MULTI-INSTITUTIONAL HEALTHCARE ETHICS COMMITTEES: THE PROCEDURALLY FAIR INTERNAL DISPUTE RESOLUTION MECHANISM

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ABSTRACT

2.6 million Americans die each year. A majority of these deaths occur in a healthcare institution as the result of a deliberate decision to stop life-sustaining medical treatment. Unfortunately, these end-of-life decisions are marked with significant conflict between patients’ family members and healthcare providers. Healthcare ethics committees (HECs) have been the dispute resolution forum for many of these conflicts.

HECs generally have been considered to play a mere advisory, facilitative role. But, in fact, HECs often serve a decision making role. Both in law and practice HECs increasingly have been given significant authority and responsibility to make treatment decisions. Sometimes, HECs make decisions on behalf of incapacitated patients with no friends or family. Other times, HECs adjudicate disputes between providers and the patient or patient’s family.

Unfortunately, HECs are not up to the task. They lack the necessary independence, diversity, composition, training, or resources. HECs are overwhelmingly intramural bodies, comprised of professionals employed directly or indirectly by the very same institution whose dispute the HEC adjudicates. HECs make decisions that are corrupted, biased, careless, and arbitrary.

To address the problems of intramural HECs, I propose that their adjudicatory authority be relocated to a multi-institutional HEC (MI-HEC).

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Thereby, no HEC could have a controlling voice in the adjudication of its own dispute. A multi-institutional HEC preserves the best but avoids the worst of intramural HECs. Specifically, the MI-HEC preserves the expertise and extrajudicial nature of the HEC. 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.

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**INTRODUCTION**

Four patients have arrived at City Hospital in a comatose state. The first patient has an advance directive but its instructions do not clearly address her current circumstances. The family of the second patient wants
everything possible done to keep the patient alive, despite the physician’s recommendation that this is medically inappropriate and not in the patient’s best interest. The hospital has been unable to identify or locate any friends or family of the third patient. The family of the fourth patient is divided. One son favors stopping further aggressive treatment. But a daughter demands that everything be done. In each case, should the patient’s preferences be honored? What is the most reliable evidence of the patient’s preferences?

Complex ethical situations like these occur on a regular basis in healthcare settings. End-of-life decisions are marked with significant conflict. Healthcare ethics committees (HECs) have been the dispute resolution forum for many of these conflicts. HECs are typically multidisciplinary groups comprised of representatives from different departments of the healthcare facility (e.g. medicine, nursing, law, pastoral care, social work). HECs were established to support and advise patients, families, and caregivers as they work together to find solutions.

Unfortunately, HECs are not up to the task. They lack the necessary independence, diversity, composition, training, or resources. HECs are overwhelmingly intramural bodies, comprised of professionals employed directly or indirectly by the very same institution whose decision the HEC adjudicates. HECs make decisions that are corrupted, biased, careless, and arbitrary.

To address the problems of intramural HECs, I propose that their adjudicatory authority be relocated to a multi-institutional HEC. Thereby, no HEC would have a controlling voice in the adjudication of its own dispute. A multi-institutional HEC preserves the expertise and extrajudicial nature of the HEC. 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 Section One, I review the history of healthcare ethics committees, and describe their three primary functions. Notable among these functions is the adjudication of treatment disputes. In Section Two, I describe four significant problems with intramural HECs: (i) their lack of independence

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1 See, e.g., Dipanjan Banerjee & Ware G. Kuschner, Principles and Procedures of Medical Ethics Case Consultation, 68 BRITISH J. HOSP. MED. 140, 140 (2007); William A. Nelson, The Organizational Costs of Ethical Conflicts, 53 J. HEALTHCARE MANAGEMENT 41, 41 (2008) (“Ethical conflicts are a common phenomenon in today’s health care settings.”).
and impartiality, (ii) their lack of sufficient size and diversity, (iii) their lack of adequate resources and training, and (iv) their lack of adequate methods and procedures.

I contend that a multi-institutional healthcare ethics committee (MI-HEC) can substantially mitigate these problems. In Section Three, I describe four types of multi-institutional ethics committees: (i) the network model, (ii) the extramural model, (iii) the quasi-appellate model, and (iv) the joint model. I illustrate each model with examples of actual implementation both in the clinical context and in the analogous research context (with the IRB). 2

In Section Four, I explain how, with greater resources and detachment from any single institution, the MI-HEC can solve the independence, composition, and resources problems of intramural ethics committees. Significant and growing experience with multi-institutional committees both in the clinical and research contexts indicates that, by replacing or supplementing intramural HECs, MI-HECs can successfully ameliorate these problems.

Finally, in Section Five, I assess why, if they are really so promising, MI-HECs have not been adopted more widely. A number of obstacles have been discussed, including: (i) transaction costs, (ii) locality, (iii) liability, and (iv) confidentiality. But the most significant obstacle is the lack of motivation to fix HECs. The current system both serves the interests of healthcare facilities and satisfies accreditation and regulatory requirements to the limited extent that such requirements exist. But as the limits of HECs are increasingly recognized, a MI-HEC solution will become more attractive.

I. BACKGROUND: HEALTHCARE ETHICS COMMITTEES

Should providers withdraw life support from a brain dead child over his parents’ objections? Should providers restrain a patient who pulls out her nasogastric tube? What is the appropriate end-of-life treatment: for a patient without family or close friends? For a patient whose family members disagree with each other? For a patient whose family members disagree with providers? To get guidance in answering such questions, medical professionals typically turn to the healthcare ethics committee. 3

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2 “IRB” is the eponymous acronym for Institutional Review Board, an entity that reviews proposed research involving human subjects. See infra notes to .

3 See Alice Herb & Eliot J. Lazar, Ethics Committees and End-of-Life Decision Making, in Medical Futility and the Evaluation of Life-Sustaining Interventions
The healthcare ethics committee is a group, established by a healthcare facility, that is charged with advising, discussing, and deciding ethical questions and policies that arise in clinical care. Its purpose is to:

Serve as a reasonable and valid institutional endeavor to increase understanding among all concerned – health care providers, families, patients, and society – as well as to resolve many of the ethical, legal, and medical dilemmas facing those who care for critically and terminally ill patients.

The very birth of bioethics is based in the idea that some healthcare decisions are too complicated and momentous to be left in the hands of physicians alone. As medicine progressed to permit us to do more and more things, bioethics grew to serve as a check on the use of medical technology. For example, in the research context, investigators must obtain the approval of an institutional review board (IRB) before engaging in research on human subjects. In the clinical context, the healthcare ethics committee serves an analogous function. The HEC offers a systematic and principled approach to the contemporary dilemma of healthcare decision making.

