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Attorneys on Bioethics Committees: Unwelcome Menace or Valuable Asset

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ATTORNEYS ON BIOETHICS COMMITTEES: UNWELCOME MENACE OR VALUABLE ASSET?

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I. INTRODUCTION

Fifteen years ago, many considered hospital ethics committees[2] to be an outlandish idea.[3] Today, the majority of hospitals have some type of committee

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[2] Bioethics committees, institutional ethics committees and hospital ethics committees will be used interchangeably to refer to committees in hospitals and other institutions, e.g. nursing homes, which respond to ethical dilemmas of administering health care. Other committees such as institutional review boards are mentioned separately.

[3] *See* John D. Golenski et al., HANDBOOK FOR ETHICS COMMITTEES 2 (1991).

charged with discussing or resolving ethical dilemmas.[4] The majority of these committees were established in the early 1980s[5] as a response to government intervention in medical decision making.[6] In their effort to establish ethics committees, however, some hospitals paid little, if any, attention to the reason for having a committee and how the committees should operate.[7]

The bioethics literature has done a good job of describing the workings of ethics committees and defining the roles of many of the committees' members.[8] Most hospital committee members agree that the committee should comprise doctors, nurses and community representatives. The one area which lacks any meaningful consensus is the role of attorneys on hospital ethics committees.[9] Should attorneys be members of bioethics committees? If so, what type of attorney should be on the committee and what should be the attorney's role?

The purpose of this paper is to examine the role(s), if any, of the attorney as a member of bioethics committees, especially hospital ethics committees. In the process of determining whether an attorney should serve on these committees, the arguments will contrast the potential role of an attorney with the different types of attorneys who may be chosen to serve as members of a hospital ethics committee.[10] The ultimate conclusion of this paper is that attorneys do have a role on ethics committees, but that the role depends on the type of attorney, the individual committee and the way the committee functions.

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[4] *See Ethics Committees Double Since '83: Survey*, 59 HOSPITALS 60-64 (Nov. 1, 1985) [hereinafter Ethics Committees Double]. Since the publication of the study, interest in ethics committees has continued to increase. Thus, the proportion of hospitals with ethics committees today is likely much higher than the sixty percent cited in the study.

[5] *Id.* A study conducted in 1982 found that approximately 1 percent of hospitals had ethics committees. Stuart Youngner et al., *A National Survey of Hospital Ethics Committees*, 11 CRITICAL CARE MED. 902 (1983). Another study found that 26 percent of hospitals had an ethics committee by 1983 and 60 percent had one by 1985. *Ethics Committees Double, supra* note 4 at 60. Ethics committees in nursing homes had a similar growth curve in the early 1980s. *See* Barbara Brown et al., *The Prevalence and Design of Ethics Committees in Nursing Homes*, 35 J. AM. GERIATRICS SOC. 1029 (1987).

[6] *See Ethics Committees Double, supra* note 4, at 64. Alexandra Gekas, director of the National Society for Patient Representatives, stated that hospitals viewed ethics committees as the best response to the restrictive Baby Doe regulations. By providing some proof that hospitals have internal controls, the hospitals were able to avoid the hot lines recommended in the initial draft of the regulations. *Id.*

[7] *See* Judith Ross et al., HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 31 (1986).

[8] *Id.* at 31-63.

[9] David A. Beuhler et al., *Hospital Ethics Committees: The Hospital Attorney's Role*, 1 H E C FORUM 183 (1989).

[10] *See* discussion *infra* part III. b. Conflicts of Interest and the Attorney. Attorneys, for the purpose of this paper, are classified by the conflicting duties the attorney may have to the hospital, or its corporate owner, and the ethics committee.

II. BACKGROUND

In order to understand the potential roles of an attorney on a bioethics committee, it is important to consider the history of bioethics committees, the purpose of the committees and what role attorneys currently have. While every committee is unique, some generalizations apply to all and are important to consider.

A. The History of Bioethics Committees

The ethics committee movement stems from, of all places, a law review article.[11] In a short article in the Baylor Law Review, Dr. Karen Teel suggested that hospitals consider having an advisory body composed of physicians, social workers, attorneys and theologians.[12] The resulting committee could assist doctors and patients by opening dialogue and diffusing the responsibility for difficult ethical decisions. By spreading responsibility, the committee would allow doctors to feel more comfortable taking actions normally avoided due to liability concerns.[13] Though relying on the opinion of other physicians could look like "passing the buck," it could also be viewed as a conscientious attempt by the physician to obtain a second opinion. If the doctor relied on the opinions of a group of health care workers, it would be much more difficult to claim that his or her actions were outside the norms of the medical profession. Because the committee's opinion would aid the doctor in making the ethically superior decision, instead of the legally superior one, the end result would ideally be more ethical treatment of the patient.[14]

Dr. Teel's article soon caught the attention of the New Jersey Supreme Court as it attempted to decide the case of *In re Quinlan*.[15] The court faced the difficult issue of what should be done with a patient in a "chronic and persistent vegetative state."[16] The patient's father sought to be appointed guardian so he could have his daughter's respirator turned off. The patient's physicians, however, were opposed to the termination of life support. The court concluded that the father should be appointed guardian and allowed him to find other physicians who would agree to follow his instructions.[17]

The future impact of *Quinlan* stemmed not only from the holding, but from the court's fascination with an idea that would have kept the matter out of the courts to begin with. Relying on Dr. Teel's article, the court found that decisions

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[11] *See* Karen Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975).

[12] *Id.* at 9.

[13] *Id.*

[14] *Id.*

[15] 355 A.2d 647 (N.J. 1976).

[16] *Id.* at 655.

[17] *Id.* at 671.

such as these could be more appropriately made by ethics committees.[18] The court viewed Dr. Teel's suggestion as an answer to two problems. First, the medical profession needed a method to diffuse responsibility for tough decisions involving life and death. Second, the judges needed a method that would help them avoid handling such difficult conflicts in the future. The court stated:

> The most appealing factor in the technique suggested by Dr. Teel seems to us to be the diffusion of professional responsibility for decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law....
>
> We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome.[19]

In the end, the court assigned Mr. Quinlan to be his daughter's guardian. The court, however, required Mr. Quinlan to consult an ethics committee before discontinuing his daughter's life support.[20] Interestingly, the "Ethics Committee" as described by the court was somewhat different than that described by Dr. Teel.[21] Instead of a committee to advise on ethical considerations, the court seemed to be envisioning something more along the lines of a prognosis committee.[22]

The court's references to Dr. Teel's article while describing a prognosis committee evidences some confusion on the part of the court. It is unclear whether the court thought that the ethics committee should decide prognoses and ethical matters, or only prognoses. The court's apparent discomfort with deciding the issue is likely one of the reasons it felt these issues should be handled within the medical profession. Regardless of the court's intent or understanding, its opinion gave judicial recognition to Dr. Teel's idea and set the foundation for ethics committees in general.

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[18] *Id.* at 669.

[19] 355 A.2d at 669.

[20] *Id.* at 672.

[21] *Id.*

[22] *Id.* The court held that:

> [i]f that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life support may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.

Id. at 672.

