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Abstract

Complex ethical situations, such as end-of-life medical treatment disputes, occur on a regular basis in healthcare settings. Healthcare ethics committees (HECs) have been a leading dispute resolution forum for many of these conflicts. But while the function of HECs has evolved from mediation to adjudication, the form of HECs has not evolved to adapt to this expanded and more consequential function.

HECs are typically multidisciplinary groups comprised of representatives from different departments of the healthcare facility: medicine, nursing, law, pastoral care, and social work, for example. HECs were established to support and advise patients, families, and caregivers as they work together to find solutions for delicate circumstances.

HECs generally have been considered to play a mere advisory, facilitative role. But, increasingly, HECs have been playing a decision making role. Both in law and in practice, state governments and healthcare facilities have been giving HECs more authority to adjudicate conflicts and more responsibility for making treatment decisions. For example, HECs sometimes make decisions on behalf of incapacitated patients with no friends or family. Other times, HECs adjudicate medical treatment disputes between providers and the patient or patient's family.

Unfortunately, HECs are not up to this task. They are not ready to evolve from being mere advisers to being deciders. HECs are overwhelmingly intramural bodies. That is, they are comprised of professionals employed directly or indirectly by the very same institution whose decision the HEC adjudicates. But a lack of neutrality and independence is not the only problem. HECs typically also lack sufficient diversity, composition, training, and resources. Consequently, HECs make decisions that suffer from risks of corruption, bias, carelessness, and arbitrariness.

In prior published work, I have argued that the adjudicatory authority of HECs be relocated to a multi-institutional HEC. Thereby, no single institution's HEC would have a controlling voice in the adjudication of its own dispute. A multi-institutional HEC preserves the expertise and extrajudicial nature of HECs. But in contrast to an intramural HEC, a multi-institutional HEC possesses better resources, a greater diversity of perspectives, and the neutrality and independence required by due process.

In this Article, my primary objective is not to further articulate this or any other solution. Instead, the objective of this Article is to further articulate the problem. As the power of HECs grows, concern over HEC fairness grows. There is a direct and positive correlation between the power of HECs and the importance of developing a fairer dispute resolution mechanism that better accords with procedural due process. In short, because we are giving HECs more authority, we must demand more accountability.

Keywords

Healthcare Ethics Committees, Healthcare, Due process, Dispute resolution, Mediation, Adjudication, End-of-life

Disciplines

Elder Law | Medical Jurisprudence

THE GROWING POWER OF HEALTHCARE ETHICS COMMITTEES HEIGHTENS DUE PROCESS CONCERNS

*Thaddeus Mason Pope**

I. INTRODUCTION

Complex ethical situations, such as end-of-life medical treatment disputes, occur on a regular basis in healthcare settings.¹ Healthcare ethics committees (HECs) have been a leading dispute resolution forum for many of these conflicts. But while the function of HECs has evolved from mediation to adjudication, the form of HECs has not evolved to adapt to this expanded and more consequential function.

HECs are typically multidisciplinary groups comprised of representatives from different departments of the healthcare facility: medicine, nursing, law, pastoral care, and social work, for example.² HECs were established to support and advise patients, families, and caregivers as they work together to find solutions for delicate circumstances.

HECs generally have been considered to play a mere advisory, facilitative role.³ But, increasingly, HECs have been playing a decision-making role.⁴ In both law and practice, state governments

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¹ See, e.g., Terrah J. Paul Olson et al., *Surgeon Reported Conflict with Intensivists about Postoperative Goals of Care*, 148 JAMA SURGERY 29, 29 (2013) (“[M]ore than 70% of ICU clinicians report experiencing conflict weekly.”); John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-sustaining Therapy from Critically Ill Patients in the United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1104–07 (2007) (“[D]isagreements between families and clinicians on end-of-life care are commonplace in the United States.”); Keith M. Swetz et al., *Report of 255 Clinical Ethics Consultations and Review of the Literature*, 82 MAYO CLINIC PROC. 686, 689–90 (2007) (finding that futility disputes are one of the primary reasons for hospital ethics consultations); Thaddeus Mason Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 183, 203–04 (2010) (collecting studies).

² Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: the Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 259–74 (2009).

³ *Id.* at 270.

⁴ See *infra* Section II.

and healthcare facilities have been giving HECs more authority to adjudicate conflicts and more responsibility for making treatment decisions. For example, HECs sometimes make decisions on behalf of incapacitated patients lacking friends and family. Other times, HECs adjudicate medical treatment disputes between providers and the patient or patient's family.

Unfortunately, HECs are not up to this task. They are not ready to evolve from being mere advisers to being deciders. HECs are overwhelmingly intramural bodies. That is, they are comprised of professionals employed directly or indirectly by the very same institution whose decision the HEC adjudicates. But a lack of neutrality and independence is not the only problem. HECs typically also lack sufficient diversity, composition, training, and resources. Consequently, HECs make decisions that suffer from risks of corruption, bias, carelessness, and arbitrariness.⁵

In prior published work, I have argued that the adjudicatory authority of HECs should be relocated to a multi-institutional HEC.⁶ Thereby, no single institution's HEC would have a controlling voice in the adjudication of its own dispute. A multi-institutional HEC preserves the expertise and extrajudicial nature of HECs. But in contrast to an intramural HEC, a multi-institutional HEC possesses better resources, a greater diversity of perspectives, and the neutrality and independence required by due process.

In this article, my primary objective is not to further articulate this or any other solution. Instead, the objective of this article is to further articulate the problem.⁷ As the power of HECs grows, concern over HEC fairness grows. There is a direct and positive correlation between the power of HECs and the importance of developing a fairer dispute resolution mechanism that better accords with procedural due process. In short, because we are giving HECs more authority, we must demand more accountability.

⁵ Pope, *supra* note 2, at 274–300; Thaddeus Mason Pope, *Dispute Resolution Mechanisms for Intractable Medical Futility Disputes*, 58 N.Y. L. SCH. L. REV. 347 (2013).

⁶ Pope, *supra* note 2, at 302–32.

⁷ It is important to expand on the scope and nature of the problem for two reasons. First, my earlier articulations were rather succinct. See, e.g., *id.* at 270–71, 302; Thaddeus Mason Pope, *Legal Briefing: Healthcare Ethics Committees*, 22 J. CLINICAL ETHICS 74, 83–85 (2011). Second, there have been material new developments over the past five years. The trend toward expanded HEC decision making has continued. See *infra* Section II. Consequently, there is even more reason to examine the due process attributes of HECs today than there was in 2009 or 2011.

II. GROWING POWER OF HEALTHCARE ETHICS COMMITTEES

In 1984, University of Texas law professor John Robertson developed an organizational framework for healthcare ethics committees.⁸ Robertson's framework has two dimensions. First, it is either optional or mandatory to consult the HEC. Second, it is either optional or mandatory to follow the HEC's advice.

The traditional and classic model is optional-optional. A healthcare provider need not consult an HEC. And if the provider does (voluntarily) consult an HEC, she or he need not follow the HEC's recommendation (assuming one is made). Indeed, even today, most HECs remain optional-optional, which appropriately leaves treatment decisions to the joint decision making of physicians and patients (or their surrogates).⁹ But there has been significant movement to optional-mandatory, to mandatory-optional, and even to mandatory-mandatory models.

