inc., 421 A.2d 1334 (Del. 1980); Leach v. Akron Gen. Med. Ctr., 68 Ohio Misc. 1 (1980).

125. *See supra* note 123 and accompanying text.

not require an immediate treatment decision.[126] Perhaps the case is limited to those facts. Although the harsh view of *Saikewicz* is not widely followed, many courts disapprove of shifting ultimate decisionmaking responsibility away from courts of law.[127]

Judicial review of treatment decisions is expensive and time-consuming.[128] This is especially relevant in the administration of health care, where both time and money are rapidly diminishing resources. The judicial process is of limited value in cases where the opinions were not written until long after the patient had died.[129] As more treatment decisions are made by courts, approval for treatment decisions is increasingly being sought.[130] One writer has suggested that this trend is difficult to reverse.[131]

A judicial determination may not completely settle the dilemma. The Supreme Judicial Court of Massachusetts stated that even if court approval was secured, it would not preclude subsequent civil liability or confer immunity from prosecution.[132] Courts may not be capable of shielding liability from those involved in the decision.[133] Other disadvantages are the possible disruption in providing medical care to the patient and exposure of matters which are inherently private to the public eye.[134] Also, there is no evidence indicating that courts make better decisions.[135]

Most courts which have addressed this issue have found that judicial involvement is necessary in a decision to forego medical treatment for a persistently vegetative patient only if the interested parties disagree. In refusing to follow the judicial-

126. *Saikewicz* at 757, 370 N.E. at 433.

127. *See, e.g., In re* Spring, 380 Mass. 629, 639, 405 N.E. 2d 115, 122 (1980).

128. *See In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64 (1981).

129. *Id.*

130. Bayley, *Who Should Decide?*, in LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS 8 (A. E. Doudera and J. D. Peters eds. 1982).

131. *Id.*

132. *In re* Spring, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980).

133. Rothenberg, *The Empty Search for an Imprimatur, or Delphic Oracles are in Short Supply*, 10 LAW, MEDICINE, & HEALTH CARE, 115. Mr. Rothenberg's research suggests that the judges making treatment decisions felt uncomfortable and unprepared. *Id.*

134. PRESIDENT'S COMM'N REPORT II at 159.

135. *Id.* at 160; Rothenberg, *supra* note 133, at 15-16.

ization view, the Supreme Court of Washington stated that "medical treatment of the terminally ill in Massachusetts in the aftermath of *Saikewicz* has been in a state of general confusion."[136]

On the other hand, there are advantages to judicial review.[137] Professor Charles Baron agrees with the *Saikewicz* court that "such questions. . . require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[138] Public scrutiny of the judicial process adds credibility to decisions.[139] Also, because judicial decisions are based on precedent, decisionmaking is "principled;"[140] this increases consistency. The judicial process strives for impartiality[141] and its adversarial nature ensures a full and fair hearing by encouraging both sides to bring evidence and present arguments before a neutral judge.[142]

C. HEC Role to Advise Family

An alternative view has been proposed which recognizes a role for HECs which is somewhat consistent with several cases.[143] This view states that the decision concerning the initiation and continuation of treatment made by the family of an incompetent, in consultation with the physician, is presumed correct.[144] The decision must be consistent with a clear and reliable prior expression of the patient's preferences when he or she was competent,[145] if one exists. This presumption is rebuttable by use of conflicting evidence. Decisions should be made by a procedure which includes open and vigorous discussion and accountability through impartial review. A true ethics committee

136. *In re* Colyer, 99 Wash. 2d 114, 126, 660 P.2d 738, 745 (1983).

137. Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 Am. J. L. & Med. 337 (1979); President's Comm'n Report II at 160.

138. Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435; Baron, *supra* note 137, at 337.

139. *Baron, supra* note 127, at 347.

140. *Id.* at 347-48.

141. *Id.* at 348.

142. *Id.* at 349.