The number of ethics committees grew slowly for the six years following *Quinlan*. By 1982 only one percent of hospitals had ethics committees with the potential to become involved in decision making in individual cases.[23] In April of that year, another ethical dilemma, more agonizing than Karen Quinlan's, presented itself. Baby Doe, a Down's syndrome infant with an esophageal atresia[24] and tracheoesophageal fistula,[25] was born in Indiana.[26] The medical staff was divided over whether surgery was appropriate. Some believed that the atresia should be repaired immediately; others felt that the child's quality of life would be poor and the baby should be allowed to die.[27]

The parents sided with the latter and refused treatment for the child. Those opposed to the parents' decision took the issue to the Indiana court. As Baby Doe died of starvation, the Indiana court upheld the right of the parents to choose nontreatment.[28] Regardless of whether the court was right or wrong, the case received primarily negative publicity.[29] The press portrayed the incident as one of cruelty to the handicapped.

More ethics committees were established as a result of the publicity. The gradual move for ethics committees then received a significant boost in the spring of 1983 when the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research released its report "Deciding to Forego Life-Sustaining Treatment."[30] The report recommended that hospitals create a means for review and consultation on decisions which had life or death consequences for incompetent patients.[31]

Later that year, the case of Baby Jane Doe brought the issue of nontreatment of severely handicapped infants back into the news. The case involved a New York couple who refused surgery for their daughter who was born with hydrocephaly, microcephaly and spina bifida.[32] Several private individuals

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[23]Stuart Youngner et al., *supra* note 5, at 904.

[24]Esophageal atresia is a deformity of the esophagus which prevents swallowing.

[25]Tracheoesophageal fistula is a hole between the trachea and the esophagus which should not be there.

[26]*See* Joseph Pless, *The Story of Baby Doe*, 309 NEW ENG. J. MED. 664 (1983).

[27]Ross, *supra* note 7, at 6.

[28]*See* Steven Smith, *Disabled Newborns and the Federal Child Abuse Amendments: Tenuous Protection*, 37 HASTINGS L.J. 765, 789 (1986).

[29]*See* Ross, *supra* note 7, at 6.

[30]*See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. AND BIOMED. AND BEHAVIORAL RES., DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983).

[31]*Id.* at 5.

[32]Alan R. Fleishman & Thomas H. Murray, *Ethics Committees for Infants Doe?*, THE HASTINGS CENT. REP., Dec. 1983 at 5. The parents did not refuse all treatment. Instead, they chose "conservative" treatment such as antibiotics instead of surgery.

and the federal government attempted to force the parents to treat the child.[33] The courts, however, held that only the relevant state agency could bring an action and allowed the parents to refuse treatment.[34]

Hospitals quickly became aware that difficult ethical questions were not going away and needed to be addressed. The solution seemed to be the establishment of ethics committees. By the end of 1983, twenty-six percent of hospitals had ethics committees.[35]

In 1984 the Department of Health and Human Services responded to the denial of treatment for disabled infants by putting forward the "Baby Doe regulations."[36] The regulations required hospitals to post notice that denial of treatment based on disability was a violation of federal law.[37] The regulations also encouraged each hospital providing newborn care, especially neonatal intensive care units, to have an "infant care review committee."[38] The support of such groups as the American Medical Association, and the American Academy of Pediatrics[39] soon followed.[40] By 1985, sixty percent of hospitals had ethics committees.[41]

The medico-legal community was excited by the rapid adoption of ethics committees. Dr. Samuel Sherman, chairman of the American Medical Association's Judicial Council, stated "before very long, all hospitals will have ethics committees."[42] Dr. Sherman also urged, however, that ethics committees be allowed to "evolve slowly according to the needs expressed at the local level."[43]

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[33] *See* Smith, *supra* note 28, at 792.

[34] *Id.*

[35] *Ethics Committees Double*, *supra* note 4, at 60.

[36] 45 C.F.R. § 84 (1985).

[37] 45 C.F.R. § 84.55(f).

[38] 45 C.F.R. § 84.55(a).

[39] The American Academy of Pediatrics actually was behind the ethics committee option under the Baby Doe regulations. In July of 1983, the Academy submitted a brief proposal suggesting "infant bioethical review committees" to the Department of Health and Human Services. *See* Fleishman & Murray, *supra* note 32, at 6-7. In 1984 the Academy published guidelines for the establishment of Infant Bioethics Committees. The guidelines gave a relatively complete overview of how the committee should function, what it should do and even who should be on the committee. The guidelines recommended that the committee have physicians, nurses, a hospital administrator, a parent of a disabled child, a lawyer and several members of the community. *See Guidelines for Infant Bioethics Committees*, 74 PEDIATRICS 307 (1984).

[40] Ronald Cranford & Edward Doudera, *The Emergence of Institutional Ethics Committees*, 12 LAW MED. & HEALTH CARE 13, 14 (Feb. 1984).

[41] *Ethics Committees Double*, *supra* note 4.

[42] Cranford & Doudera, *supra*, note 40, at 14.

[43] *Id.*

In the hurry to establish hospital ethics committees, several considerations were overlooked. First, many committees were formed before the hospitals or even the committee members determined the committees' objectives.[44] Second, there was, and still is, a lack of understanding about how the committees should operate.[45] Third, if the committee is not sure of its goals, or how it is to function, it is difficult to know who should be on the committee in the first place. For example, if the committee's goals and functions are to determine the patient's prognosis, as recommended in *In re Quinlan*,[46] it would be illogical to have a social worker, an attorney or a member of the dietary staff on the committee.[47] In comparison, if the committee is to serve as a multidisciplinary board for addressing ethical dilemmas,[48] it would be unwise to have the committee consist solely of physicians or nurses. Thus, the purpose of the committee should be clear before its membership is chosen.

Ironically, Dr. Teel's suggestion had addressed both the purpose and membership of the committees.[49] Dr. Teel believed that the primary purpose of the committee was to review difficult ethical cases. Furthermore, because ethical viewpoints can differ depending on one's background, Dr. Teel felt the committee also should be multidisciplinary.[50] Thus, the committee should include theologians, social workers and even attorneys.

The literature that followed the growth of the committees has done a good job of addressing the first and second problems. While recent literature has discussed who should be on the committee, there is a clear lack of agreement on whether attorneys should be included.[51] If attorneys should not be on ethics committees, the discussion is moot. If, however, attorneys can be a helpful addition to the committees, some agreement ought to be reached concerning their role. In order to look at the potential roles of an attorney on an ethics committee, we must first consider the purpose of the committee as a whole.

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[44] Beuhler, *supra* note 9.

[45] Judith W. Ross, *Why Cases Sometimes Go Wrong*, HASTINGS CENT. REP., Jan./Feb. 1989 at 22.

[46] *See supra* note 22 and accompanying text.

[47] The above situation assumes that the medical condition did not relate to a social or nutrition problem.

[48] While there are differences, most ethics committees are interdisciplinary and have members from several fields other than medicine. James F. Drane & Russell B. Roth, *Institutional Ethics Committees: What How and Why*, HEALTH PROGRESS, Oct. 1985 at 30, 31.

[49] Dr. Teel's article viewed the committee as serving the purpose of what is now referred to as case review. The article also suggested that part of the benefit of the committee comes from the fact that it is multidisciplinary. Thus, it should include medical staff, attorneys, theologians and social workers. *See* Teel, *supra* note 11.