The mandatory-optional model might be analogized to court-ordered mediation, in which the disputing parties must engage the mediator but ultimately need not follow the mediator's recommendations.¹⁰ Mediation is often mandated in child custody and visitation decisions, because it has been proven effective in those contexts.¹¹ Similarly, the use of HECs is often mandated, because HECs have been successful in achieving consensus and informally resolving treatment conflicts.¹²

In New York, for example, if an attending physician has determined that a patient lacks decision-making capacity and the practitioner consulted for a concurring determination disagrees, then the matter must be referred to an HEC if it cannot be resolved otherwise.¹³ But while referral and submission are mandatory, compliance with the HEC's decision is optional.

⁸ John A. Robertson, *Committees as Decision Makers: Alternative Structures and Responsibilities*, in RONALD E. CRANFORD & A. EDWARD DOUDERA, *INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING* 85 (1984).

⁹ Pope, *supra* note 7, at 82.

¹⁰ David C. Albalah & Jesse D. Steele, *For Business Dispute Solutions, Process Matters*, 11 CARDOZO J. CONFLICT RESOL. 385, 393 (2010) ("Mediation by definition is non-binding; the third-party neutral cannot force anyone to do anything.").

¹¹ See Sandra J. Perry, Tanya M. Marcum & Charles R. Stoner, *Stumbling Down the Courthouse Steps: Mediators' Perceptions of the Stumbling Blocks to Successful Mandated Mediation in Child Custody and Visitation*, 11 PEPP. DISP. RESOL. L.J. 441 (2011).

¹² Pope, *supra* note 7, at 82-3.

¹³ N.Y. PUB. HEALTH L. § 2994-c(3)(d).

In contrast, HEC decisions on certain other matters in New York and other states are binding. Increasingly, states have been adopting the optional-mandatory and mandatory-mandatory models. Such states have been giving HECs certain decision-making authority. A significant number of states have given HECs one or more specific authoritative roles: (A) making treatment decisions for patients without surrogates, (B) adjudicating futility disputes, (C) adjudicating surrogate “ties,” (D) adjudicating other treatment disputes, and (E) gate-keeping and check-pointing. Furthermore, even when HECs have not been given any formal authority in one of these five ways, (F) they still often have substantial de facto power.

A. *Making Treatment Decisions for Patients without Surrogates*

A frequent issue confronting HECs is how to make treatment decisions for incapacitated patients without surrogates.¹⁴ Most states have developed several processes for making treatment decisions on behalf of patients without decision-making capacity.¹⁵ But none of these decision-making mechanisms can help the unrepresented, because they lack advance directive, healthcare agent, and available friends or family.

Facilities across the United States, and even within a given state, take varying approaches to this problem. Some facilities permit an attending physician to make the decision.¹⁶ Other facilities require the appointment of a guardian.¹⁷ Texas law requires the concurrence of a second physician who is not involved in treatment of the patient or “who is a representative of an ethics or medical committee of the healthcare facility.”¹⁸

But some states give HECs broader and more direct authority for such decisions. For example, Alabama, Arkansas, Georgia, and Tennessee place ethics committees right into the priority list of de-

¹⁴ See Thaddeus M. Pope, *Medical Decision Making for Patients without Surrogates* 369 *NEW ENG. J. MED.* 1976-78 (2013); Thaddeus Mason Pope & Tanya Sellers, *Legal Briefing: The Unbefriended: Making Healthcare Decisions for Patients without Proxies (Part 1)*, 23 *J. CLINICAL ETHICS* 84 (2012).

¹⁵ See Thaddeus Mason Pope, *Legal Fundamentals of Surrogate Decision Making*, 141 *CHEST* 1074 (2012).

¹⁶ See Thaddeus Mason Pope & Tanya Sellers, *Legal Briefing: The Unbefriended: Making Healthcare Decisions for Patients without Proxies (Part 2)*, 23 *J. CLINICAL ETHICS* 177 (2012).

¹⁷ *Id.* at 177-81.

¹⁸ *TEX. HEALTH & SAFETY CODE* §§ 166.039(e) & 166.088(f).

fault surrogates.¹⁹ If no family member or “close friend” is reasonably available, then an ethics committee can be a patient’s surrogate decision maker.

A similar rule in California long-term care facilities permits treatment decisions for incapacitated patients without surrogates to be made by an “interdisciplinary team.”²⁰ Similarly, Iowa established a statewide network of “local substitute medical decision-making boards.”²¹ That law permits a “county board of supervisors” to “appoint and fund a hospital ethics committee to serve as the local decision-making board.”²²

In contrast to these states, in which HECs have the decision-making authority of a regular surrogate, HECs in other states play a narrower role. Yet, even in these states, the HEC possesses “veto” authority. Arizona, for example, requires a physician to consult with and obtain the recommendations of an ethics committee.²³ In Florida, for surrogate-less patients in a persistent vegetative state, life-prolonging procedures may be withheld or withdrawn only with approval of a “medical ethics committee of the facility where the patient is located.”²⁴

B. Adjudicating Futility Disputes

Like treatment decisions for “unrepresented” or “unbefriended” patients, futility disputes also comprise a significant portion of HEC cases.²⁵ A medical futility dispute is one in which the parties disagree over whether a current or proposed medical inter-

¹⁹ See Pope & Sellers, *supra* note 16, at 183–85 (collecting authority).

²⁰ CAL. HEALTH & SAFETY CODE § 1418.8. A recently-filed lawsuit challenges the constitutionality of the IDT procedure. California Advocates for Nursing Home reform v. Chapman, No. RG13700100 (Alameda Cty. Sup. Ct., Cal. Oct. 22, 2013) (filed). But others have defended the IDT. See e.g., Robert Gibson & James G. Bond, *Medical Decision Making in California Long-Term Care Facilities: Health & Safety Code Section 1418.8: A Mandated Alternative to Conservatorship*, 19 CAL. TRUSTS & ESTATES Q. 5 (2013).

²¹ IOWA CODE ANN. § 135.09.

²² IOWA ADMIN. CODE R. 641-85.2(5); Iowa Department of Public Health, *Substitute Medical Decision-Making Board*, http://www.idph.state.ia.us/bh/substitute_decision.asp.

²³ ARIZ. REV. STAT. § 36-3231(B).

²⁴ FLA. STAT. ANN. § 765.404(2). This committee must conclude: (1) that the condition is permanent, (2) that there is no reasonable medical probability of recovery, and (3) that withholding or withdrawing life-prolonging procedures is in the best interest of the patient.

