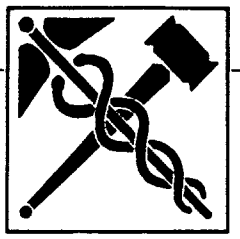

# *The Influence of* Law and Lawyers *on Patient Care*

*by Diane E. Hoffmann*

Maryland is currently the only state that requires all hospitals to have in place a patient care advisory committee or ethics committee.

The Maryland Patient Care Advisory Committee Act, MD. HEALTH-GEN. CODE ANN. §19-370 *et seq.* (1990 and Supp. 1990) which became effective in July, 1987, requires all hospitals in the state to establish an advisory committee that will "offer advice in cases involving individuals with life threatening conditions," to patients, their families or anyone involved in the care of patients. *Id.* at §19-373(a). The Act further provides that the committees may (1) educate hospital personnel, patients and patients' families concerning medical decision-making and (2) review and recommend institutional policies and guidelines concerning the withholding of medical treatment. *Id.* at §19-373(b). Recently the Act was amended to require all "related institutions," which include nursing homes, to establish their own ethics committee or participate in a multi-institutional ethics committee. *Id.* at §19-371(a)(1) and (b)(3).

In terms of composition, the Act requires that the committees include in their membership at least four individuals: a physician, a nurse, a social worker and the chief executive officer or designee from each of the institutions represented by the committee. *Id.* at §19-372(a). The statute provides that the committee may consist of other individuals as designated establishing institutions and suggests that such other individuals might include representatives of the community and ethical advisors or clergy. *Id.* Nowhere are lawyers mentioned.

Although Maryland is unique among the fifty states in requiring the estab-

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lishment of these committees, ethics committees are not unique to Maryland. Many hospitals have established such committees on a voluntary basis. Most often the committees deal with cases involving the withholding or withdrawal of life sustaining treatment such as ventilators and artificially administered nutrition and hydration. In some institutions committees deal with treatment of the severely compromised newborn with multiple life threatening conditions.

One characteristic common to all ethics committees, both inside and outside of Maryland, is that their utilization is optional and adherence to their advice is discretionary. Those who request the assistance of the committees are under no obligation to follow the recommendation of the committee. Most ethics committees also share the traditional functions of case review, policy development and education. Aside from these common characteristics, ethics committees vary considerably from state to state and institution to institution. The Maryland statute is the first effort to provide some standards for ethics committee operations.

In addition to requiring that all hospitals establish an advisory committee, the Maryland Act sets forth procedural requirements that the committee must follow. Specifically, the Act requires that the committee have in place a written procedure setting forth how it will be convened MD. HEALTH-GEN. CODE ANN. §19-371(a)(2) (1990 and Supp. 1990) and that it make a good faith effort to notify patients and their immediate family members of their right to "be a petitioner; to meet with the advisory committee concerning the options for medical care and treatment; and to receive an explanation of the basis of the advisory committee's advice." Furthermore, the Act requires that the committee must consult all members of the patient's treatment team: the patient and the patient's family when the committee is petitioned to give advice. The Act provides no substantive guidance for the committees' actions.

The question of whether lawyers should play a role on ethics committees and whether or not legal issues should be considered by such committees has been and continues to be debated in the literature and among ethics committee members. Lawyers themselves seem to be divided on the issue with some lawyers arguing that these are "ethics committees" and should be dealing with ethics not law. Others argue that some knowledge of the law is essential for these committees to give sound advice and that the law, in fact, embodies societal values on these difficult ethical dilemmas.

**TABLE 1**

## List of Interviewees by Profession

| | Maryland | D.C. | Virginia | Total |
|---|---|---|---|---|
| Physicians | 18 | 4 | 4 | 26 |
| Nurses | 20 | 6 | 5 | 31 |
| Social workers | 21 | 5 | 1 | 27 |
| Lawyers | 9 | 6 | 3 | 18 |
| Community reps | 4 | 1 | 3 | 8 |
| Ethicists | 6 | 2 | 1 | 9 |
| Other/administrators/ patient reps | 3 | | 1 | 5 |
| | | | | 124 |

### Maryland Study

In order to ascertain to what extent law and lawyers influence the functioning of ethics committees the University of Maryland's Law and Health Care Program in 1989 and 1990 undertook a study of hospital ethics committees in Maryland, the District of Columbia and Virginia. One hundred ninety-nine (199) questionnaires were mailed to the chief executive officers (CEOs) of all hospitals in Maryland, D.C. and Virginia. The CEOs were asked a number of questions including whether their hospital had established an ethics committee and if so, the composition of the committee, by profession.

In a separate part of the study, four to five members of committees which had been in existence for over one year and that had done more than one case consultation were interviewed by telephone. This included 124 members from 38 committees. For each committee an effort was made to interview one physician, one nurse, one social worker and one attorney. Attempts were made to interview an ethicist and a community representative if the committees had them. A break down of individuals interviewed, by profession, is presented in Table 1.

Committee members were asked who on the committee, by profession, most influences the outcome of the committee's discussions. In addition, they were asked, on a scale of 1–5, to rate how much they thought the committee was influenced by the legal consequences of its recommendations and whether they thought that level of influence was too much, too little or the right amount. They were also asked whether concern about legal action against them personally or against members of the hospital staff influenced their position on matters before the committee.

Another phase of the survey studied hospital staff to determine their knowledge and perceptions of ethics committees. In this phase, a written questionnaire was sent to a random sample of physicians, nurses, and social workers at four Maryland hospitals with longstanding ethics committees. The sample size was over 1500 and the response rate was 26%. Respondents were asked whether their hospital had an ethics committee and what they perceived to be the role of such a committee.