[50] *Id.*

[51] Beuhler, *supra* note 9, at 183.

Then we must look to the individual benefits and drawbacks that different types of attorneys have for the committee.

B. The Roles of a Hospital Ethics Committee

In the literature, a general consensus emerged that hospital ethics committees serve three major functions.[52] First, the committee has a policy development role.[53] Because the committee deals with ethical problems, it is a logical starting point for developing policies which deal with troubling ethical issues. For example, the committee may draft guidelines on what procedures are to be followed when terminating life support or writing do-not-resuscitate orders. If physicians have well drafted guidelines to follow, they may be more likely to withhold life-sustaining treatment in medically indicated cases than they would be if no guidelines were available.[54]

A second important function of ethics committees is that of education.[55] The education the committee sponsors is of two kinds. First, the committee must educate new members. The exact education needed for an individual is likely to vary. For example, a new doctor may need to be versed in the methodology that the committee uses when dealing with ethical issues. The social worker, in contrast, may need to acquire a basic understanding of medical terms so she will not feel intimidated or lost when the doctors and nurses begin discussing the medical issues involved.[56] Each of the committee members also needs to be versed on the latest legal developments[57]and guidelines from various professional groups, and they should be up to date on bioethics literature.[58] Continuing education for members is particularly important because the

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[52] *See* Marshall B. Kapp, *The Attorney's Role as Institutional Ethics Committee Member*, FLA. B.J., July/August 1987 at 19.

[53] While all of the literature refers to a role in which the committee deals with policy formulation, there are several different views of exactly what the committee is to do. *See, e.g.*, American Academy of Pediatrics, *supra* note 39, at 308 (describing the committee's role of policy development); Kapp, *supra* note 52, at 20 (discussing the committee's role as policy drafting); Drane & Roth, *supra* note 48, at 30 (discussing policy creation by the committee).

[54] *See* Drane & Roth *supra* note 48, at 32.

[55] Cynthia Cohen, *Birth of a Network*, HASTINGS CENT. REP., Feb./March 1988, at 11.

[56] Some committees literally have a doctor interpret for those who do not have a medical background. After the case has been presented, the doctor puts the medical terms in "plain English" so everyone can participate.

[57] The majority of the literature seems to hold the view that while the advice given by ethics committees may exceed legal standards, it should not violate the relevant laws. *See* American Medical Association, Judicial Council, *Guidelines for Ethics Committees in Health Care Institutions*, 253 JAMA 2698 (1985); Robert Orr, *Should HECs Provide Advice Counter to the Law When They Believe It Inappropriate? No*, 3 H E C FORUM 167 (1991). Therefore, the committee members should at least be aware of which options are clearly outside the law.

[58] *See Consultation Revisited*, 18 ETHICAL CURRENTS, Spring 1989 at 3.

literature about ethics committees is growing at an astounding rate, and new insights are being continually added.

The committee also has the important function of educating others in the hospital. It does little good for an ethics committee to exist if no one else knows of its existence.[59] The committee's education of others may occur both directly and indirectly. The direct education occurs when the committee sponsors seminars, publishes newsletters and conducts other activities that teach hospital staff to deliver more ethical medical care. The committee is also likely to be put in charge of educating other members of the hospital community about new legislation such as The Patient Self Determination Act[60] and how it will affect each of them.

The indirect educational function is a by-product of membership on the committee. As influential members of the committee learn more about medical ethics, that information is likely to be passed on to their colleagues. Whether it is through consultation or daily conversation, the committee member is likely to convey either the ethical methodology she is learning or relate examples of typical conduct that is unethical. As a result, the committee member's colleagues will hopefully learn more about how to ethically deliver medical care.

The ethics committee's educational function can also extend into the community. By sponsoring programs that let the public know of the committee's existence, the committee can build ties with the community and help avoid some ethical dilemmas. For example, if more people thought about advance directives, fewer ethical problems would arise. Committees could sponsor programs with such groups as the American Association of Retired Persons to help their members conform to the local requirements for a living will. The committees could also petition state legislatures to change laws that hamper the ethical delivery of medical care.

The third purpose of ethics committees is case analysis.[61] While most of the literature refers to some type of case analysis, there is no uniformity of what exactly is to be done with respect to individual cases. As Judith Ross points out, the different words used to describe case analysis often show the differences in what is happening within the committee.[62] Case analysis is often referred to as "case review," "case consultation," "case counseling" or "case discussion." Each of these, while often used as synonyms, implies a different approach by the

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[59]Studies have shown that the majority of hospital patients are unaware that their hospital had an ethics committee. *See* Stuart Youngner et al., *Patient's Attitudes Toward Hospital Ethics Committees*, 12 LAW, MED. & HEALTH CARE 21 (Feb. 1984) (finding that only eight percent of people asked were aware that their hospital had an ethics committee).

[60]42 U.S.C. § 1395.

[61]The words "case analysis" are used in place of the more common phrase "case review". As will be shown, references to the activity as case review, case consultation or other similar names carry certain distinct connotations.

[62]Ross, *supra* note 45, at 22.

committee. These differences often seem to reflect the field of expertise of the particular author.[63] The differences in what is envisioned by these different activities affect the role of each member of the committee and who should be on the committee in the first place.

As each approach to individual cases is discussed, it is important to realize that different members of the same committee can be operating under differing approaches as they discuss the same case. The committee itself may also move from one approach to another within the same case.

"Case review" tends to be legalistic in nature. When John Robertson and Susan Wolf discuss case review, they seem to be envisioning a process similar to what happens when a termination of treatment decision is brought into the judicial system.[64] Committees relying on this model are more likely to focus on procedural concerns and the roles of the committee members.[65] Such committees are likely to look at such issues as who may bring a case before the committee, who attends the review, who acts as the patient's advocate and who votes. The committee may also look at traditional legal concerns such as whether the patient was afforded due process.[66] Committees which use this model are also more likely to refer to decisions they have made at the same time they claim that they are not decision-makers.[67] The end result is that this type of committee adopts a quasi-judicial approach to resolving ethical issues.

Case review requires a methodology. There are now many books and other publications which provide detailed methodologies for committees to follow.[68] These methodologies usually provide the committee with a routine to follow while analyzing a case. This insures consistency and helps to give each case a fair analysis.

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[63] The differing forms of case analysis espoused by various people seem to be slanted toward a methodology that is used in their profession. Thus, those who are attorneys are likely to view case analysis with a quasi-judicial tint. Commentators that come from medical backgrounds tend to view case analysis as being an extended form of medical consultation. *See infra* notes 63, 75, 79 and 83 and accompanying text.

[64] Ross, *supra* note 45, at 22. *See also* Judith Ross, *Ethics Committees: Who Wrote the Script* (Presentation to LDS Bioethics Seminar, Mar. 13, 1992).

[65] Ross, *supra*, note 45, at 22.

[66] *See* Susan M. Wolf, *Hospital Ethics Committees and The Law: Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991).

[67] Ross, *supra* note 45, at 22.

[68] *See, e.g., Guidelines for Infant Bioethics Committees*, 74 PEDIATRICS 307 (1984); Judith Ross et al., HANDBOOK FOR HOSPITAL ETHICS COMMITTEES (1986) and John D. Golenski et al., HANDBOOK FOR ETHICS COMMITTEES (1991).