²⁵ See, e.g., Andrew G. Shuman et al., *Clinical Ethics Consultation in Oncology*, J. ONCOLOGY PRACTICE (2013); T.P. Gonsoulin, *A Survey of Louisiana Hospital Ethics Committees*, 119 LARYNGOSCOPE 330 (2009).

vention is medically and ethically appropriate. The paradigmatic medical futility dispute is one in which the surrogate requests aggressive treatment interventions for an imminently dying or catastrophically chronically ill patient. However, that patient's health-care providers consider such treatment to be non-beneficial or medically and ethically inappropriate.²⁶

Uniquely in Texas, the HEC is the forum of last resort in a futility dispute. If a Texas physician cannot reach consensus with a surrogate in a conflict over inappropriate or non-beneficial treatment, then the physician can commence a five-stage review process. This process gives the final word to the HEC.²⁷

The first stage entails giving the surrogate at least forty-eight hours' notice of an HEC meeting.²⁸ Second, the committee reviews the treating physician's determination.²⁹ Third, if the committee agrees that the disputed treatment is inappropriate, then the surrogate is given the committee's written decision.³⁰ Fourth, the provider is obligated both to continue providing the disputed treatment for ten days, and to attempt to transfer the patient to another provider who is willing to comply with the surrogate's treatment request.³¹

In the final stage, if the patient has not been transferred, then the provider may unilaterally stop the disputed treatment on the eleventh day.³² Providers who follow the Texas law's prescribed notice and meeting procedures are immune from both disciplinary action and civil and criminal liability.³³ The decision of the HEC cannot be challenged or reviewed in court.³⁴

Because of either legal requirements or legal uncertainty, healthcare providers in other states usually cave in to what they think are medically inappropriate surrogate demands.³⁵ So there has been significant interest in copying the Texas law and empowering HECs in futility disputes.

²⁶ Thaddeus M. Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 8-42 (2007).

²⁷ Pope, N.Y. L. SCH. L. REV., *supra* note 5.

²⁸ TEX. HEALTH & SAFETY CODE § 166.046.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ TEX. HEALTH & SAFETY CODE § 166.045.

³⁴ Pope, *supra* note 26, at 79-80.

³⁵ Thaddeus M. Pope & Ellen Waldman, *Mediation at the End-of-Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143 (2007).

For example, both Idaho and New Jersey have recently considered adopting the HEC adjudication provisions in the Texas law. An Idaho bill was passed unanimously by the state Senate, but died in the House.³⁶ In New Jersey, a joint brief by the New Jersey Hospital Association and the Medical Society of New Jersey asked the Appellate Division of the state Superior Court to adopt these provisions.³⁷ Furthermore, professional medical associations in other states have passed resolutions calling on their legislatures to empower their HECs.³⁸

C. Adjudicating Surrogate “Ties”

Futility disputes are not the only type of conflict that HECs are authorized to adjudicate. Some states have authorized HECs to decide which of two or more equally “ranked” surrogates can act as an incapacitated patient’s surrogate decision maker.

Because most individuals do not effectively complete advance directives designating healthcare agents, when patients lose capacity, their surrogate decision maker is typically chosen from the state’s statutory default list.³⁹ These statutes specify a priority list of individuals whom the physician should or must designate. Typically, at the top of this hierarchy are the patient’s spouse, adult child, parent, and adult sibling. The hierarchy prioritizes those relatives who are typically more likely to know the convictions and beliefs of the patient and be concerned for the patient.

Sometimes there is conflict among surrogates of the same class. For example, two daughters may disagree about their mother’s care. With which daughter’s decision should clinicians comply? Ethics committees in all states can help resolve such disputes by facilitating communication and mediation. But in some states the HEC is not just a mediator, but also an adjudicator. These HECs are empowered to determine the appropriate surrogate. Moreover, these statutes grant clinicians immunity for following the HEC’s decision.

³⁶ Idaho S.B. 1114 (60th Legisl.) (passed Senate 3 March 2009).

³⁷ Brief of Amici Curiae New Jersey Hospital Association, Catholic Healthcare Partnership of New Jersey, and Medical Society of New Jersey, *Betancourt v. Trinitas Hospital*, No. A-003-849-08T2 (N.J. Super. A.D. 2009).

³⁸ Pope, N.Y. L. SCH. L. REV., *supra* note 5.

³⁹ Pope, *supra* note 15, at 1076.

For example, in Maryland, if surrogates with equal decision-making priority disagree about a healthcare decision, then either an attending physician or one of the default surrogates must refer the case to the institution's HEC. A physician who acts in accordance with the recommendation of the committee is not subject to liability for any claim based on lack of consent to or authorization of the action.⁴⁰

Similarly, a Delaware ethics committee can also decide such disputes.⁴¹ As in Maryland, the Delaware attending physician, acting in accordance with the committee's recommendation, is not subject to civil or criminal liability or to discipline for unprofessional conduct. Basically, if two children disagree about a parent's medical treatment, the HEC can determine which one is the appropriate surrogate, and the clinician may safely look to that individual for consent.

D. *Adjudicating Other Disputes*⁴²

While some states authorize HECs to adjudicate futility disputes and some authorize HECs to adjudicate surrogate ties, Hawaii authorizes HECs to make decisions across a far broader range of issues: the power of a Hawaii HEC is not limited to any particular type of issue or dispute.

Hawaii defines an "ethics committee" as "an interdisciplinary committee appointed by the administrative staff of a licensed hospital, whose function is to consult, educate, review, and *make decisions* regarding ethical questions, including decisions on life-sustaining therapy."⁴³ Moreover, the statute limits review of HEC decisions by affording immunity: "There shall be no civil liability for . . . any acts done in the furtherance of the purpose for which the . . . ethics committee . . . was established."⁴⁴

⁴⁰ MD. HEALTH-GEN. CODE § 5-605(b)(1).

⁴¹ DEL. CODE, tit. 16 § 2507(b)(8).

⁴² HECs may also have authoritative roles with respect to rationing and triage decisions, for example in disaster situations. See e.g., New York Department of Health, Task Force on Life and the Law, *Allocation of Ventilators in an Influenza Pandemic: Planning Document* (Mar. 15, 2007) (suggesting that HECs should serve in an "appeals process" for reviewing triage decisions), available at http://www.health.ny.gov/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf.

⁴³ HAW. REV. STAT. § 663-1.7(a) (emphasis added).

⁴⁴ HAW. REV. STAT. § 663-1.7(b).

E. Gate-keeping and Check-pointing

The original function of an ethics committee was one of gate-keeper or checkpoint. Certain healthcare decisions could not be implemented without consulting (and often without the approval of) an HEC. For example, the antecedents to today's ethics HECs served as gatekeepers that would grant or deny permission to perform an abortion or conduct research with human subjects.⁴⁵

HECs continue to play this gate-keeping and check-pointing role. For example, in a Texas mental health facility, behavioral interventions using highly restrictive interventions and aversive techniques such as faradic stimulation (with electric current) require the documented written approval of an HEC.⁴⁶

But most HEC gatekeeping involves approving the withholding or withdrawal of life-sustaining treatment like ventilators, dialysis, cardiopulmonary resuscitation, and clinically-assisted nutrition and hydration. HECs play a significant role in these healthcare decisions in New Jersey, New York, Minnesota, and Massachusetts.