143. *See In re* Torres, 357 N.W. 2d 332 (Minn. 1984); *In re* L.H.R., 321 S.E. 2d 716, 253 Ga. 439 (1984); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

144. Buchanan, *supra* note 119, at 97.

145. *See supra* notes 6-10 and accompanying text.

(neither a medical prognosis review committee nor an administrative agency of the hospital) plays a central role in achieving the institutional framework that promotes an open forum for medical practitioners and family members. A decision will likely be reached without need for judicial intervention.[146] Under this method of decisionmaking, legal intervention can be sought whenever any of the participants deems necessary.[147]

One expert has suggested that decisionmaking by families, physicians, nurses and moral advisors, consulting together, may be as "principled" as decisions made by a court.[148] HECs may even approximate the qualities of the court system.[149] Even if the family presumption method could not possess all of the virtues of our legal system, a court decision certainly could not replace the more intimate concerns of those who are close to and care for the patient.

In states where the issue of whether the conservator of an incompetent person in a vegetative state with no hope of recovery may decide to terminate life supports, after considering medical advice and the conservatee's best interest, courts have

---

146. It is likely that at least two cases which were litigated would have been handled differently had an HEC been involved. Cranford & Doudera, *The Emergence of Institutional Ethics Committees*, 12 LAW, MEDICINE & HEALTH CARE, 13, 15.

147. "There are enough possibilities for error that the process should sometimes be reviewed judicially." President's Comm'n Report II at 160.

148. Bayley, *supra* note 130, at 8. Sister Corrine Bayley, as a member of an ethics committee at Saint Joseph Hospital in Orange, California, assisted in drafting general guidelines for decisionmaking which begin as follows:

> 1) Competent adults have the right to direct the course of their own medical treatment. A patient and his/her family should have access to significant information regarding the patient's condition.
>
> 2) Questions of when to withhold or withdraw medical treatment are not only medical questions; they involve personal values as well. Therefore, decisions in these matters should not be made by the physician alone, but should involve the patient and those closest to the patient.
>
> 3) Biological life need not be preserved at all costs. There are times when it is more in keeping with respect for life to let it go than to cling to it.
>
> 4) A decision to withhold or withdraw treatment which is potentially life-prolonging does not mean the staff has abandoned the patient, but that it is the time for an intensification of efforts to provide physical and emotional comfort.

Id. at 10.

149. *Id.* at 9.

almost unanimously decided in favor of the conservator's decision to terminate treatment.[150] This is evidence of the willingness of courts to defer such a decision to a person who is closer to the patient. In a case which dismissed homicide charges against physicians who had complied with the request of a comatose patient's family to disconnect life support systems, the court stated that "the determination as to whether the burdens of treatment are worth enduring for any individual patient depends upon the facts unique to each case," and "the patient's interests and desires are the key ingredients of the decision-making process."[151]

Some drawbacks of this view are that the HEC may exert undue influence over the family members and, as a hospital committee, HEC members may have a conflict of interest. There is also a possibility of a conflict between the patient and his or her family,[152] but it is more likely that the family members will choose according to the patient's desires.[153]

VI. THE POSSIBILITY OF A UNIFORM ROLE IN DECISIONMAKING

Although some experts believe that it is only a matter of time before all hospitals will have ethics committees,[154] there is disagreement as to whether HEC members deserve deference in bioethical matters.[155] Almost all of those involved in the adoption of ethics committees agree that the committee serves as a

150. The courts of twelve states, including the highest courts of ten, have approved decisions to forego life-sustaining treatment for permanently comatose patients. Decisions to the contrary have apparently been reversed by higher courts. *See, e.g., In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988), Rasmussen by Mitchell v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987), John F. Kennedy Hosp. v. Bludworth, 452 So.2d 921 (Fla. 1984), *In re* LHR, 253 Ga. 439, 321 S.E. 716 (1984), *In re* Gardner, 534 A.2d 947 (Me. 1987), *In re* Torres, 357 N.W. 2d 332 (Minn. 1984), *In re* Jobes, 108 N.J.394, 529 A.2d 434 (1987), *In re* Peter, 108 N.J. 365, 529 A.2d 419, *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied* 429 U.S. 922 (1976).

151. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 492 (1983).

152. "The emotional, physical, or financial drain of a patient's prolonged death could be so devastating to relatives that the interests of the family and the patient could diverge." Pollock, 41 Rutgers L. Rev. 505, 522 (1989).

153. *Id.*

154. Cranford & Doudera, *supra* note 146, at 13-14 (quoting Samuel R. Sherman, M.D., Chairman of the Judicial Council of the AMA).

155. *Id.*

forum to provide and discuss information relevant to particular ethical dilemmas at the institution.[156]

There is certainly a danger in allowing committee approval of foregoing treatment amounting to clearance and immunity for such decisions. It seems a better role for hospital ethics committees to serve as a consultive device to institutions, medical practitioners, patients, and their families.

The utilization of HECs for family decisionmaking combined with the possibility of judicial review is the most advantageous option. Developing a uniform standard on this issue, however, would be a challenge to our system of jurisprudence. Cases which have decided on the issue of termination of treatment are not in agreement as to the basis of such a right.[157] Some courts have invited legislation to address the issue of terminating treatment.[158] A legislative change may be a quicker and more appropriate solution.[159] Statutes already exist which immunize certain hospital committees from liability.[160] Some states have legal protection for Institutional Review Committees,[161] but not HECs. Although amending current legislation to include HECs may seem appealing, a better approach would be to draft new legisla-

156. Kushner, *Ethics Committees: How Are They Doing?*, 16 HASTINGS CENTER REPORT 11 (1986).

157. For example, the New Jersey Supreme Court first determined that the right to remove the patient's respirator was based on the right to privacy under both the New Jersey and federal Constitutions. *In re* Quinlan, 70 N.J. 10, 38-40, 355 A.2d 647, 662-63, *cert. denied*, 429 U.S. 922 (1976). The same court later predicated the right to remove life-sustaining treatment on the common law right of self-determination. *In re* Conroy, 98 N.J. 321, 346-48, 486 A.2d 1209, 1221-23 (1985). Finally, both rationales were recognized by the court in *In re* Farrell, 108 N.J. 335, 347-48, 529 A.2d 404, 410 (1987).

158. "[T]he Legislature is better equipped than we to develop and frame a comprehensive plan for resolving these problems." *Conroy* at 388, 486 A.2d at 1244. *See also In re* Hamlin, 102 Wash. 2d 810, 822, 689 P. 2d 1372, 1379 (1984).

159. One court has recognized that, "[n]o matter how expedited, judicial intervention in this complex and sensitive area may take too long. . . . Too many patients have died before their right to reject treatment was vindicated in court." *Farrell* at 355, 529 A.2d at 415.

160. *See* Merritt, Tort Liability of Hospital Ethics Committees, 60 S. CAL. L. REV. 1239, 1249 (1987).

161. *See supra* note 2.

tion to define, authorize, and protect the role of HECs.[162] The only other option for full recognition of the role of HECs to assist in the decisionmaking process is a comprehensive judicial opinion in an appropriate case.

HECs can best be utilized by recognizing their role in advising those close to the patient and establishing a legal presumption in favor of the choice of close family members. Physicians then must either accept the choice or challenge the decision in court as unreasonable. The guidance of an HEC in reaching a decision may allay the fears of those concerned about the influence of physicians on the family at a time of emotional turmoil. Open discussion may reveal the views of those who may have false motives for their sentiment.