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4 See Carol Levine, Questions and (Some Very Tentative) Answers About Hospital Ethics Committees, HASTINGS CENTER REP., June 1984, at 9, 9.
6 See Warren Reich, Revisiting the Launch of the Kennedy Institute: Revisioning the Origins of Bioethics, 6 KENNEDY INST. ETHICS J. 323 (1996) (bioethics is a shift away from science, away from insiders to outsiders; human life is too precious to leave to any one group of specialists).
7 21 C.F.R. part 56; 45 C.F.R. part 46.
8 Throughout this Article, I look to the IRB as a “close cousin” of the HEC. Cf. Stuart A. Westbury Jr., Trends in Ethical Decision Making, in CRANFORD & DOUDERA, supra note __, at 31, 37; Alexander Morgan Capron, Decision Review: A Problematic Task, in CRANFORD & DOUDERA, supra note __, at 174, 181; Joanne Lynne, Roles and Functions of Institutional Ethics Committees: The President Commission’s View, in CRANFORD & DOUDERA, supra note __, at 22, 27 (“The experience of IRBs is very instructive.”); Robert M. Veatch, The Ethics of Institutional Ethics Committees, in CRANFORD & DOUDERA 35, 45 (“An IRB . . . is similar in many ways to ethics committees . . . .”).
9 See Gergory A. Jaffe, Institutional Ethics Committees: Legitimate and Impartial Review of Ethical Health Care Decisions, 10 J. LEG. MED. 393, 394 (1989) (“IECs have
In this Section, I first review the origin and history of healthcare ethics committees. I then describe their three primary functions: education, policy development, and case consultation. Finally, I explain that HECs are usually intramural decision makers. They are intramural in that they typically are formed by and within a single healthcare facility to serve that same facility. HECs are decision makers in that, while serving their case consultation function, they often have de jure or de facto adjudicatory authority.

A. Origin and History of HECs

One of the earliest issues prompting the creation of modern ethics committees involves the allocation of dialysis machines. Renal dialysis became technologically available in the early 1960s, but was not covered by Medicare until 1972. During this time, demand for dialysis far exceeded supply. So, committees were established to determine which patients with renal failure would be eligible to receive the treatment.

At about the same time, biomedical research was transitioning to “shared decision making – between scientists, their interdisciplinary peers, and the public.” It had become “clear that the research team, acting alone, was not able to protect human subjects.” So, in 1966, the Public Health Service promulgated a policy announcing that grants for research involving human subjects would be approved only if a local review board had first approved

been endorsed because they check the physician’s influence over patients.”).

10 End Stage Renal Disease Act, Pub. L. No. 95-292, 92 Stat. 307 (codified at 42 U.S.C. 1395e(3)).

11 Shana Alexander, They Decide Who Lives, Who Dies, LIFE, Nov. 9, 1962, at 102, 104 (“[A]gonizing practical decisions must be made . . . someone must choose which patient out of 50 shall be permitted to hook up to Seattle’s life-giving machines and which shall be denied.”).

12 Alexander, supra note __, at 124 (describing “the novel double-screening device of a medical board back-stopped by a lay committee . . . all segments of society, not just the medical fraternity [c]ould share the burden of choice as to which patients to treat and which to let die.”). See also President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forgo Life-Sustaining Treatment 155-56 (1983). Indeed, even after Medicare funding until 1978, candidates were screened by local medical review boards for appropriateness. Pub. L. No. 95-292.

13 John C. Fletcher & Edward M. Spencer, Ethics Services in Healthcare Organizations, in Introduction to Clinical Ethics 257, 259 (2d ed. John C. Fletcher et al., eds. 1997).

14 Fletcher & Spencer, supra note __, at 259.
the project and its plans for informed consent.\textsuperscript{15} By 1974, Congress had enacted the National Research Act, requiring that all institutions supported by federal funds have their research reviewed by an IRB.\textsuperscript{16}

Looking both to the dialysis committees of the 1960s and to the research committees of the early 1970s,\textsuperscript{17} in 1975, Texas pediatrician Karen Teel proposed the use of multidisciplinary committees for “exploring all of the options for a particular patient.”\textsuperscript{18} Dr. Teel’s proposal was famously endorsed the very next year by the New Jersey Supreme Court in \textit{In re Quinlan}.\textsuperscript{19}

In \textit{Quinlan}, the Court held that Karen Ann Quinlan had a privacy right to terminate the medical treatments sustaining her non-cognitive, vegetative existence and that such a right could be asserted on her behalf by her father. The Court did require that the hospital ethics committee first confirm that there was no reasonable possibility of Karen emerging from her comatose state. The Court further suggested that HECs, rather than courts, should review decisions to withhold or withdraw treatment as “a general practical procedure.”\textsuperscript{20}


\textsuperscript{19} 355 A.2d 647 (N.J. 1976).

\textsuperscript{20} \textit{Id.} at 669 (“[T]he value of additional views and diverse knowledge is apparent.”). \textit{Quinlan} is emblematic. Most of the work of ethics committees has concerned end-of-life issues.
While some hospitals had ethics committees in the early 1970s, ethics committees in the clinical context (as compared to the research context) were still quite rare.\textsuperscript{21} \textit{Quinlan} changed that, by “giving credence to the importance of such committees for end-of-life cases.”\textsuperscript{22} Over the next decade, appellate courts in many states similarly endorsed the notion that most end-of-life health decision making could be, and should be, handled by ethics committees.

In 1983, the President’s Commission endorsed hospitals’ use of ethics committees. The Commission even published a model statute on the role and function of ethics committees as an appendix to its widely influential report, \textit{Deciding to Forgo Life-Sustaining Treatment}.\textsuperscript{23} In 1986, the New York State Task Force on Life and the Law also encouraged resolving patient care dilemmas at the institutional level.\textsuperscript{24} By the mid-1990s, many major medical associations had also endorsed the idea.\textsuperscript{25}

Soon, ethics committees were not only encouraged but even legally required at the federal level.\textsuperscript{26} In its 1984 “Baby Doe” rule, the Department of Health and Human Services suggested the usefulness of “Infant Care Review Committees.”\textsuperscript{27} Like earlier “Baby Doe” rules,\textsuperscript{28} those regulations

\textsuperscript{21} By the early 1970s, there had been public calls for clinical ethics committees. Elizabeth Heitman, \textit{Institutional Ethics Committees: Local Perspectives on Ethical Issues in Medicine}, in \textit{SOCIETY’S CHOICES: SOCIAL AND ETHICAL DECISION MAKING IN BIOMEDICINE} 409, 409 (1995). Some hospitals even had functioning committees. \textit{See}, e.g., \textit{Optimum Care for Hopelessly Ill patients: A Report of the Clinical Care Committee of the Massachusetts General Hospital}, 295 NEW ENG. J. MED. 362 (1976); \textit{Hennepin County Medical Center Biomedical Ethics Committee}, in \textit{CRANFORD & DOUDERA}, supra note __, at 275 (formed in 1971).

\textsuperscript{22} Glen McGee et al., \textit{Successes and Failure of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs}, 11 CAMBRIDGE Q. HEALTH CARE ETHICS 87, 87 (2002).

\textsuperscript{23} PRESIDENT’S COMMISSION, supra note __.

\textsuperscript{24} NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, \textit{DO NOT RESUSCITATE ORDERS: THE PROPOSED LEGISLATION AND REPORT OF THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW} (April 1986).


\textsuperscript{26} An early bill for the Patient Self Determination Act would have also specified HECs. Heitman, supra note __, 1995; Hoffman 1991, supra note __, at n.42. But that was deleted from the final version “because of concerns among smaller hospitals about the costs.” Fletcher, supra note __, at 871. Significant subsequent developments include Medicare “Patient’s Bill of Rights” regulations. 64 Fed. Reg. 36,060 (1999).

were struck down for administrative law reasons. But Congress authorized new regulations under the Child Abuse Prevention and Treatment Act. In response, DHHS promulgated new regulations in 1985. Those regulations, which remain in effect today, “encourage each recipient healthcare provider that provides healthcare services to infants . . . to establish an Infant Care Review Committee.”