1. New Jersey

In the mid-1990s, the New Jersey Office of the Ombudsman for the Institutionalized Elderly (OOIE) directed the formation of a statewide network of "Regional Long Term Care Ethics Committees" to serve the state's nearly 400 long-term care facilities.⁴⁷ These HECs "provide to the long-term care community expertise of multi-disciplinary members who offer case consultation and support to residents and health care professionals who are facing ethical dilemmas."⁴⁸

While decisions to withhold or withdraw life-sustaining treatment from an elderly, incapacitated resident of a long-term care facility must normally be reported to the OOIE, the decisions need not be reported when they have been reviewed by an approved ethics committee.⁴⁹ In short, while it retains and exercises some oversight, the OOIE has delegated its oversight and approval responsibility to the several HECs.

⁴⁵ See Pope, *supra* note 2, at 261–65.

⁴⁶ TEX. ADMIN. CODE § 404.166(f).

⁴⁷ See *id.*; STATE OF N.J. OFFICE OF THE OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY, 2006 ANNUAL REPORT 10 (2006), available at <http://www.state.nj.us/publicadvocate/home/reports/pdfs/elderlyombudsmanreport.pdf>.

⁴⁸ N.J. ADMIN. CODE §§ 10:48B-2.1 & 15A:3-2.2.

⁴⁹ N.J. ADMIN. CODE § 15A:3-2.3(d)(6).

2. New York

HECs serve three gate-keeping roles in New York. One role is similar to the function that New Jersey HECs serve for the OOIE. In a New York residential healthcare facility, a surrogate has the authority to refuse life-sustaining treatment (other than cardiopulmonary resuscitation [CPR]) only if the ethics committee reviews the decision and determines that it meets statutory standards.⁵⁰

The other two gate-keeping roles served by New York HECs are unique to New York. First, an emancipated minor patient with decision-making capacity has the authority to decide about life-sustaining treatment only if an ethics committee approves the decision.⁵¹ Second, in a general hospital, if an attending physician objects to a surrogate's decision to withdraw or withhold medically provided nutrition and hydration, the decision may not be implemented until the ethics review committee reviews the decision and determines that it meets statutory standards.⁵²

3. Minnesota

Like New Jersey and New York, Minnesota also recently gave HECs gate-keeping power that was previously exercised by state government officials. In 2012, a Minnesota probate court held that court-appointed guardians do not have the authority to consent to the withholding or withdrawing of life-sustaining treatment unless the court specifically grants them that power.⁵³ This was an unexpected ruling, because Minnesota guardians had been making such treatment decisions for decades.

The Hennepin County court had appointed a guardian for Jeffers Tschumy in 2008. In April 2012, Tschumy suffered a cardiac arrest after choking on some food at his group home. This event resulted in irreversible brain injury that left Tschumy in a persistent vegetative state. Clinicians at Abbott Northwestern Hospital determined that further medical interventions would not be appropriate. The HEC similarly determined that Tschumy could not benefit from further intensive treatment. Tschumy's guardian

⁵⁰ N.Y. PUB. HEALTH L. § 2994-d(5)(B). This determination can alternatively be made by "a court of competent jurisdiction." *Id.*

⁵¹ N.Y. PUB. HEALTH L. § 2994-e(3).

⁵² N.Y. PUB. HEALTH L. § 2994-d(5)(c).

⁵³ *In re Tschumy*, 27-GC-PR-07-496 (Hennepin Cty. Dist. Ct., Minn. Oct. 18, 2012), available at <http://www.mnbar.org/sections/health-law/12-21-12%20Handout.pdf>.

agreed. But despite this consensus, the hospital filed a motion to clarify the guardian's authority.⁵⁴

While the court authorized the guardian to consent to the withdrawal of life-sustaining treatment, it cautioned that its specific authorization would always be required. The court explained that because of the "time gap" between the commencement of a guardianship and the possible need for that guardian to make an end-of-life decision on behalf of the ward, judges could not "practically evaluate potential guardians for the ability to make an end-of-life decision."⁵⁵ Moreover, guardians "rarely (if ever) receive training on end-of-life issues."⁵⁶ The court concluded that clinicians must "involve the judicial system—to provide experienced and impartial examination and evaluation of termination decisions."⁵⁷

But in 2013, the Minnesota Court of Appeals reversed the district court. The appellate court determined that judicial oversight is unnecessary when a medical ethics committee has already concurred with the treatment plan of the ward's physicians.⁵⁸ It explained:

Although courts are experienced in making reasoned and impartial decisions, doctors and medical ethics committees have the most appropriate knowledge and expertise to evaluate the potential for a ward's long-term recovery and quality of life and advising a guardian on end-of-life decisionmaking.⁵⁹

The Court of Appeals endorsed "a private, medically based model of decisionmaking,"⁶⁰ holding that HECs, not courts, are the best checkpoints on guardian decisions to stop life-sustaining treatment. In October 2013, the Minnesota Supreme Court granted the ward's petition for review.⁶¹

4. Massachusetts

Like New Jersey, New York, and Minnesota, Massachusetts also delegated a gate-keeping role to HECs. As in Minnesota, the issue was prompted by a specific case.

⁵⁴ *Id.* at 3.

⁵⁵ *Id.* at 15.

⁵⁶ *Id.* at 16.

⁵⁷ *Id.* at 17.

⁵⁸ *In re Tschumy*, 834 N.W.2d 764 (Minn. App. 2013).

⁵⁹ *Id.* at 774.

⁶⁰ *Id.*

⁶¹ *In re Tschumy*, No. A12-2179 (Minn. Oct. 15, 2013) (Order granting petition for review).

In 2005, Haleigh Poutre was hospitalized with severe brain injuries after she was beaten into a coma by her stepfather, Jason Strickland. The Department of Social Services assumed custody for Poutre.⁶² It then moved to terminate Poutre's life support after physicians declared she was in a persistent vegetative state. The Massachusetts Supreme Judicial Court approved this request.⁶³

But Poutre's condition then improved. She could breathe on her own and follow simple commands.⁶⁴ At least in retrospect, the decision to stop life support seemed both premature and not in Poutre's best interest. The case garnered significant negative publicity. The Massachusetts child welfare system came under intense scrutiny.⁶⁵ Consequently, new legislation was enacted to address discovered weaknesses in the system. The new statute provides that proceedings in end-of-life cases require, among other things, a "written recommendation from the ethics committee of the hospital at which the child is a patient."⁶⁶

F. *De Facto Decision Making Power*

Even without any official, formal authority, ethics committees still have significant power. HEC decisions, even if not legally binding, often have an effect of being practically binding.⁶⁷ There are three reasons for this. First, families perceive HECs as authoritative. Second, even when they recognize the non-binding nature of HEC decisions, families lack the resources to challenge those decisions. Third, families recognize that courts grant significant deference to HEC decisions, even when no such deference is formally required.

⁶² This department is now called the Department of Children and Families.

⁶³ *In re Care and Protection of Sharlene*, 445 Mass. 756, 840 N.E. 2d 918 (2006).

⁶⁴ M. Underwood, *Chance of Recovery Rare, but Possible, Says Brain Doc*, BOSTON HERALD (Feb. 28, 2008).