Casuistry is one method for case review that has been recently popularized.[69] Casuistry is the application of a case system to moral, or in this case, ethical reasoning. Instead of starting with general principles from which answers are deduced, casuistry begins with specific cases for which there is a consensus on the appropriate outcome.[70] An essential element of a casuistic approach is to identify cases that are taxonomically similar to the case under consideration.[71] The case in issue is then analyzed in light of those cases to discover what the proper decision in the case ought to be.[72] For example, if a committee is reviewing a case which involves withdrawing life support, the committee looks to other cases in which the issue was raised. After discussing each case, the committee decides which of the other cases is most like the case at hand and follows the decision from the prior case. To an extent, every attempt to deal with an ethical dilemma must be somewhat casuistic in that it is case centered.[73]

The most common example of casuistry today is the legal system. The casuistic method is the basis for Anglo-American common law.[74] As they function today, American courts are constantly comparing like cases to like cases in order to reach their rulings. Because a lawyer is schooled in the art of legal analysis, he or she may assist the committee in developing an ethical analysis that resembles that of the law. While the particular focus of the committee is not identical to the law, the methodology is similar and can help the committee reach ethical decisions.[75] Because case review tends to be legalistic, it is the most likely approach to adopt a casuistic methodology.

A casuistical approach may be particularly beneficial to small hospitals that cannot establish a full ethics committee. A network could be set up allowing these institutions access to the cases discussed by other hospitals. Thus, the doctor or nurse who is facing the dilemma could see how similar cases were solved at another institution.

The other approaches to case analysis differ greatly. The "case consultation" approach as proffered by John LaPuma and Mark Siegler is a good example.[76]

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[69] For a detailed analysis of casuistry, its development and its application to bioethical issues, see ALBERT R. JONSEN & STEPHEN TOULMIN, THE ABUSE OF CASUISTRY: A HISTORY OF MORAL REASONING (1988).

[70] Golenski, *supra* note 3, at Legal Issues - 3.

[71] *Id.*

[72] Thomas H. Murray, *Medical Ethics, Moral Philosophy and Moral Tradition*, 25 SOC. SCI. MED. 637, 639 (1987).

[73] *Id.* at 640.

[74] *Id.* at 639.

[75] *Id.* at 643. "The common law, for instance, shares many concerns with a society's moral tradition (where they are not one and the same), as do the traditions governing the actions of the various professions."

[76] *See* Ross, *supra* note 64.

LaPuma and Siegler seem to view the committee as a body with a consultative role; analogous to the specialist called in to consult with a general practitioner facing a difficult problem. Committees with this view of case analysis tend to see themselves as experts in ethics.[77] In their perception, they are specialists, just like a neurologist or toxicologist, who have been asked to consult on a difficult case. In this function, these committees essentially view themselves as a doctor and attempt to behave like one. They may be concerned over such issues as whether there is a need to see the patient, interview family members or formally place the recommendation on the patient's chart.[78] When following the case consultation approach, committees are also less likely to ask whether "the committee *should* make a recommendation but *to whom* it should make the recommendation."[79]

Committees adopting the case consultation approach are likely to fall into one of two methodologies. Like some specialists, one method is to provide the doctor with multiple options and the likely outcome of each. Thus the committee's recommendation may merely serve to clarify what options are available to the physician and what the likely consequences will be. The other method is adopting a referral view of consultation. Like other specialists, the committee may feel that the case is being "turned over" to it and thus, it must decide what is best for the patient. The person referring the case may even be able to choose the committee's method. Moreover, the person may request that the committee only discuss options, or that the committee reach a conclusion.

A different approach is taken by Bill Winslade. His theory is that committees should serve the role of case counseling.[80] Committees adopting this approach attempt to contour the understanding of the case and advise on that basis. Such committees tend to focus more on the conversational development of the case with the expectation that feasible solutions to the problem will become manifest.[81] Unlike the case review and consultation methods, those using the counseling idea look less to reaching a recommendation, and more to reshaping the problem so those facing the ethical dilemma can see appropriate solutions.[82] The ultimate assumption in this theory of case analysis seems to be that the cause of ethical conflicts is miscommunication. Thus, by assisting the involved parties in coming to a common understanding of the facts, the ethical problem will be resolved.[83]

The final method of case analysis is what I refer to as case discussion. This theory of analysis is closest to that espoused by Corrine Bayley and Joan

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[77] *Id.*

[78] *Id.*

[79] *See* Ross, *supra* note 45, at 22.

[80] Ross, *supra* note 64.

[81] *See* Ross, *supra* note 45, at 22-23.

[82] *Id.* at 23.

[83] Ross, *supra* note 64.

Gibson.[84] The role of case discussion is primarily educational. As cases are discussed, the understanding of the committee members and others increases. Thus, the more cases that one deals with, the greater one's understanding. These committees tend to focus less on reaching decisions or making recommendations and more on the educational benefit that can be derived from case analysis.

Though many committees may fit within one of these categories, many do not. The most common scenario is a committee that operates under two or three of these approaches. Which approach is used, and what methodology accompanies the approach, depend in large part on the individual case. Some committees, and even members, may operate in two or more of the scenarios within the same case analysis.

The varying approaches of case analysis are important for our discussion because the approach used by a committee, or an individual, has a large impact regarding who should serve on the committee. Additionally, the approach also affects the individual roles of the committee's members. For example, an attorney would probably be more comfortable and helpful to a committee that is performing case review than to one engaged in either case counseling or case consultation. In a case review paradigm, the attorney is called on to play some role that is analogous to his or her profession. If the committee is quasi-judicial, the attorney may serve the role of an advocate or a fact finder. In comparison, a case counseling scenario may require the attorney to use his or her sensitivity to ambiguity in a person's language to help the participants understand each other better.

C. The Current Standing of Attorneys on Bioethics Committees

Some commentators hold the view that attorneys of any type do not belong on a hospital ethics committee.[85] Despite this view, it seems that approximately half of all ethics committees have an attorney as a member of the committee.[86] The inclusion of attorneys on ethics committees is relatively consistent with public sentiment about the issue. Two surveys have found forty-two percent

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[84] *Id.*

[85] George Annas, *Ethics Committees: From Ethical Comfort to Ethical Cover*, HASTINGS CENT. REP. May/June 1991, at 18, 20.

[86] *See* Andrew L. Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1246 n. 36 (citing a survey finding 62% of ethics committees with attorneys); Ann Helm & Dennis Mazur, *The Role of Attorneys on Hospital Ethics Committees: Potential Influence on Committee Decisionmaking*, 1 H E C FORUM 195, 197 (1989) (citing a VA study in which 56.5% of VA ethics committees had legal representation-even though they are immune from suit). *See also* Brian Carter, *Medical Ethics Committee-A Survey of Army Hospitals*, 153 MIL. MED. 426, 427 (Aug. 1988) (citing three studies which found 41%, 62% and 42% of ethics committees have attorneys as members).

of interviewed patients feel that a lawyer should serve on the hospital ethics committee.[87]

Those committees with attorneys are most likely to have the hospital's attorney.[88] While having the hospital's attorney seems convenient, it may limit the effectiveness of both the ethics committee and the attorney. Because the hospital attorney owes a duty of loyalty to the hospital, the situation may present a conflict of interest for the attorney also serving on a committee that may expose the hospital to liability.[89]

III. TWO CAVEATS FOR ATTORNEYS ON BIOETHICS COMMITTEES

There are two major problems with attorneys serving as members of bioethics committees. The first is the tendency to want to control the proceedings.[90] The second is the unique conflict of interest problems that attorneys face.