Ethics committees were also legally mandated at the state level. In 1986, Maryland became the first state to enact legislation requiring hospitals and nursing homes to establish “patient care advisory committees.” New Jersey followed in 1990. And Colorado and Texas enacted laws in 1992. While other states do not categorically mandate the formation of an ethics committee, many of those states do mandate its use for certain types of treatment decisions.

But perhaps the most significant event in the history of ethics committees occurred in 1992, when having a HEC effectively became a necessary condition for hospital accreditation. The Joint Commission, an independent, not-for-profit organization, is the nation’s predominant standards-setting and accrediting body in healthcare. Joint Commission accreditation is critically important to a healthcare facility’s certification for

28 Jaffee, supra note __, at 398-400.
32 45 C.F.R. § 84.55; see also 45 C.F.R. § 1340.15.
34 N.J. ADMIN. CODE tit. 8, § 43G-5.1(h) (including as hospital licensing standards: “The hospital shall have a multidisciplinary bioethics committee . . . .”). See also N.J. STAT. ANN. § 26:2H-65a (requiring all healthcare facilities to establish an institutional dispute resolution mechanism to deal with issues surrounding advance directives); N.J. ADMIN. CODE tit. 8 § 8:39-9.1 (requiring long-term care facilities, residential care facilities, and home health agencies to maintain a mechanism for dealing with ethical dilemmas).
35 COLO. REV. STAT. § 15-18.5-103(6.5) (“The assistance of a health care facility medical ethics committee shall be provided . . . .”); TEX. ADMIN. CODE § 405.60(a) (“An ethics committee must be established by each facility.”).
36 See, e.g., FLA. STAT. ANN. § 765.404 (requiring a guardian to consult with a HEC before withdrawing life-sustaining medical treatment from a patient in a persistent vegetative state).
Medicare and Medicaid and to licensing in many states. Consequently, most facilities not only took notice but also took action when, in 1992, the Joint Commission amended its accreditation standards to require a “mechanism” for considering ethical issues. “[H]ospital ethics committees have been the most common response to [this] mandate.”

**B. Missions and Functions of HECs**

So, most healthcare facilities have an ethics committee. But what exactly does an ethics committee do? HECs have three primary functions: education, policy development, and case consultation. All these functions primarily concern end-of-life situations such as determinations of patient capacity and the withholding and withdrawal of life-sustaining medical treatment.

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41 While statistically true, it is important not to overstate the prevalence of HECs. Many rural healthcare facilities lack a functioning HEC. Cook & Hoas, *supra* note __.


Most HECs, like most Institutional Review Boards in the research context, are institutionally based. Each facility establishes its own IRB to review its own scientists’ research proposals. Similarly, each healthcare facility establishes its own HEC to educate and develop policies for its staff and to review treatment issues regarding its own patients. It is generally believed that the best review is local review. Intramural committees have substantial advantages over extramural bodies. They know both the institution and the treatment team. And intramural committees can readily meet with the patient, the patient’s family, and the treatment team.

1. Education

HECs provide information and education to three separate groups. First, the HEC engages in self-education, often through literature review and invited presentations. After all, the HEC must be familiar with the relevant legal framework for healthcare decisions, with the principles of bioethics and ethical reasoning, and with relevant institutional policies. Second, HECs educate the institution’s staff and residents through in-service programs. Third, HECs educate the community, often making presentations about advance care planning.

2. Policy Development

See infra notes __ to __ and accompanying text.

1991, supra note __, at 819, 826; Susan M. Wolf, Ethics Committees in the Courts, HASTINGS CENTER REP., June 1986, at 12, 12.


IRBs review research proposals to safeguard the rights, safety, and well-being of human subjects. “The granting or withholding of ethical approval decides whether a given research project can be realized . . . .” MIRIAM SHERGOLD, GUIDING GOOD RESEARCH: BIOMEDICAL RESEARCH ETHICS AND ETHICS REVIEW 23 (RAND 2008).

1991, supra note __, at 819, 826; Susan M. Wolf, Ethics Committees in the Courts, HASTINGS CENTER REP., June 1986, at 12, 12.


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MD. HEALTH-GEN. CODE § 19-373(b)(1).


Kathy Kinlaw, The Hospital Ethics Committee as Educator, in ETHICS BY COMMITTEE 203 (D. Micah Hester ed. 2008).
In addition to education, ethics committees are also typically responsible for the development of policies pertaining to end-of-life and other bioethical issues involving patient consent and refusal of treatment.  

Specifically, HECs often review and recommend institutional policies and guidelines, pertaining to: (i) decision making capacity, (ii) confidentiality, (iii) informed consent, (iv) Do-Not-Resuscitate (DNR) Orders, (v) withholding and withdrawing life-sustaining treatment, (vi) organ donation, (vii) advance directives, (viii) medical futility, and (ix) brain death.  

To a lesser extent, HECs also deal with (x) genetic testing, (xi) abortion, (xii) fertility treatments, and (xiii) compromised infants.

3. Case Consultation

While education and policy development are important tasks, the paradigm function of an ethics committee is prospective case consultation.  

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51 See, e.g., N.J. Admin. Code tit. 8, § 43G-5.1(h) (“The committee . . . shall have the following functions . . . policy related to bioethical issues . . . policy related to advance directives . . . ”); Md. Health-Gen. Code § 19-373(b)(2).  
52 These are now often referred to as Do Not Attempt Resuscitation (DNAR) or Allow Natural Death (AND) orders. They are also subsumed under POST, POLST, MOST in many states.  
54 Aulisio & Arnold, supra note __, at 420; McGee et al., supra note __, at 92; P. Schneider, A Study of Twelve Hospital Ethics Committees in Eastern South Carolina, 96 J. S.C. Med. Ass’n 409 (2000).  
55 Capron, supra note __, at 178; John F. Monagle & Michael P. West, Hospital Ethics Committees: Roles, Memberships, Structures, and Difficulties, in HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY 251, 257 (Eileen E. Morrison ed. 2009); Veatch, supra note __, at 42 (“[T]he first task people think of for an institutional ethics committee is participation in individual patient care decisions.”). In this article, I do not distinguish between HECs and ethics consultation services. Cf. Banerjee & Kuschner, supra note __, at 140. Some argue that ethics committees are less needed due to the availability of bioethics consultants. See, e.g., Terrence F. Ackerman, Conceptualizing the Role of the Ethics Consultant: Some Theoretical Issues, in ETHICS CONSULTING IN HEALTH Care 37, 37 (John C. Fletcher et al. eds., 1989); Kenneth A. Berkowitz & Nancy Neveloff Dubler, Approaches to Ethics Consultation, in HANDBOOK FOR INSTITUTIONAL ETHICS COMMITTEES 139, 140-42 (2006); Hipps, supra note __, at 170-71. Indeed, most clinical ethics issues are resolved by individual consultants or small teams rather than full committees. See Fox, supra note __, at 16; Wayne Shelton & Dyrleif Bjarnadottir, Ethics Consultation and the Committee, in CRANFORD & DOUDERA, supra note __, at 49, 72-74.  

But the HEC still plays a central role. First, where a dispute cannot be resolved, the case is typically referred to the full committee. See, e.g., Sibley Memorial Hospital, Ethics Consultation Services (June 2008) (“The on-call group . . . may be able to help those involved come to agreement . . . . If not, the full Ethics Advisory Committee . . . will be
the HEC reviews specific patient care situations and offers advice and recommendations. While HECs typically review end-of-life cases, they also review cases concerning capacity determinations, informed consent, and other issues. Prospective case consultation is generally considered to be the HEC’s most important role.