⁶⁵ Massachusetts Executive Order No. 471, *Establishing the Governor's Special Panel for the Review of the Haleigh Poutre Case* (Feb. 3, 2006).

⁶⁶ MASS. STAT. ch.119 § 38A.

⁶⁷ See Autumn Fiester, *Bioethics Mediation and the End of Clinical Ethics as We Know It*, 15 CARDOZO J. CONFLICT RESOL. 501 (2014) ("ECS are self-deceived in defining their work as mere 'suggestion' or 'advice.' In practice on the ground, their work is more akin to 'mandate' or 'rendered judgment.'").

1. Families Perceive the HEC as Authoritative

In 2010, the Pennsylvania Attorney General filed a consumer protection lawsuit against a debt collection company that used deceptive tactics, such as “fake court proceedings,” to mislead and frighten consumers into making payments without following lawful procedures for debt collection.⁶⁸

The company had individuals who appeared to be “sheriff deputies” hand-deliver “hearing notices.” These papers summoned consumers to an office at the debt collection company referred to as “the courtroom,” which contained furniture and decorations similar to those used in actual court offices, including a witness stand and a raised bench area where a judge would be seated. Clearly, all of this was designed to mislead and deceive consumers into thinking that they had no choice but to comply with the debt collection company’s “decisions.”

I do not mean to suggest that HECs make deliberate or willful efforts to disguise themselves as entities more powerful than they really are. But the misimpression exists nonetheless: patients and surrogates perceive the HEC as authoritative.⁶⁹ Here are two recent examples.

⁶⁸ *Erie debt collection company sued*, PENNSYLVANIA ATTORNEY GENERAL, <http://www.attorneygeneral.gov/press.aspx?id=5763>.

⁶⁹ See George J. Agich, *Authority in Ethics Consultation*, 23 J.L. MED. & ETHICS 273, 275 (1995) (observing that recommendations have a “practical effect akin to power”); LISA BELKIN, *FIRST DO NO HARM* 73 (1992) (“Officially, the committee only gives consultation and advice . . . [but t]he advice is almost always followed.”); Ronald E. Cranford & A. Edward Doudera, *The Emergence of Institutional Ethics Committees*, in CRANFORD & DOUDERA, *supra* note 8, at 5, 16 (“[I]t is hard to believe that a committee’s recommendation would not carry weight.”); Gonsoulin, *supra* note 26, at 339 (“While HEC recommendations were considered advisory, they were usually followed by the physicians involved.”); BOWEN HOSFORD, *BIOETHICS COMMITTEES: THE HEALTH CARE PROVIDER’S GUIDE* 94 (1986) (“It is inescapable that a bioethics committee will influence physicians’ decisions”); *id.* at 231 (explaining that HEC “recommendations carry weight”; “De facto we are making decisions” (quoting Ronald Cranford)); *id.* at 232 (“A gradual evolution will probably take place, with committees assuming more authority.”); *id.* at 277 (quoting Dr. Norman C. Fost describing HECs as engaged in “de facto decision making” because they can place “enormous pressures on physicians”); Shelia A.M. McLean, *Clinical Ethics Committees, Due Process and the Right to a Fair Hearing*, 15 J.L. & MED. 1, 1 (2008) (finding that HECs are “increasingly authoritative”); Carmel Shachar, *Strengthening Clinical Ethics Committees: An Examination of the Jurisprudence and a Call for Reform*, 3 HARV. L. & POL’Y REV. 1, 7 (2009) (“[A] patient’s family may feel disempowered . . . lack of resources . . . [or perceive the HEC decision] as authoritative.”); Margaret Somerville, *The Ethics of Allowing Babies to Die*, MONTREAL GAZETTE, Mar. 25, 2009 (“Ethics committees . . . are very influential.”); David N. Sontag, Comment, *Are Clinical Ethics Consultants in Danger? An Analysis of the Potential Legal Liability of Individual Clinical Ethicists*, 151 U. PA. L. REV. 667, 700–03 (2002) (discussing causal relationship between HEC decisions and harm caused by medical negligence).

For example, in the high-profile *Ashley X* case, neither the providers nor the family of Ashley, a severely disabled six-year-old girl, sought a legally required court order for Ashley's sterilization, because they thought that HEC approval alone was sufficient. In 2004, Seattle Children's Hospital determined that it was ethically permissible to perform a hysterectomy and other interventions on Ashley. The parents and clinicians were in agreement, and the interventions were performed.

But in 2006, the Washington Protection and Advocacy System (WPAS)⁷⁰ investigated the hospital.⁷¹ WPAS concluded that the surgery violated Ashley's constitutional and common law rights, because Washington courts had ruled earlier that sterilization of a developmentally disabled person requires court approval. Court approval was never sought in Ashley's case, in large part because HEC review and approval was thought to be sufficient.⁷²

Similarly, in a Montreal case, a patient's family thought that the HEC had more power than it actually did.⁷³ The parents of a severely disabled girl, Phebe Mantha, decided to take her off life support. Phebe's treatment providers agreed. But the HEC disagreed. The parents reluctantly acceded to the HEC.

But the parents agreed to continue life support only because they thought they had no choice. They thought (wrongly) that they needed the HEC's "permission" to stop treatment. Phebe was later discharged and is being cared for at home with substantial medical support. The parents brought a \$3.5 million lawsuit against the hospital, complaining about its failure to disclose the HEC's merely advisory status. The parents claim that the HEC should have informed them that it actually had no decision-making power.

2. Families Lack Resources to Challenge HECs

The (mis)perception of HECs as authoritative is not the only reason that HECs have de facto power. Even if patients and surrogates recognize that an HEC's decision is non-binding, they may

⁷⁰ WPAC is now called Disability Rights Washington.

⁷¹ WASHINGTON PROTECTION AND ADVOCACY SYSTEM, INVESTIGATIVE REPORT REGARDING THE "ASHLEY TREATMENT" (May 8, 2007), http://www.disabilityrightswa.org/home/Full_Report_InvestigativeReportRegardingtheAshleyTreatment.pdf.

⁷² Douglas S. Diekema and Norman Fost, *Ashley Revisited: A Response to the Critics*, 10(1) *AM J. BIOETHICS* 30 (2010).

⁷³ *Laurendeau v. LaSalle Hosp.*, No. 500-17-048988-094 (Quebec Sup. Ct. Mar. 12, 2009) (filed); see also C. Lewis, *Hospital Sued for Keeping Infant Alive*, *NATIONAL POST* (Mar. 14, 2009).

still accede to an HEC-rendered decision with which they disagree. A challenge to the HEC may require a lawsuit. Many patients and families lack the sophistication and resources to initiate litigation against healthcare providers.⁷⁴ And the confidentiality afforded to HEC records and proceedings presents additional obstacles.⁷⁵

3. Courts Defer to HEC Recommendations

Furthermore, patients and surrogates know that even if they did challenge the HEC, the court would probably defer to the HEC's supposed expertise. Recognizing that decisions to withdraw life-sustaining treatment would be frequent and routine, courts have wisely determined that such decisions could and should be made without judicial review.⁷⁶ Judges do not want to decide these cases.⁷⁷ Moreover, the general consensus has been that there is no need for judicial review⁷⁸ because HECs are both better positioned and better equipped to resolve treatment disputes.⁷⁹

⁷⁴ Cf. Keren Ladin & Douglas W. Hanto, *Rationing Lung Transplants — Procedural Fairness in Allocation and Appeals*, 369 *NEW ENG. J. MED.* 599 (2013). For similar reasons, most patients injured by medical malpractice never sue. See Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice Crisis*, 23 *STAN. L. & POL'Y REV.* 473 (2011). Some HECs have offered to equalize the power differential by paying for the family's attorney. See, e.g., Lance Lightfoot, *Incompetent Decisionmakers and Withdrawal of Life-Sustaining Treatment: A Case Study*, 33 *J. L. MED. & ETHICS* 851 (2005).