A. Attorney Control Thy Tongue

An attorney may attempt to control things either by being appointed chair of the committee, or by steering the considerations of the committee toward the legal issues.[91] While serious, neither of these problems is fatal. While an attorney may be an asset to the committee, he or she should not be appointed the chair of the committee.[92] Instead, the chair should be someone who is respected by both doctors and nurses. Some approaches, especially case review, may work best with two chairs, one a doctor and one a nurse.[93]

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[87] *Id. See also* Stuart Youngner et al., *Patients' Attitudes Toward Hospital Ethics Committees*, 12 LAW HEALTH & MED. Feb. 1984 at 21, 23.

[88] *See* Willard Green, *The Philadelphia Story*, HASTINGS CENT. REP. Sept./Oct. 1989 at 26 (finding that 39 percent of committees had the hospital's attorney as a member and only 12 percent had outside lawyers).

[89] Golenski *supra* note 3, at 12. In the discussion on the membership of the committee, Golenski starts the discussion on attorneys as members by saying, "Under no circumstances should the hospital counsel sit on the ICE; it's a[n] absolute conflict of interest, since the hospital counsel can't look after the hospital's interests while considering ethical questions of patient care."

[90] Kapp, *supra* note 52, at 21-22.

[91] *Id.* at 20.

[92] Appointing an attorney as chair of the committee may scare other members. Medical personnel, especially doctors likely will give less credence to the committee if they believe that it is being run by an outsider. Furthermore, many doctors do not like attorneys and may feel less comfortable bringing a case before the committee. *See* Golenski, *supra* note 3, at Getting Started - 3.

[93] *Id.* at 3-5. The advantages of having a nurse and a doctor as co-chairs are several. First, nurses are not likely to speak up at ethics committee meetings if they feel intimidated by doctors. If one of the chairpersons is a nurse with influence, the other nurses may feel more comfortable with bringing up problems they see. In contrast, the doctors are not likely to be cooperative if they think that the ethics committee is stacked

The solution to attorneys who try to dominate the discussion is simple—leave them off the committee. The literature gives good guidelines on what type of person should be invited to join the committee.[94] A person who tries to dominate the conversation, whether a doctor, nurse or anyone else, should not serve on the committee. Those people who can be considered inflexible should also be left off the committee.[95] The disadvantages of having such a person on the committee outweigh any benefits the person will bring.[96]

The other solution is to limit the discussion of any legal concerns to the end of the discussion. Any member should be able to ask questions or make comments at any time. The members of the committee, including the attorney, should also be free to make comments regarding the ethical dilemma. The attorney, however, should understand that legal comments are only to be made at the *end* of the discussion.[97] A poorly placed legal comment stifles ethical discussion. A good example is the following conversation from an ethics committee meeting:

Doctor 1: I would like to ask [Dr. 2], based on his experience in following children like this who have had significant damage and so on in the developmental evaluation clinic, how he thinks this child is going to fare. That would kind of put in perspective the extent of effort that we should put in this child.

Doctor 2: I would go along with what the neurologist has said. The high probability that this child would have significant brain damage with neurological impairment like cerebral palsy or possibly seizure disorders and other neurological impairments, but I think the other compounding factors are all of the other things we haven't discussed.

Attorney: Excuse me for one moment, I really do need to comment on something that [Dr. 1] just said and I know that this is never a welcome comment when it comes in these meetings, and I understand your feelings in this regard when you look at the quality of life that this child would have and that being significant in your view in terms of aggressiveness with which we treat the medical problem. I need to remind the

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against them. If a doctor serves as one of the chairpersons, the other physicians may be more likely to accept the role of the committee rather than considering it a doctor review committee.

[94] *See generally,* Ann Helm & Dennis J. Mazur, *The Role of Attorneys on Hospital Ethics Committees: Potential Influence on Committee Decisionmaking,* 1 H E C FORUM 195 (1989).

[95] *See* Golenski, *supra* note 3, at Getting Started 13-14.

[96] The committee may wish to invite someone with a "radical" viewpoint if that viewpoint is particularly germane to that meeting's discussion. The person however, should not be a regular member of the committee. *Id.*

[97] *Id.* at Methodology-25.

> committee, as we have discussed on many occasions in the past, that quality of life is not a permissible consideration under the Baby Doe Legislation. We know that there is a legislative determination that sets forth the conditions under which it is permissible to withhold medically indicated treatment and it is very specific in there that quality of life is not one of those considerations that we can even discuss at this point. So what I generally say at this point is let's look at the medical conditions and try not to look at future neurological impairment. If the neurological condition is *itself* one of the life threatening conditions we are talking about and that *itself* requires treatment that is different . . . If we are looking only at what the neurological outcome is for the child because of a preexisting condition and that's quality of life, we can't do it whether we like it or not.[98]

The attorney's misplaced comment was remarkably effective in ending that line of conversation. The two doctors discussing an important concern ceased the discussion and did not speak for the rest of the meeting. The doctors were essentially told that their ethical concerns were important, but should not be discussed in the ethical deliberation. Perhaps the saddest thing is that this discussion is on tape and is shown to doctors and nurses to teach them how to serve on their hospital's ethics committee. It is no wonder that doctors are wary of attorneys on ethics committees (or anywhere else for that matter).

To avoid problems such as this, the attorney should save any discussion of pertinent legal issues to later parts of the case.[99] Some questions may arise which affect legal concerns as well as ethical ones. For example, the question of whether the patient knows of the committee's discussion of her case is an ethical issue as well as a legal one. Such questions are beneficial so long as they are not an attempt at turning the conversation to other legal concerns which might interfere with the ethical discussion.

Such an approach allows the committee to look at all of the ethical alternatives. Once these have been narrowed, the committee can look at how the law views each alternative. Then the committee can decide if the preferred recommendation is clearly legal, clearly illegal or somewhere in between. The clearly illegal should not be recommended,[100] leaving the clearly legal and the questionable recommendations. The committee, depending upon the model under which it operates, may recommend a course of action or give the people involved a list of options and their potential outcomes.

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98 The exact committee in which this happened will not be cited for confidentiality reasons. The italics represent emphasis made by the attorney.

99 Golenski, *supra* note 3, at Methodology-25.

100 *See supra* note 57 and accompanying text.

If the attorney addresses the legal implications of a case, there is also a risk that the entire meeting will devolve into a discussion of the law and not of ethics.[101] Instead of looking at the ethical issues and how they may be resolved, the committee may end up discussing the legal issues and how to deal with them. Such an approach steers the committee away from its intended purpose and does a disservice to all involved.[102] Thus, the legal discussion should come last, after the ethical options have been enunciated.