But how do HECs fulfill this case consultation function? HECs are generally described as mere advisory bodies. They facilitate problem resolution by encouraging dialogue, identifying issues, and offering viable options. But HECs certainly also can and do make decisions. “HCECs called together to consider a case.” Second, the committee must still exercise oversight over the individual consultants. See, e.g., AMA CODE OF MEDICAL ETHICS § E-9.115; N.J. Admin. Code tit. 8, § 43G-5.1(h)(3) (“The committee . . . shall have the following functions . . . resolution of patient-specific bioethical issues . . . responsibility for conflict resolution concerning the patient’s decision-making capacity and in the interpretation and application of advance directives”).

See Aulisio & Arnold, supra note __, at 41; Eric Racine, Enriching Our Views on Clinical Ethics: Results of a Qualitative Study of the Moral Psychology of Healthcare Ethics Committee Members, 5 BIOETHICS INQUIRY 57, 63 (2008).

Pinnock & Crosthwaite, supra note __ (also listing genetic testing of children, pre-implantation genetic diagnosis, sterilization, nonresident access to healthcare, HIV infection, and confidentiality).

See Sharon E. Caulfield, Health Care Facility Ethics Committees, HUMAN RIGHTS, Fall 2007 (“Case consultation is perhaps the most useful role . . . a committee can play.”) (quoting M.D. Jenkins, Ethics Committees: Creation and Purposes, Remarks before the Am. Acad. Hosp. Attorneys, 25th Annual Meeting 1992); Bernard Lo, Behind Closed Doors: Promises and Pitfalls of Ethics Committees, 317 NEW ENGL. J. MED. 46, 46 (1987); David C. Thomasma, Hospital Ethics Committees and Hospital Policy, QUALITY REV. BULL., July 1985, at 204, 206 (“Perhaps the most important . . . role of the hospital ethics committees is consultation.”). But see Aulisio & Arnold, supra note __, at 420 (“[E]ducation is ultimately the most important function of an ethics committee because the majority of ethical issues in clinical medicine will always be handled by clinicians . . . .”).

See, e.g., Merritt, supra note __, at 1273 (“Most ethics committees . . . do not have formal authority to issue binding opinions . . . . More typically, ethics committees are advisory bodies that offer recommendations rather than mandatory directives.”).

See 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).

HAW. REV. STAT § 663-1.7(a) (defining HEC as a committee “whose function is to . . . make decisions regarding ethical questions including decisions on life-sustaining therapy”); Fox, supra note __, at 18; Robin Fretwell Wilson, Rethinking the Shield of
in most states serve a role as a mechanism for ‘alternative’ dispute resolution.\textsuperscript{63} For example, they are formally authorized to decide treatment for surrogateless patients.\textsuperscript{64} HECs adjudicate when there is a dispute between default surrogates of the same class.\textsuperscript{65} And even when HECs do not have formal authority, their recommendations often have a practically dispositive effect.\textsuperscript{66}

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.\textsuperscript{67} Courts have enthusiastically supported HECs.\textsuperscript{68} Judges do not want to decide these cases.\textsuperscript{69} Moreover, the general consensus has been that there is no need for judicial review\textsuperscript{70} because HECs are both better positioned and better equipped to resolve treatment disputes.\textsuperscript{71}

\textit{Immunity: Should Ethics Committees Be Accountable for their Mistakes?} 14 HEC FORUM 172, 172 (2002) (states “repose considerable authority for ethical decisions in individual institutions”).

\textsuperscript{63} Hoffman & Tarzian, \textit{supra} note __, at 46.

\textsuperscript{64} See, e.g., ALA. CODE § 22-8A-11(d)(7) (2001); ARIZ. REV. STAT. § 36-32319(B); FLA. STAT. § 765.404; GA. CODE ANN. § 31-39-2 (2000); IOWA CODE § 135.29(1); TENN. COMP. RULES & REGS. § 1200-18-11-.12(16)(h)(1); TEX. HEALTH & SAFETY CODE ANN. § 166.046 (Vernon 2000); TEX. ADMIN. CODE tit. 25 § 405.60(c)(1).

\textsuperscript{65} See, e.g., TEX. HEALTH & SAFETY CODE § 166.039(e) (Vernon 2000); TEX. ADMIN. CODE tit. 25 § 405.60(c)(2); W. VA. CODE § 16-30-5(d).


\textsuperscript{67} \textit{RIGHT TO DIE, supra} note __ §§ 3.19-20, 3.23 & 3.26.

\textsuperscript{68} \textit{See infra} notes __ to __.

\textsuperscript{69} In re A.C., 573 A.2d 1235 (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 Longeway, 549 N.E.2d 292 (Ill. 1989); Christopher (NY 1998); Nemser, 273 N.Y.S.2d 624, 629 (N.Y. Sup. Ct. 1966).

\textsuperscript{70} \textit{RIGHT TO DIE, supra} note __ § 3.19 n.265 (collecting cites).

\textsuperscript{71} \textit{Wendland Amicus Curiae brief, supra} note __, at 31 (“[E]thics committees are capable of an interdisciplinary review that no trial or appellate court could ever match . . . .”); Weinstein, \textit{supra} note __, at 289-90 (arguing that bioethics disputes are “probably better resolved privately”). This has been the general position. It has been challenged,
Judicial review is generally thought to be an inappropriate mechanism for resolving medical treatment disputes. First, it is cumbersome, being both slow, time-consuming, and expensive. Therefore, it cannot usefully address complex, urgent medical issues. Second, it is adversarial and open to the public. Therefore, courts are an unwelcome forum in which to resolve sensitive medical treatment disputes. Third, judicial review is an encroachment on the medical profession.

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

Courts themselves recognize these comparative strengths and weaknesses. While courts remain open to resolve intractable disputes, courts have often relied upon the recommendations of HECs as a significant factor in their decision making. Therefore, HECs are often the effective forum of last most forcefully by Washington & Lee University law professor Robin Wilson. 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); Wilson, supra note __, at 187-88 (collecting cites and arguing that judges have other highly technical cases, court proceedings can be kept confidential, and they can be sped up).

Ethics committees might be considered, and evaluated, as a form of ADR. (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, mothing the dispute. See Thaddeus Mason Pope, Involuntary Passive Euthanasia in U.S. Courts: Reassessing Judicial Treatment of Medical Futility Disputes, 9 MARQ. ELDER’S ADVISOR 229 (2008).

Quill v. Vacco, 80 F.3d 716, 731 n.4 (2d Cir 1996); DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993); In re L.W., 482 N.W.2d 60, 73-74 (Wis. 1992); In re Moorhouse, 593 A.2d 1256, ___ (N.J. Super. AD 1991); In re Jobes, 529 A.2d 434, 463-64 (N.J. 1987); In re Doe, 45 Pa. D. & C. 3d 371 (Pa. Com. Pl. 1987); In re AC, 573 A.2d 1235 (D.C. App. 1990); In re Spring, 405 N.E.2d 115, 120 (Mass. 1980) (“[T]he concurrence of qualified consultants may be highly persuasive . . . .”); Severns v. Wilmington Med. Center, 421 A.2d 1334, 1341-44 (Del. 1980); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d
II. PROBLEMS WITH INTRAMURAL ETHICS COMMITTEES

Since their beginnings, ethics committees have been subjected to nearly constant criticism. Neither this prior criticism nor the criticism in this article is directed at all ethics committees. Many do a fine job. But ethics committees are subject to almost zero oversight and accountability through government regulation, self-regulation, certification, or accreditation. Consequently, there is enormous variation in quality among HECs at different facilities.