⁷⁵ See Pope, *supra* note 7, at 85.

⁷⁶ See generally ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* §§ 3.19-20, .23, .26 (3d ed. 2004 & Supp. 2012) (collecting relevant authority).

⁷⁷ See, e.g., *In re A.C.*, 573 A.2d 1235, 1237 n.2 (D.C. 1990) (“[I]t would be far better if judges were not called to patients’ bedsides Because judgment in such a case involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment . . . of another tribunal to make these decisions”); *In re Nemser*, 273 N.Y.S.2d 624, 629 (N.Y. 1966) (“[I]n no way does [this] court intend to imply that an individual must be judicially declared incompetent before it will or may intervene in his or her behalf. . . . It seems incongruous in light of the physicians’ oath that they even seek legal immunity prior to action necessary to sustain life. . . . Emergency requirements . . . should not be delayed nor the responsibility therefor shirked while fearful physicians and hospitals first seek judicial sanction”).

⁷⁸ See MEISEL & CERMINARA, *supra* note 76, at § 3.19 n.265.

⁷⁹ *Id.* at § 3.25(a); Jack B. Weinstein, *Some Benefits and Risks of Privatization of Justice through ADR*, 11 *OHIO ST. J. ON DISP. RESOL.* 241, 289–90 (1996) (arguing that bioethics disputes are “probably better resolved privately”). This general position has been challenged most forcefully by Professor Robin Fretwell Wilson, of Washington and Lee University School of Law. See Robin Fretwell Wilson, *Hospital Ethics Committees as the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 *N.C. L. REV.* 353 (1998); Robin Fretwell Wilson, *Rethinking the Shield of Immunity: Should Ethics Committees Be Accountable for Their Mistakes?*, 14 *HEC FORUM* 172, 187–88 (2002) (stating that judges have resolved highly technical cases and stressing the benefits of court proceedings).

Judicial review is generally thought to be an inappropriate mechanism for resolving medical treatment disputes.⁸⁰ First, it is cumbersome, being both time-consuming and expensive.⁸¹ Thus, it cannot usefully address complex, urgent medical issues. Second, because courts are adversarial and open to the public, they are an unwelcome forum in which to resolve sensitive medical treatment disputes worthy of privacy.⁸² Third, judicial review is an encroachment on the medical profession's decision making.⁸³

In contrast, the responses of ethics committees are "more rapid and sensitive" and "closer to the treatment setting."⁸⁴ "[T]heir deliberations are informal and typically private,"⁸⁵ which is important for medical decisions and the informal resolution of disputes.⁸⁶ And ethics committees better respect the role and judgment of physicians.

Courts themselves recognize these comparative strengths and weaknesses. While they remain open to resolving intractable disputes, courts have shown a willingness to consider the role and capabilities of the HEC, as well as the substance of its recommendations, as having a significant impact on the final re-

⁸⁰ MEISEL & CERMINARA, *supra* note 76, at § 3.26. Bear in mind that ethics committees may be considered, and evaluated, as another form of alternative dispute resolution. They offer most of the same benefits: speed, low cost, ease of access, informality, and confidentiality.

⁸¹ See PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 159 (1983) [hereinafter PRESIDENT'S COMM'N] (describing court involvement with treatment disputes as intrusive, slow, costly and framed in adversarial terms). In futility disputes, for example, courts typically issue a temporary injunction ordering continued treatment pending a full evidentiary hearing; but the patient often dies in the meantime, mooted the dispute. See Thaddeus Mason Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQ. ELDER'S ADVISOR 229 (2008). Requiring judicial review for approval of treatment decisions may, because of the required time and expense, effectively deny a right to such treatment. See, e.g., Mike E. Jorgensen, *Today Is the Day We Free Electroconvulsive Therapy?* 12 QUINN. HEALTH L.J. 1, 1, 56 (2008).

⁸² See Alice Herb & Eliot J. Lazar, *Ethics Committees and End-of-Life Decision Making*, in MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 110, 110, 111 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

⁸³ See Wilson, *supra* note 79.

⁸⁴ PRESIDENT'S COMM'N, *supra* note 81, at 169.

⁸⁵ *Id.*

⁸⁶ See *In re Jobs*, 529 A.2d 434, 451 (N.J. 1987) (stating that "committee review can be more sensitive, prompt, and discreet" than judicial review); PRESIDENT'S COMM'N, *supra* note 81, at 165 (observing that "ethics committees will probably be less formal and burdensome than judicial review in any particular case").

sult.⁸⁷ Thus, it appears HECs significantly influence—and sometimes control—the outcome.⁸⁸

G. Summary of Growing HEC Power

Increasingly, state legislatures, agencies, and courts have endowed HECs with three types of decision-making authority. First, today's HECs have more adjudicatory power to resolve futility disputes, surrogate ties, and other treatment conflicts. Second, today's HECs have the power to make decisions for unbefriended patients. Third, today's HECs have the authority to act as gatekeepers and checkpoints, especially for decisions regarding life-sustaining treatment. Furthermore, HEC power has grown because of not only expanded roles officially delegated by state governments, but also greater deference from the courts. Even when they lack de jure power, HECs often have de facto power.

III. DUE PROCESS PROBLEMS

The primary purpose of this article is neither to identify nor to argue for the due process problems with HECs. That task has already been substantially performed.⁸⁹ Instead, the primary mission

⁸⁷ See, e.g., *Bernstein v. Sup. Ct.*, No. B212067, at 21 (Cal. App. Feb. 2, 2009); *Quill v. Vacco*, 80 F.3d 716, 731 n.4 (2d Cir. 1996) (suggesting states allowing assisted suicide might “require the establishment of local ethics committees as resources for physicians faced with questions relating to requests for lethal medications”), *rev'd*, 521 U.S. 793 (1997); *Severns v. Wilmington Med. Ctr., Inc.*, 421 A.2d 1334, 1341–44 (Del. 1980); *In re A.C.*, 573 A.2d 1235 (D.C. 1990); *DeGrella v. Elston*, 858 S.W.2d 698, 710 (Ky. 1993); *In re Spring*, 405 N.E.2d 115, 120 (Mass. 1980) (“[T]he concurrence of qualified consultants may be highly persuasive”); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 429 (Mass. 1977); *In re Torres*, 357 N.W.2d 332, 336 n.2 (Minn. 1984) (“[T]hese committees are uniquely suited to provide guidance”); *In re Jobes*, 529 A.2d at 463–64; *In re Moorhouse*, 593 A.2d 1256, 1257 (N.J. Super. Ct. App. Div. 1991); *In re Doe*, 45 Pa. D. & C.3d 371 (C.C.P. 1987); *In re L.W.*, 482 N.W.2d 60, 63–4 (Wis. 1992); see also BETHANY SPIELMAN, *BIOETHICS IN LAW* 41–56 (2007); Alexander M. Capron, *Legal Perspectives on Institutional Ethics Committees*, 11 J.C. & U.L. 416 (1985). In some respects, HECs are analogous to medical review panels in the liability context. While the decisions of neither forum typically are formally dispositive, they have significant practical effect. Cf. N.H. REV. STAT. ANN. § 519-B:1 (2008).