Health care institutions are the common thread in decisions to forego treatment. They are involved with the care of the patient even when courts or family members are not. It is appropriate for hospitals to continue caring for the patient, even when all hope of recovery is gone, by ensuring that the patient's right to self-determination is honored.[163]

The appropriate representatives of the patient are family members or non-family friends who are in the best position to know the patient's feelings and desires, would be most affected by the decision, are concerned for the patient's comfort and welfare, and have expressed an interest in the patient by visits or inquiries to the patient's physician or hospital staff.[164] Under this standard, the term "family member" has a broad definition to include lovers and, if applicable, close friends.[165]

---

162. Cranford, Hester, & Ashley, *supra* note 113, at 58.

163.

> [I]nstitutions need to develop policies because their decisions have profound effects on patient outcomes, because society looks to these institutions to ensure the means necessary to preserve both health and the value of self-determination, and because they are conveniently situated to provide efficient, confidential, and rapid supervision and review of decisionmaking.

PRESIDENT'S COMM'N REPORT II at 4.

164. Barber v. Superior Court, 147 Cal. App.3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983).

165. The principle behind family decisionmaking is to allow those who have an intimate relationship with the patient to make the decision.

Family members are normally in the best position to make the most appropriate treatment decision for the truly incompetent patient. Not only are family members most likely to be privy to any relevant statements that the patient may have made regarding treatment decisions, but they also have knowledge of the patient's character traits. The relationship which exists between the patient and his or her family members simply does not exist with treating physicians or judges.

There will certainly be instances where the family's decision will not carry any weight. These include where the patient has suffered from a history of neglect or abuse by family members.[166] Also, many patients do not have close family members or friends. The presumption obviously cannot be applied to those situations. Although many cases still must be decided by a court of law, a large number of these dilemmas would be solved discreetly and without delay.

In order for HECs to provide useful support in decision-making, careful consideration must be given to their membership, operations, confidentiality, and immunity. Some uniformity should be attempted among HECs which must be true ethics committees and not prognosis confirmation committees. Also, HECs must safeguard against prejudice by committee members.[167]

VII. CONCLUSION

The issue of the proper role of a hospital ethics committee is complex. The seemingly simplistic solution of establishing a presumption in favor of a decision made by the patient's family with the help of an HEC may not be ideal, but it is a workable solution to a very difficult situation.

If the decision must be made by a court of law, the determinations should be taken into account by the court. Where proper procedures are in place, the determination should be admitted into evidence. Even if no actual decision is made by the HEC, the fact that an HEC aided in discussion should add some clout

166. Buchanan, *supra* note 119 at 113.
167. *Id.* at 111.

to a decision made by others. Before HECs are given this deference, however, procedures must be established so that courts will believe that the HEC was an impartial body facilitating open communication.

In many cases, the decision should not have to go to court at all. In those situations, the presumption of family members as the decisionmakers is appropriate considering the nature of the decision. The decision to forego life-sustaining treatment is neither purely legal nor purely medical, but a very difficult personal and moral decision. Even an objective guardian ad litem appointed to assure that the patient's best interests are being met often may not know as much about the patient's preferences as family members.

The proper role of HECs in decisionmaking is to provide an open forum for discussion, especially where the presumption of a family decision may be applied. This solution would alleviate the alienation felt by family members caused by the medical paternalism approach as well as dramatically decrease the time that it would take for a judicial decision to be made. Although the presumption approach is the best of the other alternatives, many loopholes remain. Overall, though, it is a better method for reaching at least some treatment decisions without resort to the courts.

In the unique case of making decisions to forego life-sustaining treatment, courts are not always the best decisionmaker. Although our court system has many positive virtues, it cannot replace the intimate relationship and struggle which those who care for the patient are confronted with in resolving these issues. Family members faced with the dilemma of making a treatment decision can benefit from the assistance of an HEC. Perhaps with increased uniformity and legal guidance, more people can utilize HECs and resolve such personal matters outside the courtroom.

*Carol A. Murphy**

* Golden Gate University School of Law, Class of 1991.