Nan Hunter describes four distinct types of risks applicable to medical decisions: (i) the risk of corruption, (ii) the risk of bias, (iii) the risk of arbitrariness, and the (iv) the risk of carelessness. Many HECs suffer...
from some or all of these decision making risks.  

A “corrupted decision” is one driven by the self-interest of the decision-maker.  For example, a treatment decision may be corrupted when the decision maker has a financial interest in the outcome. A “biased decision” is one reflecting a pattern of unfairness, which disparages the interests of certain persons or classes of persons.  For example, a treatment decision may be biased when the decision maker is prejudiced against the race of the patient.

A “careless decision” is one based on ill-considered or unsupported beliefs due to insufficiencies in the decision maker’s training.  For example, a treatment decision may be careless when the decision maker misapplies relevant standards (e.g. for determining capacity). Finally, an “arbitrary decision” is one that is the product of an abuse of appropriate process norms.  For example, a treatment decision may be arbitrary when the decision maker fails to obtain relevant information or engage in adequate deliberation.

A. Intramural HECs Make Corrupt Decisions.

Ideally, HECs are independent and neutral forums. After all, the whole point is to get a perspective broader than that of the clinical team involved with the patient’s treatment. The American Medical Association advises

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86 Id.
87 Id.
88 Id.
89 Id.
90 See PRESIDENT’S COMMISSION, supra note __, at 4 (“Health care institutions . . . have a responsibility . . . to overcome the influence of dominant institutional biases . . . .”); Daniel Wikler, Institutional Agendas and Ethics Committees, HASTINGS CENTER REP., Sept.-Oct. 1989, at 21, 22 (“Giving some weight to institutional concerns . . . would deliberately skew the results of moral judgment toward expediency . . . . [T]he ethics committee will generally do its job best if it does not concern itself with the hospital’s interests.”).
91 See Susan B. Apel, Access to Assisted Reproductive Technologies, 12 MICH. ST. U. J. MED. & L. 33, 42-43 (2008) (“The advantage of using the ethics committee is that it
that “[c]ommittee members should not have other responsibilities that are likely to prove incompatible with their duties as members of the ethics committee.”\textsuperscript{92} The Universal Declaration of Bioethics states that to “provide advice on ethical problems in clinical settings,” HECs should be “independent, multidisciplinary, and pluralist.”\textsuperscript{93}

But the objectivity of HECs is seriously compromised. Structural factors inhibit their ability to act impartially. Since 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. Furthermore, this corruption is only exacerbated by the dynamics of group decision making.

1. HEC Conflicts of Interest

Intramural committees suffer from a significant conflict of interest. Most (and often all) members of HECs are employed directly or indirectly by the very institution in which the committee is situated.\textsuperscript{94} As a result of this economic dependence, the committee members may tend to act from a sense of duty to the institution.\textsuperscript{95} “As an institutional player, an HEC may removes the dispute from those most intimately involved, and places the issue before a new-and supposedly neutral-audience that is skilled in making ethical determinations.”\textsuperscript{96}

\textsuperscript{92} AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS § E-9.11; \textit{see also} Judicial Council, \textit{Guidelines for Ethics Committees in Health Care Institutions}, 253 JAMA 2698, 2698 (1985).


\textsuperscript{94} Fleetwood & Unger, \textit{supra} note __, at 323 (“[M]ost ethics committee members are employees of the facility . . . .”); Miller, \textit{supra} note __, at 205 (“[T]he preponderance of ethics committee members are health care professionals and work in the hospital (even if not technically hospital employees) . . . .”); Robert D. Truog, \textit{Tackling Medical Futility in Texas}, 357 NEW ENG. J. MED. 1 (2007), 2 (“[T]hey are unavoidably ‘insiders’ . . . .”).

\textsuperscript{95} George Annas, \textit{Do Ethics Committees Work: No}, TRUSTEE, July 1994, at 17 (“[E]thics committees . . . can’t be objective.”); Annas 1981, \textit{supra} note __, at 19 (arguing that the failure of IRBs “can generally be traced to an over-identification with the perceived needs and interests of the institution”) (citing the artificial heart experiment at the University of Utah and the Baby Fae experiment at Loma Linda); Mildred K. Cho et al., \textit{Strangers at the Benchside: Research Ethics Consultation}, 8 AM. J. BIOETHICS 4 (2008) (“[C]ritics have questioned the independence of most institutionally-based ethics consultation and have raised the worry that a built-in conflict of interest could undermine the value of such a service.”); Mildred K. Cho & Paul Billings, \textit{Conflict of Interest and Institutional Review Boards}, 45 J. INVESTIGATIVE MED. 154, 155 (1997) (“[T]he placement of the IRB within its own institution and its composition being primarily of members of the institution may itself create conflicts of interest.”); ROBERT P. CRAIG ET AL., \textit{ETHICS COMMITTEES: A PRACTICAL APPROACH} 5 (1986) “IECs might be tempted to look after the interests of their colleagues and the institution they serve.”); Deville 2001, \textit{supra} note __, at 25; Fleetwood & Unger, \textit{supra} note __, at 323 (“[M]embers may feel inclined to make
internalize and perpetuate the interests and biases of its parent hospital.\footnote{Wilson 1998, supra note \_\_\_ at 379 (see role as serving the physician, preserving their place in the institution); Wilson 2002, supra note \_\_\_ at 180 (bias of parent hospital); Wilson & Gallegos, supra note \_\_\_ at 372 (“This proximity within institutions increasingly puts such committees in danger of being controlled by forces outside the actual committee itself.”); Wolf 1991, supra note \_\_\_ at 838 (“Still dominated”), id. at 852 (“[I]f the committee exists within a health care institution and is composed of members of that institution’s staff, then the committee will never provide the independent judgment of a body such as a court.”). Cf. Bagenstos, supra note \_\_\_ at 28 & 31; Ryan, supra note \_\_\_ at 4 (“The concept of a neutral in-house decision maker obviously leads to complex problems and to skepticism about IDR . . . .”); id. at 13 (“Persons chosen as neutrals may not want to damage their own careers in the firm by antagonizing management.”); Saver, supra note \_\_\_ at 2 (“Inside directors . . . . may be averse to challenging current management . . . .”).} Therefore, HECs may not promote patient interests that conflict with institutional interests.

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\footnote{LISA BELKIN, FIRST DO NO HARM (1992) (showing HEC considering the financial impact of care provided); Cynthia B. Cohen, The Social Transformation of Some American Ethics Committees, HASTINGS CENTER REP., Sept.-Oct. 1989, at 21, 21 (“Ethics committees are experiencing new pressures to safeguard the institution’s financial interests . . . to help meet institutional marketing goals . . . .”); Kenneth DeVille & Gregory Hassler, Healthcare Ethics Committees and the Law: Uneasy but Inevitable Bedfellows, 13 HEC FORUM 13, 25 (2001); Hoffman 1991, supra note \_\_\_ at 785 (“[T]here is a danger that ethics committees may act as ‘puppets’ of the health care institution in which they serve.”); Hoffman \_ MILBANK Q. \_ (1993); Richard A. McCormick, Ethics Committees: Promise or Peril, L. MED. & HEALTH CARE, Sept. 1984, at 150, 154 (describing “inhouse protectionism” as “a potential problem against which we should guard”); Randal, Are Ethics Committees Alive and Well? HASTINGS CENTER REP., Dec. 1983, at 10, 12 (warning that ethics committees might “be pressed into service and handmaiden to money saving strategy”). See also In re Smith, 133 P.3d 924, 926 (Or. App. 2006) (Department of...
Admittedly, most HEC members have no personal, direct, substantial pecuniary interest. Still, those members are not impartial. Giles Scofield asks, “Who hires them? Who are they accountable to? What group do they least wish to offend?” Scholars and policymakers have extensively discussed the influence of even small gifts (especially from the drug industry) on physician behavior. When pharmaceutical companies established their own ethics committees, many seriously questioned whether bioethicists can be “taken seriously if they are on the payroll of the very corporations whose practices they are expected to assess.”