⁸⁸ On the other hand, courts may grant less deference when they perceive the HEC to lack independence and competence. See, e.g., *Inquest into the death of Paulo Melo* [2008] NTMC 080; Pope, *supra* note 2, at 299.

⁸⁹ See, e.g., Pope, *supra* note 2; Nora O'Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 BAYLOR L. REV. 527

of the article is to demonstrate the increasing relevance and importance of these already-articulated due process problems. They matter more, because HECs matter more.

In prior work, I have described four distinct types of risks applicable to HEC decisions: the risk of corruption, the risk of bias, the risk of arbitrariness, and the risk of carelessness.⁹⁰ I will not revisit that discussion here. But while all these risks materially increase the chance of error, the risk of corruption may be the most significant.⁹¹ Accordingly, I separately address this particular risk below.

A. *Bias, Arbitrariness, and Carelessness*

A “biased decision” is one reflecting a pattern of unfairness, which disparages the interests of certain persons or classes of persons.⁹² For example, a treatment decision may be *biased* when the decision maker is prejudiced against the race of the patient.⁹³

A “careless decision” is one based on ill-considered or unsupported beliefs due to insufficiencies in the decision maker’s training.⁹⁴ For example, a treatment decision may be *careless* when the decision maker misapplies relevant standards, such as those for determining capacity.⁹⁵

An “arbitrary decision” is one that is the product of an abuse of appropriate process norms.⁹⁶ For example, a treatment decision may be *arbitrary* when the decision maker fails to obtain relevant information or engage in adequate deliberation.⁹⁷

(2008); Nora O’Callaghan, *When Atlas Shrugs: May the State Wash Its Hands of Those in Need of Life-Sustaining Medical Treatment?* 18 HEALTH MATRIX 291 (2008).

⁹⁰ Pope, *supra* note 2.

⁹¹ Cf. Jennifer E. Miller & William English, *Corruption*, in *Handbook of Global Bioethics* 599 (H.A.M.J. ten Have & B. Gardijn eds. 2014).

⁹² Pope, *supra* note 2, at 274–75.

⁹³ For examples of HEC bias, see Pope, *supra* note 2 nn.153–186 & accompanying text.

⁹⁴ *Id.* at 274–75.

⁹⁵ For examples of HEC carelessness, see Pope, *supra* note 2 nn.187–219 & accompanying text.

⁹⁶ *Id.* at 274–75.

⁹⁷ For examples of HEC arbitrariness, see Pope, *supra* note 2 nn.220–235 & accompanying text.

B. *Corruption and Conflict of Interest*

A “corrupted decision” is one driven by the self-interest of the decision maker.⁹⁸ For example, a treatment decision may be *corrupted* when the decision maker has a financial interest in the outcome.

Ideally, HECs are independent and neutral forums. After all, their purpose is to provide a perspective broader than that of the clinical team involved in the patient’s treatment. The American Medical Association advises that “[c]ommittee members should not have other responsibilities that are likely to prove incompatible with their duties as members of the ethics committee.”⁹⁹ The Universal Declaration of Bioethics states that to “provide advice on ethical problems in clinical settings,” HECs should be “independent, multidisciplinary, and pluralist.”¹⁰⁰

But the objectivity of HECs is seriously compromised.¹⁰¹ Structural factors inhibit their ability to act impartially. Because most members of an intramural HEC work for the institution, they have a conflict of interest when adjudicating disputes in which the institution has a stake. This insider composition corrupts the HEC’s decisions.¹⁰²

Most (and often all) members of HECs are employed directly or indirectly by the very institution in which the committee is situated. As a result of this economic dependence, the committee members may act out of a sense of duty to the institution. “As an institutional player, an HEC may internalize and perpetuate the interests and biases of its parent hospital.”¹⁰³ Therefore, HECs may not promote patient interests that conflict with institutional interests.

⁹⁸ *Id.* at 274–75; see also *id.* at 276–87.

⁹⁹ AMA CODE OF MEDICAL ETHICS Opinion 9.11.

¹⁰⁰ UNITED NATIONS, EDUC., SCIENTIFIC & CULTURAL ORG., UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS, at art. 19, U.N. Doc. SHS/EST/BIO/06/1 (2005), available at <http://unesdoc.unesco.org/images/0014/001461/146180E.pdf>.

¹⁰¹ I am not here providing a knock-down, drag-out argument for this assertion. My primary objective is to demonstrate a trend toward increased and expanded decision-making roles for HECs. Establishing this shift in function highlights the urgency of addressing due process problems that have already been articulated.

¹⁰² Pope, *supra* note 2 nn. 96–151.

¹⁰³ Robert G. Wilson & Thomas G. Gallegos, *The Community Bioethics Committee: A Unique Pathway Out of Bioethical Dilemmas*, 4 HEC FORUM 372, 382 (1992).

1. Four Examples of HEC Corruption

Indeed, this risk is not just theoretical. HECs often get pressed into serving the institution's financial goals, mainly in avoiding uncompensated care and liability exposure. Many ethics committees in fact deliberately aim to serve a risk-management role for the institution. This should not be surprising, considering that HECs often include institutional risk managers and lawyers, and that the very creation of such committees was motivated in part by a need for legal protection. Here are just four examples.

First, in *In re Edna M.F.*, the sister (who was also the guardian) of a 71-year-old severely demented patient sought HEC review of her decision to withdraw the patient's feeding tube.¹⁰⁴ Fulfillment of the patient's wishes or best interests, not consensus, is the appropriate healthcare decision-making standard. But in conducting this review, the HEC abandoned the procedures it should have followed.

"The committee seemed to understand that its function was to reach a determination that would insulate the facility from legal liability."¹⁰⁵ So, the HEC agreed to the withdrawal of the feeding tube only if no family member objected. One did object, so the HEC disallowed the withdrawal, even though it was likely in the patient's best interest. Wisconsin Chief Justice Abrahamson wrote a special concurring opinion criticizing the HEC for its marked institutional bias.