B. Conflicts of Interest and the Attorney

Another major consideration in whether an attorney should be a member of an ethics committee is the potential for conflicts of interest. There are three different types of attorneys in relationship to an ethics committee. Each of these presents different advantages and disadvantages to the committee, depending on the case analysis approach adopted by the committee.

Due to the nature of legal representation, potential conflicts of interest are important to the discussion of whether attorneys belong on hospital ethics committees. Though the medical profession faces conflicts of interest (e.g. best interest of one's patient versus the best interests of the hospital) the attorney's interests are fundamentally different. The proper functioning of an attorney is premised on absolute loyalty to his or her client. Therefore, the loyalties of each type of attorney must be considered.

The first type of lawyer is the hospital's attorney. This person usually works in, and is employed directly by, the hospital (or the organization which owns the hospital). The popular name for attorneys in this situation is "in-house" counsel. The attorney in this type of situation is also personally interested in the welfare of the hospital because it is his or her employer. Failure to protect the hospital could result in the loss of his or her job.

The second type of attorney is one retained by the hospital, but not directly "employed" by the institution. Attorneys in this situation are usually referred to as outside counsel.[103] Unlike the employee/employer relationship of the hospital's lawyer, the outside counsel and the hospital have a relationship more like the traditional view of an attorney and client. Even though the attorney is not an employee of the hospital, the attorney may have a duty of loyalty to the hospital that requires the attorney to act in the hospital's best interests.

The third type of attorney is comprised of all the attorneys that do not fit into type one or type two. The field the attorney practices in is irrelevant, with the possible exception of medical malpractice. These attorneys are all inherently different in that, unlike attorneys one and two, they owe no duty of loyalty to the hospital or to its parent corporation. This lack of duty allows the attorney to focus more on the ethical considerations in the case and less on the legal

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[101] *See* Kapp, *supra* note 52, at 22.

[102] *Id.*

[103] Some people refer to these attorneys as outhouse counsel, a name which may or may not be deserved.

liabilities.[104] Thus, the attorney can be more concerned about helping the committee reach an ethical decision than about protecting the hospital from lawsuits.

Some commentators have argued that the hospital attorney (presumably meaning attorneys one and two) has no greater duty of loyalty to the hospital than do the hospital's other employees.[105] This view, however, is false. Unlike the doctor who often has a conflict between what is best for the hospital and his or her duty to the patient, the attorney's duty of loyalty lies solely with the hospital. If a hospital attorney sits on a committee making decisions that may not be in the hospital's best interests, the attorney faces a conflict of interest. Should the attorney assist the committee in reaching a recommendation that is likely to result in the hospital being sued? If the attorney does, the duty of loyalty to the hospital has been breached. If the attorney acts in the best interest of the hospital, he or she may keep the committee from reaching the most ethical recommendation.

IV. THE ATTORNEY'S ROLE AND THE COMMITTEE'S PURPOSE

As previously discussed, there are three major purposes of the hospital ethics committee. When determining whether an attorney should be included on the committee, it is important to look at the benefits and liabilities of having an attorney on the committee in light of each purpose.

A. Policy Development

One place an attorney may be valuable to a committee is in its policy development functions.[106] In several ways, the attorney can add a different perspective to the development of such policies and may be able to help implement them after they have been written.

One benefit of having an attorney on a hospital ethics committee, when drafting policies, is the role she can play as a "devil's advocate." While this role would be negative in the other contexts of the committee's purpose, it is important in policy formation. The attorney is most likely to catch subtle ambiguities in the wording of a policy. Attorneys have a tendency to critique policies by posing hypotheticals. This may be useful when one is considering the desirability of having a policy and how the policy should be worded. Does

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[104]"Legal liabilities" is used because the attorney still needs to be concerned with legal matters. The attorney should not be encouraging a committee to make recommendations that are clearly illegal. The attorney, however, also should not be overly concerned with the committee taking actions that, while legal, may result in the hospital being sued.

[105]Bruce White, *Point and Counterpoint: Should an Institution's Risk Manager/Lawyer Serve as HEC Members?*, 3 H E C FORUM 87, 88 (1991).

[106]Policy development may vary depending on the committee. Some committees will actually make policies while other committees may draft policies for review by the hospital administration.

the policy say what the committee wants it to say? Is the policy clear in how it applies to different situations? Many policies are drafted with good intent only to be misunderstood by those who later read them. Attorneys, due to their legal training, tend to be careful about word choice. Thus, by critiquing the policy, the attorney may help the policy to more effectively reach its aim.[107]

The attorney could also help in making sure that policies are formed to decrease potential liability. While avoidance of liability should not be the major concern of the ethics committee, some potential legal problems can be avoided merely by the way a policy is written. The ideal situation is to have a policy that furthers ethical treatment *and* decreases the risk of legal action. Providing clear guidelines on how a policy should be carried out is critical to those who are supposed to follow it. A good policy will encourage ethical care and result in more ethical treatment as the medical staff realizes that they are legally protected.

Particular knowledge of the hospital attorney may imply that he or she would be the most helpful type of attorney during policy drafting. The hospital attorney is probably more familiar with the language that doctors and nurses use than other attorneys. However, the attorney is also likely to err in favor of decreasing the hospital's liability over the ethical consideration behind the policy. Outside counsel may also be prone to err on the side of the hospital's interests. Therefore, the attorney who is not affiliated with the hospital is probably the best choice. If help is needed with medical language, the outside attorney can talk with doctors or even the hospital attorney.

Another benefit of having a nonhospital attorney is having a second opinion. For example, if a hospital administration rejects a policy prepared by the ethics committee on the grounds that it is not within the law, the committee can turn to its attorney member to research the issue objectively. Sometimes the attorney will find that the hospital is correct. In other circumstances, the hospital's view will have been overly conservative or incorrect. In this situation, the attorney member of the committee can talk with the administration to explain why the committee feels the policy is within the law, and possibly negotiate wording that is acceptable to the hospital as well as the hospital's ethics committee.

B. Education

An attorney is also a valuable tool in the education of the committee itself and its goal of educating others. Because most of the members of the committee are not lawyers, an attorney can help by educating the committee members about the law.[108] In a recent article, Alan Meisel described eight legal myths

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[107]Hopefully, the attorney will use the opportunity to critique the policy to make sure the policy is clear. The attorney could have a detrimental effect if he or she turned the policy into multi-clause legalese as is common in government regulations.

[108]Kapp, *supra* note 52, at 21.

that are common within the medical profession.[109] These myths are: 1) anything not specifically permitted by law is illegal; 2) termination of life support is murder (or suicide); 3) a patient must be terminally ill for life support to be stopped; 4) it is only permissible to terminate "extraordinary" treatment; 5) it is permissible to withhold treatment, but not to stop it once started; 6) the withdrawal of tube feeding is different from terminating other treatments; 7) a court order must be obtained to terminate life support; and 8) living wills are illegal.[110] It seems hard to imagine any eight misconceptions that could interfere more with the proper working of a hospital ethics committee than these. A well informed attorney, or one who is willing to become informed, could be an asset by warning the committee of these myths and explaining what the law allows.

An attorney also should help to ensure that doctors and nurses are familiar with the law in areas related to the termination of treatment. For example, a survey done two years ago showed that roughly two-thirds of the physicians and nurses likely to be involved in organ procurement for transplantation could not properly identify the medical and legal criteria for determining death.[111] It is important that those involved in ethically sensitive areas of medicine such as organ transplantation be up-to-date on the legal as well as medical definitions relevant to their work.