The tendency of insiders to favor their own institution is well-recognized. For example, the New Jersey Medical Society Futility Guidelines caution ethics committee members to watch their “allegiance.” The Alameda-Contra Costa Medical Association criticized giving ethics committees the authority to make decisions for “friendless incompetents,” incapacitated patients without friends or family to speak on their behalf. The Association doubted whether committee members could make decisions “that were free and independent of their hospital’s administrative or

Human Services did not seek appointment as healthcare guardian of severely disabled three-year-old because “such an appointment could create the appearance of a conflict of interest, in that . . . continued care of T could cost the state a large amount of money.”); F. Ross Woolley, Ethical Issues in the Implantation of the Total Artificial Heart, 310 New Eng. J. Med. 292 (1984) (describing how the IRB responsible for approving the protocol for the artificial heart was under intense pressure to approve it).


See supra notes .


Jason Dana & George Loewenstein, A Social Science Perspective on Gifts to Physicians from Industry, 290 JAMA 252 (2002). If corporations and other business entities have a significant advantage in third-party ADR, then they certainly have it in internal dispute resolution (IDR), where they more directly and completely control the process. See Jack B. Weinstein, Some Benefits and Risks of Privatization of Justice through ADR, 11 Ohio St. J. on Disp. Resol. 241, 260-61 (1996); Peter L. Murray, The Privatization of Civil Justice, 91 Judicature 272, 275, 315 (2008).


See supra notes .


These concerns appear to be well-grounded. HECs do seem to get pressed into serving the institution’s financial goals, mainly in avoiding uncompensated care and liability exposure. For example, the very day after three-year-old Brianna Rideout’s insurance was exhausted, the Hershey Medical Center HEC authorized the unilateral withdrawal of her ventilator over her parent’s vehement objections.

Financial relationships influence intramural HECs not only in subtle ways but also in rather overt ways. Many ethics committees deliberately aim to serve a risk management role for the institution. This is not surprising

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106 Id.
107 Intramural HECs also suffer from a conflict of interest when they serve as the designated decision makers regarding whether the institution can proceed with high-profit procedures like organ transplants. In Singapore and the Philippines, for example, where most organs come from live donors, intramural HECs have been attacked as insufficiently robust to ensure donations are bona fide. See, e.g., Alastair McIndoe, Filipinos Find It Harder to Sell Organs, STRAITS TIMES, Oct. 8, 2008; Lee Siew Hua, Transplants: No National Ethical Panel, STRAITS TIMES, Aug. 27, 2008.
109 See George Annas, Ethics Committees in Neonatal Care: Substantive Protection or Procedural Diversion? 74 AM. J. PUB. HEALTH 843 (1984) (“Institutions and their staffs often see the primary function of ethics committees as protecting them against potential liability for treating or not treating particular patients.”); Capron, supra note __, at 429 (“[S]ome people . . . favor ethics committees in the belief that they will protect physicians or hospitals.”); Capron, supra note __, at 177 (“[T]here is a real danger in this area that institutions will regard the purpose of protecting hospitals and physicians as the primary one . . . .”); Caulfield, supra note __; Cohen, supra note __, at 21 (Ethics committees “have been encouraged to gloss over especially difficult cases to avoid expensive legal maneuvers that could work to the institution’s disadvantage. The structure of some committees has been designed to protect institutional interests . . . .”); Fletcher & Hoffman, supra note __, at 336; Hoffman 1991, supra note __, at 112 (72% of surveyed DC-area ethics committees responded that they were significantly influenced by legal consequences); Hoffman 1991, supra note __, at 767 (noting a conflict among goals: to protect the institution, providers, and the patient); Levine, supra note __, at 11; McGee et al., supra note __, at 91 (“One [survey respondent] wrote that the ethics committee functioned ‘mostly for risk management.’”); Melinda Murray & Amy Templeton, The Role of Legal Counsel on Hospital Ethics Committees, ETHICSCOPE [Children’s Nat’l Med. Center], Spring 1990 (“[T]he committee often considers whether or not an action is legal or at least defensible, from a risk management perspective.”); O’Reilly 2008, supra note __ (“[T]oo many ethics committees and consult teams operate under the aegis or with the review of risk management at their institution.”) (quoting Arthur Caplan); Kevin B. O’Reilly, AMA: Delegates Weight Ethics Committee’s Role, AM. MED. NEWS, Dec. 1, 2008 (“[D]elegates complained that ethics services too often operate in secrecy and avoid cases that could pose challenges for the organization. . . . It’s not the committee’s job to cover the hospital’s butt.”); John A. Robertson, Committees as Decision Makers: Alternative Structures and
since HECs often include institutional risk managers and lawyers.  It is also not surprising since the very creation of HECs was “motivated in part by a need for legal protection.” Even the U.S. Supreme Court observed that “the committee’s function is protective. It enables the hospital appropriately to be advised that its posture and activities are in accord with legal requirements.”

In *Edna MF*, for example, 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. But in conducting this review, “[t]he committee seemed to understand that its function was to reach a determination that would insulate the facility from legal liability.” Fulfillment of the patient’s wishes or best interests, not consensus, is the appropriate healthcare decision making standard. But the HEC agreed to 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. Chief Justice Abrahamson refused to give weight to the HEC recommendation and criticized the HEC for its marked responsibilities.

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**Responsibilities, in **CRANFORD & DOUDERA, supra note __, at 88-89; Spielman 2001, supra note __, at 190; J.W. Summers, Closing Unprofitable Services: Ethical Issues and Management Responses, 30 HOSPITAL HEALTH SERVICES ADMIN. 8, 10 (1985). See also Palms of Pasadena, supra note __ (“Any medical staff member may order an ethics consult . . . by contacting the Director of Risk Management . . . .”); University of Chicago MacLean Center for Clinical Medical Ethics, <http://www.medicine.uchicago.edu/centers/ccme/consult.htm> (“The ethics consultation service works closely with the Office of Medical Legal Affairs . . . .”)

110 Hoffman 1991, supra note __ (86%). See also Lawrence E. Gottlieb, Point and Counterpoint: Should an Institution’s Risk Manager/Lawyer serve as HEC Members? 3 HEC FORUM 91 (1991); Weir, supra note __, at 106 (“Rather than giving primacy to the institution’s interests, this conflict of interest means that the hospital legal counsel will advise – urge, try to compel – the committee to take the position on a case that is least likely to cause legal problems for the institution.”); Bruce White, Point and Counterpoint: Should an Institution’s Risk Manager/Lawyer serve as HEC Members? 3 HEC FORUM 87 (1991); Wilson 1998, supra note __, at n.194.