Study results found that approximately 90% of hospitals in Maryland have established ethics committees or patient care advisory committees. This percentage is significantly greater than the percentage in Virginia (25%)

and the percentage nationwide (60%). This large proportion seemingly can be explained by the Maryland statutory requirement. However, in spite of the fact that the District of Columbia has no statute mandating the establishment of ethics committees, 78% of D.C. hospitals have established such a committee. This can largely be explained that D.C. has a disproportionately large number of large hospitals and teaching hospitals, both of which are very likely to have an ethics committees.

The average size of the committees were 12.5 members in Maryland, 16.2 in D.C., and 13.8 in Virginia. The "typical" committee in Maryland is composed of 5 physicians, 3 nurses, 1 social worker, the hospital CEO or designee, 1 community representative and 1–2 others. Only 43% of the committees in Maryland included a lawyer, although some committees used a lawyer for consultation purposes on occasion. The percentage of committees with lawyers in Maryland was comparable to that of committees in Virginia—44% of Virginia committees included an attorney. The percentage in D.C., however, was much greater—92% of D.C. committees included an attorney. One explanation for the relatively low percentage of committees with lawyers in Maryland is that the Maryland statute immunizes committee members who act in "good faith" from legal liability. *Id.* at §19-374(c). Thus, committees in Maryland may not feel the need for attorney members. This does not, however, explain the relatively low percentage of committees in Virginia with attorneys.

In Maryland, 48% of the committees with lawyers included attorneys that were employed by the hospital only. In D.C., 67% of committees with attorneys used D.C. hospital attorneys. But, in Virginia, none of the committees with attorneys relied exclusively on hospital attorneys. The use of hospital attorneys on these committees has been somewhat controversial. Arguably, if the role of the committees is to protect the interests of the patient, the attorney who represents the hospital will have conflicting, or at least competing, interests. There is no obvious explanation as to the significant variation among the jurisdictions on the use of hospital attorneys.

When committee members were asked which individuals by profession most influence the outcome of the committee's discussions, 60% of all respondents indicated that physicians were among those most likely to influence the outcome of the committee's discussions; 23% said lawyers, 17% said ethicists, and 11% said nurses. The answers were somewhat different, however, when broken down by profession. Although 60% of respondents overall said physicians were among those most likely to influence the outcome of the committee's recommendation, 88% of the attorneys questioned felt that physicians were among the most influential. In all jurisdictions, the lawyers perceived that they had a greater influence than others perceived them to have. Although 23% of all respondents said they thought lawyers were among the most influential, 53% of lawyers perceived members of their own profession to be among the most influential. Because the number of respondents from each profession was relatively small, it is not possible to draw any specific conclusions from these responses yet these differences provide a basis for further study in this area.

When asked, on a scale of 1–5, with 5 being a great deal and 1 not at all, how much the committee is influenced by the legal consequences of its recommendations, a majority of respondents in Maryland and Virginia responded with a 4 or 5. The results by jurisdiction, and overall, are listed in Table 2.

Based on how they responded to that question, in Maryland, 32% of respondents felt that level of influence was too much, 6% said it was too little, and 63% thought it was about right. Table 3 presents the responses for each of the jurisdictions studied.

Overall, physicians and nurses were most likely to think the level of legal influence was too much while lawyers were most likely to think it too little or just right.

In Maryland, 12% responded that concern about legal action against them personally influences their position on matters before the committee. In D.C. and Virginia, the percentages were 17% and 11% respectively. Overall, social workers, nurses and physicians were more likely to be concerned about legal action against them than lawyers, ethicists and community representatives. In Maryland, one would expect this concern to be relatively unimportant for committee members given that the Act exempts committee members from liability for their advice.

**TABLE 2**

## Influence of Legal Consequences

| | D.C. | Maryland | Virginia |
|---|---|---|---|
| 1 (not at all) | 12% | 5% | |
| 2 | 16% | | |
| 3 | 36% | 21% | 33% |
| 4 | 28% | 31% | 39% |
| 5 (a great deal) | 8% | 23% | 17% |

**TABLE 3**

## Level of Legal Influence

| | D.C. | Maryland | Virginia |
|---|---|---|---|
| Too Much | 21% | 32% | 22% |
| Just Right | 79% | 63% | 78% |
| Too Little | 0% | 6% | 0% |

Regarding concern about legal action against members of the hospital staff, in Maryland, 38% of respondents said concern about such legal action influenced their position on matters before the committee. In D.C., only 30% said the issue influenced their position, but in Virginia, 65% said the concern influenced their stance on cases they were considering. Overall, 41% of respondents said that this was a concern for them. Attorneys tended to be most concerned about this issue (66%).

Whether or not law actually plays or should play a significant role in ethics committees, hospital staff perceive that a primary role of the committees is to provide them with legal advice on issues relating to patient care. Almost two thirds of health care providers surveyed felt that one of the functions of a committee was to provide legal advice to health care providers. This is especially interesting given that the Maryland statute does not require that the committees include an attorney.

**Conclusion**

The Maryland Patient Care Advisory Committee Act provides no clear role for lawyers or law on ethics committees. In spite of this fact, results of a recent study of ethics committees in Maryland, D.C. and Virginia, reveals that law and lawyers do play a substantial role in ethics committee deliberations. Furthermore, hospital staff perceive that a primary purpose of ethics committees is to provide legal advice. The survey looked only at whether law and lawyers play an active role in the operations of ethics committees. The more controversial question is whether lawyers *should* play a role on these committees. Although some have argued that ethics committees should stick to ethics, law can be a useful tool and lawyers a useful resource for ethics committees. Lawyers can be especially helpful in educating members about the law generally on issues likely to come before the committee and in reviewing policies developed by the committee. The role of law and lawyers in case consultation is more controversial and should be discussed by committee members early on in the committee's establishment. ■