Second, the very day after the insurance of comatose three-year-old Brianna Rideout was exhausted, the Hershey Medical Center HEC authorized the unilateral withdrawal of her ventilator over her parent's vehement objections.¹⁰⁶ The hospital denied that resources or the financial cost of caring for Brianna factored into the medical decisions. But in addition to the suspicious timing, the medical records showed notations that Brianna's insurance was running out.¹⁰⁷

Third, more recently, Kalilah Roberson-Reese underwent a Cesarean section at Houston's Memorial Hermann Hospital. But amniotic fluid began to leak into her lungs, forcing providers to put her on a ventilator. Later, her tracheal tube fell out and she went

¹⁰⁴ *In re Edna M.F.*, 563 N.W.2d 485, 495-96 (Wis. 1997).

¹⁰⁵ *Id.* at 496.

¹⁰⁶ *Rideout v. Hershey Med. Ctr.*, 30 Pa. D. & C.4th 57 (C.C.P. 1995).

¹⁰⁷ Frank Bruni, *A Fight over a Baby's Death and Dignity*, N.Y. Times, Mar. 9, 1996, at A6; Alison Delsite, *Suit against Hershey Raises Touchy Questions*, THE PATRIOT, Mar. 8, 1996, at A1.

without oxygen for twenty minutes, which caused serious brain damage. Within days, the hospital initiated Texas's statutory process by which, with approval of the HEC, providers could withdraw life-sustaining treatment, even over family objections. But again, the HEC was conflicted: the patient had exhausted her Medicaid benefits and it appeared that the hospital was trying to "bury mistakes" and avoid exposure to both liability and uncompensated treatment.¹⁰⁸

Fourth, in yet another medical futility case, in New Jersey, there was again evidence that the ethics committee was motivated by the desire to limit both malpractice exposure and uncompensated treatment. After a medical error left Ruben Betancourt in a vegetative state, the HEC at New Jersey's Trinitas Hospital determined that continued dialysis would be medically and ethically inappropriate. This review was apparently driven by money, not by medicine. This was not a bottom-up process, where the bedside physician sees bad care and then seeks the support of the administration. This was top-down. Even the CEO was involved. The Medical Director testified that the administration was fully aware of Ruben Betancourt: "Would they like him transferred? I'm sure they would." First, Mr. Betancourt had a huge unpaid bill.¹⁰⁹ Second, there was a pending malpractice action, the value of which would be far less if Mr. Betancourt were dead.

Mr. Betancourt's family obtained an injunction ordering the hospital to continue dialysis.¹¹⁰ The hospital appealed that order, and asked the appellate division to defer to the determination of its ethics committee.¹¹¹ The court refused, specifically citing both the "anticipated medical malpractice action" and the hospital's "expo-

¹⁰⁸ Todd Ackerman, *Texas' Patient Care Law at Hub of Houston Dispute*, HOUS. CHRON., July 9, 2006, at A1.

¹⁰⁹ As the cost of Mr. Betancourt's treatment was approaching nearly \$2 million, the hospital realized that it would be able to recover only a portion from Medicare. Trial Transcript 10:23–11:2 (Jan. 22, 2009) ("[T]here may be other economic motivation. There is a sizable medical bill that remains unpaid."), available at http://thaddeuspope.com/images/Transcript_order_to_show_cause_hearings_1.22.09_2.17.09_2.23.09.pdf.

¹¹⁰ *Betancourt v. Trinitas Hosp.*, No. C-12-09 (N.J. Super. Mar. 4, 2009) (Malone, J.).

¹¹¹ Brief and Appendix on Behalf of Appellant, Trinitas Hospital (May 29, 2009), available at http://thaddeuspope.com/images/Defendant_s_merit_brief_05-28-09.pdf. An amicus brief asked the court to adopt a prospective rule requiring judicial deference to HECs. Brief and Appendix of Amici Curiae New Jersey Hospital Association, Catholic Healthcare Partnership of New Jersey, and Medical Society of New Jersey 54–64 (Aug. 7, 2009), available at http://thaddeuspope.com/images/Betancourt_NJHA_CHP_MSJNJ_amicus_small.pdf.

sure to negative financial impact” since Mr. Betancourt’s “‘sizable’ hospital bill remained unpaid.”¹¹²

2. Other HEC Corruption

HECs may be beholden to not only their respective institutions, but also the individual physicians who refer the cases to the committee. The repeat-player phenomenon provides that the party that negotiates many disputes (hospitals) will have greater experience with and exposure to the process than the party that typically negotiates just one dispute (patient, surrogates). Eager to maintain relationships with physicians, committees over-identify with their interests.

Indeed, the same corruption and conflict-of-interest problems plague the close cousin of the intramural HEC, the intramural IRB that approves research with human subjects. IRB members are conflicted for three main reasons. First, the investigator’s research grants may affect both the IRB members’ own compensation and the prestige of their institution. Second, members review the proposals of colleagues and friends. Third, members know that their own proposals will be reviewed and the rules extracted from their review decisions will be applied to review of their own research protocols.

Because of this “built-in self-interest,” IRBs “are often friendly regulators.”¹¹³ Famously, in *Grimes v. Kennedy Krieger Institute*, the Maryland Court of Appeals found that IRBs have a conflict of interest because they are committees of the very research institute that they are charged to oversee.¹¹⁴ The IRB at issue in *Grimes* had approved research exposing small children to risks of lead poisoning while offering those same children no prospect of direct medical benefit.

In sum, HECs are creatures of the healthcare institutions in which they are situated. Because, in many treatment disputes, the interests of the institution may not align with those of the patient, HECs cannot act as sufficiently impartial, independent decision makers. They serve “two sets of masters.”¹¹⁵ Susan Wolf states that “to ask institutional committees dominated by caregivers to be

¹¹² *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 832 (N.J. Super. A.D. 2010).

¹¹³ Leonard H. Glantz, *Contrasting Institutional Review Boards with Institutional Ethics Committees*, in CRANFORD & DOUDERA, *supra* note 8, at 129, 131.

¹¹⁴ 782 A.2d 807 (Md. 2001).

¹¹⁵ Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 819, 820 (1991).

the guardians of patients' rights and interests is like asking the fox to guard the chicken coop."¹¹⁶ As if an actual lack of neutrality were not bad enough, moreover, the perception of bias creates among patients and families "serious suspicions of complicity, rubber-stamping, or cover-up."¹¹⁷

IV. CONCLUSION

State legislatures, courts, and agencies are increasingly delegating adjudicatory and gate-keeping roles to HECs. As HECs get more power and authority, the quality and integrity of their decision-making processes should improve. Form should follow function. There should be a direct and positive correlation between due process and authority.

But this has not happened. The fairness and legitimacy of HEC procedures has not improved. HEC decisions are at substantial risk of making decisions tainted by corruption, bias, carelessness, and arbitrariness. Given the stakes (often life and death), the risk of error is too great. Policymakers must attend to the design of HECs to mitigate these risks.

¹¹⁶ Susan M. Wolf, *Due Process in Ethics Committee Case Review*, 4 HEC FORUM 83, 92-93 (1992).

¹¹⁷ Ronald B. Miller, *Extramural Ethics Consultation: Reflections on the Mediation/Medical Advisory Panel Model and a Further Proposal*, 13 J. CLINICAL ETHICS 203, 205 (2002).