111 See Fred Rosner, Hospital Medical Ethics Committees: A Review of their Development, 253 JAMA 2693, 2694 (1985); see also George J. Annas, Illegal Aspects of Ethics Committees, in CRANFORD & DOUDERA, supra note __, at 51, 52-53 (“[I]t is really a ‘risk management’ or ‘liability control’ committee.”); id. at 55 (“[F]ear that they might be criminally and civilly liable is the real genesis of the modern ethics committee.”); Robertson, supra note __, at 85, 88-89; H. Hirsch, Establish Ethics Committees to Minimize Liability, 3 HOSPITAL RISK MANAGEMENT 45 (1981).

112 Doe, 410 U.S. at 197.

113 Id.

114 In re Edna M.F., 563 N.W.2d 485, 495-96 (Wis. 1997) (refusing to allow a woman to withdraw LSMT from her sister where the sister was not in a PVS).
institutional bias.\textsuperscript{115}

More recently, Kalilah Roberson-Reese had a cesarean section at 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 without oxygen for twenty minutes, which caused serious brain damage. Within days, the hospital initiated a Texas 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 liability and uncompensated treatment.\textsuperscript{116}

The same corruption and conflict of interest problems plague the close cousin of the intramural HEC, the intramural IRB.\textsuperscript{117} IRB members are conflicted because of three main reasons. First, the investigator’s research grants may affect the IRB member’s own compensation and the prestige of their institution.\textsuperscript{118} Second, members review the proposals of colleagues and friends. Third, members “know that they will have their own proposals reviewed . . . and the rules that they develop will be applied to them.”\textsuperscript{119} Because of this “built-in self-interest,” IRBs “are often friendly regulators.”\textsuperscript{120}

Famously, in \textit{Grimes v. Kennedy Krieger Institute}, the Maryland Court of Appeals found that IRBs have a conflict of interest because IRBs are committees of the very research institute that they are charged to oversee.\textsuperscript{121} The IRB at issue had approved research exposing small children to risks of lead poisoning while offering those same children no prospect of direct medical benefit.\textsuperscript{122}

\textsuperscript{115} Id.
\textsuperscript{117} See DeVries & Forberg, \textit{supra} note __, at 253-55.
\textsuperscript{119} Leonard H. Glantz, \textit{Contrasting IRBs with IECs, in Cranford & Doudera, supra note __}, at 129, 131.
\textsuperscript{120} 782 A.2d 807 (Md. 2001).
\textsuperscript{121} At least federal regulations address this conflict of interest in some contexts. 45
HECs may be beholden not only to the institution but also to the individual physicians who refer to cases to the committee. The repeat player phenomenon provides that the party that arbitrates many disputes (hospitals) will have greater experience with and exposure to the process than the party that typically arbitrates just one (patient, surrogates). Here, to maintain relationship with physicians, committees over-identify with their interests.

In sum, HECs are creatures of the healthcare institutions in which they are situated. Since, in many treatment disputes, the interest of the institution may not align with that of the patient, HECs cannot be sufficiently impartial, independent decision makers. They serve “two sets of

C.F.R. § 46.304 (requiring that with research on prisoners that the majority of the IRB “have no association with the prison involved” and at least one member “shall be a prisoner or prisoner representative.”

123 Cf. Cho & Billings, supra note __, at 156 (“[I]ndividual conflicts stem from the relationship between an individual IRB member and his or her colleagues. Institutional conflicts are linked to the relationship between the IRB as a group and its institution.”). Accountability defined by location in institutional hierarchy. Heitman, supra note __, at 419. If a HEC reported to the medical executive committee, it might not have independence to question physicians. If, a HEC reported to the administration, it might be too aligned with risk management.


125 Harper, 494 U.S. at 251-52 (Stevens, J., dissenting) (arguing that psychiatrists had a conflict of interest in reviewing their colleagues who would then review their performance); Moreno 1991, supra note __ (describing intricacies of small group relations); Winifred Ann Meeker-O’Connell, IRBs: Current Compliance Trends and Emerging Models, 9(2) J. HEALTH CARE COMPLIANCE 5 (2007) (“Members may also face non-financial conflicts in an academic setting, for example, when approving a colleague’s or competitor’s project could impact an IRB member’s career.”); Spielman 2001, supra note __, at 183-84; id. at 190 (reputation COI); STARR, supra note __, at 80 (“[C]ollegial manner ethics committees become sites of resistance to the institutional power-over-dynamic.”); Tilden, supra note __, at 112-13 (describing “procedural inadequacies with a HEC that approved skin harvesting from six-year-old girl for her sister: The only surgeon on the committee “worked as the direct supervisor to and colleague of [the burned girl’s] surgeon.” He may have been “conflicted regarding the preservation of his interpersonal relationship . . . demonstration of supportive leadership for his faculty, maintenance of divisional harmony, and avoidance of encroachment on the surgeon-patient relationship.”); Wilson at 382. See also Saver, supra note __, at 2 (“[M]embers can become entangled in a web of personal associations.”); Wilson 1998, supra note __, at 379 (defer to HCPs, group decision making)
masters.” Susan Wolf states that “to ask institutional committees dominated by caregivers to be the guardians of patients’ rights and interests is like asking the fox to guard the chicken coop.” Moreover, as if an actual lack of independence were not bad enough, the perception of bias creates among patients and families “serious suspicions of complicity, rubber-stamping, or cover-up.”

2. Exacerbating Conflicts with Groupthink and Bandwagons

Even if only some individual members are motivated or affected by a conflict of interest, the overall HEC decision making process may still be corrupted. Sometimes a few individuals or the chairperson dominates the deliberation. Sometimes when an aggressive lawyer speaks, other members of the HEC feel as though the discussion has ended. The
remaining members may not independently reflect or assert their position but instead just go along with the crowd. ¹³¹

This bandwagon phenomenon means that not all arguments, perspectives, or alternatives are considered because people just want to go along with the flow. ¹³² The committee will not consider the less powerful and the less vocal. ¹³³ Once the more powerful members hint or broadcast their position, discourse is hindered and participation demobilized. ¹³⁴

Increasingly, this problem is being recognized and addressed. The Food and Drug Administration, for example, now requires that the members of its advisory panels vote simultaneously. ¹³⁵ When they voted one-by-one, panel members altered their positions based on how colleagues voted. ¹³⁶ Unfortunately, such a quick-fix procedural rule is unlikely to work for intramural HECs. Bandwagon thinking does not corrupt an otherwise neutral HEC such that one or a few members with a conflict “infect” the other members. Rather, the bandwagon phenomenon exacerbates already-

¹³¹ Fleetwood & Unger, supra note __, at 323 (“[C]ommittee members may pressure one another . . . may fail to consider alternatives . . . may be pushed into hasty decisions . . .”); Gramelspeak, ___, 7 ISSUES L. & MED. 73 (1992); Hoffman 1991, supra note __, at 764 (too homogenous, too isolated, too cohesive) (citing Callahan, HEALTH PROGRESS, Oct. 1988, at 76). Lo, supra note __, at 48 (“[C]ommittees may inadvertently pressure members to reach consensus . . . .”); Saver, supra note __, at 2 (describing “pressures to conform to the group” that “discounts critical examination of alternatives and urges consensus among members even if suboptimal and inaccurate decisions result”); Schluppi & Fraser, supra note __, at 297; Wilson, supra note __, at 180 (“[T]he dynamics of group decisionmaking may inadvertently cause committees to avoid controversial alternatives that prevent quick agreement.”). Cf. Gardiner Harris, British Balance Benefit vs. Cost of Latest Drugs, N.Y. TIMES, Dec. 2, 2008 (“[G]aps in the idea of openness remain. . . . The committee’s chairman . . . was so intent on keeping the meeting brief that he told a committee member ‘This must be the last question. It must be relevant. Otherwise you will feel my wrath.’”).