C. Case Analysis

In case analysis, the attorney can play many different roles. What those roles are varies from committee to committee and case to case. An attorney should be as free as any other member to ask questions[112] or make comments on ethics. If an attorney, whether a hospital attorney or not, is giving legal advice, the attorney should speak last.[113] When the attorney speaks out on the legal status of the case, the ethical consideration is chilled.[114] Rather than stopping important conversation, the legal implications should be discussed only after some ethically acceptable alternatives have been found. Then each may be considered in light of the law.[115]

The exact role of the attorney will also vary with the type of case analysis followed by the committee. While an attorney may be of assistance under each

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[109]Alan Meisel, *Legal Myths About Terminating Life Support*, 151 ARCH. INTERN. MED. 1497 (1991).

[110]*Id.*

[111]Stuart Youngner et al., *"Brain Death" and Organ Retrieval*, 261 JAMA 2205 (1989).

[112]Questions should not lead the conversation into a legal discussion and should be nonconfrontational.

[113]*See supra* note 96 and accompanying text.

[114]*See supra* note 98 and accompanying text.

[115]Golenski, *supra* note 3, at Methodology -25.

methodology, the role in each will likely be different. Thus, each must be analyzed separately.

1. Case Review

Committees that operate under a case review methodology are most suited for an attorney in his or her traditional role. Because the committee is following a quasi-judicial methodology, many of the functions of the committee fit well with someone trained in the law. Thus, the attorney can be a benefit to the committee in helping them to "think like a lawyer."[116]

If a committee is going to operate under a quasi-judicial methodology, it is important for the committee to understand the obligations that follow. One of the major benefits of having ethics committees is to avoid having to take issues such as the termination of life support to court. If the committees are to be viewed as a potential substitute for the courts, the committee must be fair to all the parties involved.

In a recent article, Susan Wolf demonstrated that many, if not most, committees lack any sort of procedural due process to protect the patient's rights.[117] If a committee is going to make recommendations[118] that may affect a patient's treatment, it is important that the patient has an opportunity to present his or her concerns to the committee.[119]

The importance of providing due process protection is heightened by the increasing legal recognition of ethics committees. Several states now statutorily recognize ethics committees and some even provide the committees with immunity.[120] Thus, it is important that the committee be required to conduct any case reviews with an emphasis on fairness.

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[116]While if overdone legal analysis could ruin the very reason for the committee, the members may be able to function better in a case review methodology if they have some training in legal analysis.

[117]Susan M. Wolf, *Hospital Ethics Committees and the Law: Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991).

[118]Ms. Wolf's article contends that committees make decisions, not recommendations. Many ethics committees claim to follow an optional/optional model as explained by Professor John Robertson. In other words, the committee's review is optional and any advice it gives is likewise optional. According to Ms. Wolf, this is a misnomer. The social and professional influence of the committee make the recommendation more of a decision, even if the committee does not intend for it to become such. Few doctors will disregard the committee's recommendations. The committee's recommendation will directly affect the patient's care. Thus, the committee is ethically obligated to afford the patient due process protection from the moment it agrees to hear a case. *Id.* at 809.

[119]*Id.* at 805-06.

[120]*Id.* at 800, 807 (citing Md. Health-Gen. Code Ann. §§ 19-370 to -374 (1990 & Supp. 1990) (requiring hospitals to have ethics committees); Haw. Rev. Stat. § 663-1.7 (Supp. 1990) (offering immunity to ethics committees) and N.Y. Pub. Health Law § 2972 (McKinney Supp. 1991) (requiring a "dispute mediation mechanism")).

Committees must also protect patients' due process rights if the committees seek to be an alternative to the courts.[121] Some commentators have even suggested that committees should attempt to position themselves in such a way that they will receive judicial deference.[122] The approach seems to be working in that several courts have admitted ethics committees' recommendations as evidence.[123] Providing due process is particularly important due to the reluctance of the courts to interfere with medical decision making.[124] If ethics committees are seen as an alternative to the courts, it is vital that they protect the due process rights of the patient. Otherwise, they will become viewed as another dialysis committee.[125] The public may end up viewing bioethics committees as modern medicine's answer to the star chamber.

An attorney as a member of the committee can help to assure that due process rights are assured. Ideally, the attorney can make sure that the patient is provided with the needed protection without turning the committee into a courtroom. The protection of due process is one area where an attorney is justified in addressing a legal issue before the end of a case. The attorney may ask if the patient has been told about the committee meeting and if the patient desired to attend. This could even be done before the committee met. The attorney may discuss with the patient's doctor or nurse what ought to be done to protect the patient's right to a fair hearing (due process). For example, the attorney may advise a doctor that the patient be notified of the meeting and given an invitation to attend. By providing the patient with due process, the committee reaches a more accurate and therefore more ethical decision.[126]

The function of case review is one of the most important reasons for having an attorney that does not represent the hospital. If a case may have a "bad outcome", the last person who should be on the committee is a hospital attorney. The best defense to a suit against a hospital ethics committee is that

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[121]Ms. Wolf conducts a detailed study of the bioethics literature and finds that many articles suggest ways that ethics committees can be used to keep these matters out of the courts. Some have even suggested things that the committee can do to improve the likelihood of a court granting deference to the committee's decision. *Supra* note 117, at 810.

[122]*Id.* (citing Cranford, Hester & Ashley, *Institutional Ethics Committees: Issues of Confidentiality and Immunity*, 12 LAW, MED. & HEALTH CARE 21 (1984)).

[123]*Id.* at 800-01 n. 16.

[124]*See* In re Quinlan, 355 A.2d 647, 669 (N.J. 1976).

[125]In 1960, Dr. Belding Scribner of the University of Washington introduced a shunt that made it possible to use hemodialysis as a treatment for end stage renal disease. Because of the limited number of dialysis machines, a committee with varying backgrounds was established to decide who would get dialysis and who would not. When the story was published in *Life* magazine, the committee received intense criticism for deciding who would live and who would die. *See* Ross, *supra* note 7, at 5-6.

[126]*See* Wolf, *supra* note 117, at 805, 857-58.

the committee acted in good faith.[127] It may be much more difficult to make out such a case if the hospital's attorney was active in promoting the decision. If it appears that the attorney was supporting a position that was in the hospital's best interest and not the patient's, it will be much harder to convince a jury (or even a judge) that the committee was acting in good faith. Instead, it will look as if the hospital's attorney was encouraging a course of action that was in the hospital's best interests but detrimental to the patient.

The ethical guidelines of all attorneys make it difficult for either attorney one or two to serve as a member of a committee with decision-making authority. All attorneys are bound by the ethics rules of the state in which they practice. All of the states look disfavorably on attorneys having conflicts of interest. Rule 1.7 of the Model Rules of Professional Conduct provides: "A lawyer shall not represent a client if the representation of that client may be materially limited by the lawyer's responsibilities to another client or to a third person, or by the lawyer's own interests . . . ."[128] Even if the attorney made his or her role clear, the attorney still has a potential conflict of interest. Despite the efforts of the attorney, the potential conflicts may occasionally interfere with the committee's proper functioning.

While it is true that most ethics committees would not consider the hospital's attorney to be "representing" them, a potential conflict still exists and should be avoided. If the hospital attorney explains the law to the committee, either the committee or the hospital usually suffers. Either the committee gets a conservative view, to its disadvantage, or the attorney gives the committee a liberal interpretation of the law to the hospital's disadvantage. The Comment to Rule 1.7 states:

> Loyalty to a client is also impaired when a lawyer cannot consider, recommend or carry out an appropriate course of action for the client because of the lawyer's other responsibilities or interests. The conflict in effect forecloses alternatives that would otherwise be available to the client.[129]

The Comment later states, "if there is a material risk that the dual role will compromise the lawyer's independence of professional judgment, the lawyer should not serve [in both capacities]."[130]

The inherent potential for conflicts of interest for attorneys one and two creates a problem under the ethics rules. In a case review approach, there are times when the ethical decisions of the ethics committee are not in harmony, if not directly opposed to the best interests of the hospital.[131] What choice is to

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[127] *See* Drane & Roth, *supra* note 48, at 32.

[128] MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7(b) and cmt. (1983).

[129] *Id.*

[130] *Id.*

[131] Golenski, *supra* note 3, at Getting Started - 12. The ethics committee's decision may not be in the best interest of the hospital from the liability standpoint. It is arguable that

be made by the hospital attorney who also serves on the ethics committee? Does the attorney recommend action that is ethical but may subject the hospital to potential liability, or recommend against the most ethical solution in order to protect his or her client? The best solution is to avoid the problem in the first place. Because of the conflict of interest involved, attorneys that are also counsel for the hospital should not serve as members of the hospital ethics committee.[132]

2. Case Consultation

A committee that operates under the case consultation model will have a different role for the attorney. Because the focus is on "consultation" rather than "review," the members view themselves as experts in some area. With a bioethics committee, the overall expertise would be one in ethics. If the committee is multidisciplinary, or has a diversity of members, each member is likely to be viewed as an expert in some specialized field. The role of the attorney may be as an expert in the interrelationship between law and ethics.[133]

The role of the attorney may be further defined by the model of consultation to which the committee subscribes. If the committee views its role as providing the doctor with numerous possibilities, a decision tree, then the attorney may want to discuss the legal ramifications of each potential decision. Thus, the doctor would be able to weigh the potential course of action against any legal concerns or liabilities.

If the committee adopts a consultation in which it takes over the case, the attorney would be responsible for telling the committee what the best course of action is from a legal standpoint. While the two roles seem fairly similar, there is a substantial difference between merely explaining the legal implications of each option and making a firm recommendation on best legal alternative.

The type of consultation may also affect the potential for a conflict of interest. The hospital's attorney is in less of a conflict if the attorney merely explains the legal ramifications of each course of action and the doctor decides. Though the attorney can influence the doctor, the doctor makes the ultimate decision. If the hospital's attorney makes a firm recommendation to the committee about what is the legally most advantageous alternative, the potential conflict with the patient's rights is increased. It may be very easy for the attorney to advance the option that is the best legally for the hospital, but not the patient. For these reasons, an attorney without a duty to the hospital would be preferable. The

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the committees recommendation is ultimately in the hospital's best interest because it will likely result in more ethical medical care and may protect the hospital in the long run.

[132]*Id.*

[133]In a recent conference, Peter Windt asserted that philosophy, law and ethics are all interconnected. This is especially true in that "all three use similar vocabulary and make judgements about human behavior." LDS Bioethics Committee, April 3, 1992.

attorney would be more likely to make legal recommendations on the basis of the best interest of the patient, since no duty is owed to the hospital.

3. Case Counseling

The case counseling policy would cast the attorney in a role that is less familiar to many attorneys. The attorney would not be giving advice or even giving an analysis on the legal implications of a potential course of action. Instead, the attorney would be helping to focus the participants' understanding to clarify the issues. The traits of an attorney are both a disadvantage and an advantage. The disadvantage comes from the traditionally adversarial role of attorneys in our legal system. It may be difficult for an attorney to step out of that role and be essentially neutral. Though this would be difficult for many, it is important for the counseling model to work properly. If participants feel that the discussion is resulting in a division of ground rather than a unification, they are likely to withhold both relevant information and their emotional support. Either of these would result in an outcome that is less than the ethical ideal.

The advantage that an attorney has in this model is the issue-based nature of it. In order for participants to reach a consensus, they must come to an agreement on what issue is presented. Because attorneys are constantly dealing with issue clarification, they may be able to help the participants agree on the issues. Then the participants can find consensus on what needs to be done to resolve the problem.

The potential for conflicts of interest are less in case counseling than in case review or case consultation. Instead of making recommendations or suggestions, the attorney merely helps the participants reach a common understanding. The only danger with an attorney that works for the hospital is that the attorney may manipulate the flow of conversation. Thus, the participants may reach a common understanding, but in a way that it works to the hospital's advantage. For example, if a doctor wishes to write a do-not-resuscitate order and the patient's family opposes the idea, the attorney may manipulate the family's statements to show the family why the doctor's decision should be supported. While this sounds bad, many attorneys are conditioned to rework others' expressions until they meet the attorney's needs. The attorney may twist what the participants are saying unconsciously.

While the nonhospital attorney has less motivation for doing so, any attorney may be guilty of the same thing. Instead of twisting things in favor of the hospital however, the attorney may twist the conversation in favor of the committee. For example, the committee may find a case very problematic. To compensate for this, the attorney may steer the conversation away from the real issues and toward an "easy answer." While the ethics committee has been let off the hook, the participants have not come to a full concurrence of belief.

4. Case Discussion

Case discussion involves another role change for an attorney. If the goal of the group is to seek intellectual edification, the attorney, like all the other disciplines serves the role of adding a different perspective. The attorney, for example, may explain to the committee how the law in the particular case

developed. By providing one more point of view, the attorney has assisted the committee in expanding its horizons.

While the committee may benefit from the discussion, the case discussion model represents the case where the attorney has the least unique role. If no recommendation is given and no course of action decided upon, the committee is of little use for the direct resolution of ethical problems. While the educating of the committee may serve some form of a trickle down effect to more ethical treatment, the committee is of little direct ethical value. Therefore, while the committee may have an attorney on the committee, she is at best an indirect asset to the delivery of ethical care.

Because no substantive decisions are made, there is little reason for a hospital attorney to be excluded from a committee that limits itself to case discussion. The effects of the attorney's statements have little possibility of directly influencing medical care. The additional medical knowledge of the attorney may also be of more value to those seeking intellectual stimulation. For these reasons, any type of attorney that has an interest would be beneficial to a hospital ethics committee.

V. CONCLUSION

Attorneys have a role on hospital ethics committees. What that role is, however, will differ from committee to committee. There are two major guidelines. First, do not have the hospital's counsel, whether in-house or outside, serve as a member of the ethics committee. It creates a potential conflict of interest and is unfair to both the attorney and the committee. Second, when the attorney is going to address legal matters in relation to a present case, it should always be the last thing to be considered. If legal issues are addressed too early in a meeting it will stifle creativity and turn the rest of the meeting into a legal discussion instead of an ethical one.