¹³² McCormick, supra note __, at 154 (“Since ethics committees can easily be oversensitive to the felt need of consensus, many people distrust them. Such a felt need, it is asserted, can flatten the sharp differences . . . in ethics.”); Silberman, supra note __, at 33.

¹³³ Don Milmore, Hospital Ethics Committees: A Survey in Upstate New York, 18 HEC FORUM 222, 235, 239 (2006). See also Howe, supra note __, at 3 (“Commonly, members ‘higher’ on the ‘medical hierarchy’ . . . tend to speak most during committee discussions, and others say less, in part, because they may feel intimidated.”).


¹³⁶ Id.
existing corruption in that a majority of the members have a conflict of interest.

B. Intramural HECs Make Biased Decisions.

HECs do not only make “corrupted” decisions, driven by the self-interest of the HEC. They also make “biased” decisions, reflecting a pattern of unfairness which disparages certain persons or classes (e.g. gender, ethnicity, age) of persons. Private dispute resolution generally exaggerates prejudices to minority participants. As a species of ADR, HECs are no different.

Bias has been well-documented from the earliest ancestor of the modern ethics committee, the dialysis allocation committee. There, the Seattle committee applied criteria of social or moral worth in allocating scarce dialysis treatment. Measuring applicants in accordance with their own middle class value system, the committee chose transplant recipients with similar backgrounds, rejecting a prostitute, a playboy, and others whom the committee perceived as lacking the requisite decency and responsibility.

No safeguards apply to the modern ethics committee that would prevent or mitigate those very same biases. These are often unconscious, so they go

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137 Hunter, supra note __, at 108-09.
138 See generally Richard Delgado et al., Fairness and Formality: Minimizing the Risk of Prejudice in ADR, 1985 WIS. L. REV. 1359, 1375-91; Kimberlee K. Kovach, Privatization of Dispute Resolution: In the Spirit of Pound, but Mission Incomplete: Lessons Learned and a Possible Blueprint for the Future, 48 S. TEX. L. REV. 1003, 1036 (2007) (collecting cites); see also Schneiderman & Capron, supra note __, at 528-29 (arguing that prejudices about the lives of some patients may affect the committee’s judgments; this is the reason for community representatives.)

139 Even earlier, therapeutic abortion committees were established because physicians disagreed about acceptable indications for abortion. These committees were criticized as a “smokescreen” and as being susceptible to being set up to “make it do anything you want.” RODMAN ET AL., supra note __, at 182.


141 Baker & Hargreaves, supra note __, at 34; FOX & SWAZEY, supra note __, at 232.

142 Miller, supra note __, at 205 (“[S]uspicions of complicity, rubber-stamping, or cover-up . . . may be more common than we think . . . .”).
uncorrected.\textsuperscript{143} “[A] committee composed completely of health care insiders might, however inadvertently, misrepresent the actual needs and concerns of patients and their family members.”\textsuperscript{144} Recommendations and decisions will be applied unevenly because HECs are influenced by patient’s income, age, political power, and gender along with an institution’s financial status.\textsuperscript{145}

Many have suggested that this bias can be substantially mitigated by attending to the composition of the HEC. A HEC will be less biased where it has a larger membership with a diversity of disciplinary and life perspectives.\textsuperscript{146} For example, the Infant Care Review Committee regulations require that the composition of the committee be “representative of a broad range of perspectives,”\textsuperscript{147} including a “representative of a disability group or a developmental disability expert.”\textsuperscript{148} Notably, after its high profile debacle in the Ashley X case, the Seattle Children’s Hospital added a disability rights representative.\textsuperscript{149}

Outsiders can reduce prejudices, biases, and cover-ups.\textsuperscript{150} Accordingly,

\begin{itemize}
\item Dana & Loewenstein, supra note ___; Christakis & Asch, supra note ___; Samuel R. Bagenstos, The Structural Turn and the Limits of Antidiscrimination Law, 94 CAL. L. REV. 1, 5-6 (2006) (collecting cites).
\item THOMPSON, supra note __, at 59; Fry-Revere, supra note __, at 100 (“I have seen the concerns of some individuals ignored because they are old, young, women, or health care personnel other than physicians.”).
\item Terese Hudson & Kevin Lumsdon, Are Futile Care Policies the Answer? Providers Struggle with Decisions for Patients Near the End of Life, 68 HOSPITALS & HEALTH NETWORKS, Feb. 20, 1994, at 26-30, 32; Karl Schupp, Discussion, 89 AM. J. OBSTETRICS & GYNECOLOGY 353, 353 (1964) (“It is perfectly obvious when you set up one of these committees that you can make it do anything want depending on how many people you put on it, what their religious convictions are . . . .”). For example, ____ 8 AM. J. BIOETHICS (2008).
\item LINDA FARBER POST, JEFFREY BLUSTEIN & NANCY NEVELOFF DUBLER, HANDBOOK FOR HEALTH CARE ETHICS COMMITTEES 203 (2007); Laszlo T. Vasvar et al., Hospital Ethics Case Consultations: Practical Guidelines, 31 COMPREHENSIVE THERAPY 279, 280 (2005).
\item 45 C.F.R. § 84.55(A).
\item 45 C.F.R. § 84.55(f)(2)(v).
\item C.L. Bosk & J. Frader, Hospital Ethics Committees: Sociological Oxymoron, Empirical Black Box, in BIOETHICS AND SOCIETY: CONSTRUCTING THE ETHICAL
most commentators agree that HECs should include representatives from the community. Indeed, in the more regulated research context, each IRB must include at least one unaffiliated member. And even this bare minimum is recognized to be insufficient. The National Bioethics Advisory Commission, for example, recommended that at least 25% of an IRB’s members be external to the institution. Other countries require at least 50% of an IRB’s members to be outsiders.

These outside members can help provide the committee with a solid sense of the moral views of the surrounding community. In this sense, the

ENTERPRISE (Raymond DeVries & J. Subedi eds. 1998) (“Membership indicates who can speak, whose opinions are counted, and whose discounted. Membership may determine wgeb which issues are seen . . . .”); Daniel Callahan, Ethics by Committee? HEALTH PROGRESS, Oct. 1988, at 76 (arguing that membership “can correct for individual idiosyncrasies and biases”); DeVries & Forsberg, supra note __, at 256 (expressing concern over “the over-representation of certain voices”); Hoffman 1991, supra note __, at 792; Ross, supra note __, at 40 (“The ethicist who comes from beyond the hospital walls may be able to broaden the committee members’ views because his or her perspective differs from theirs . . . .”); DAVID ROTHMAN, STRANGERS AT THE BEDSIDE (1991); Daniel Wikler, Institutional Agendas and Ethics Committees, HASTINGS CENTER REP. Sept. 1989, at 21 (“insulate from less noble imperatives in their midst”); Saver, supra note __, at 2 (“Nonaffiliated members drawn from the community are supposed to . . . provide a check against bias . . . .”); Jordan Silberman et al., Pride and Prejudice: How Might Ethics Consultation Services Minimize Bias? 7(2) AM. J. BIOETHICS 32, 33 (2007) (“One method to offset these biases is to purposefully create diversity within the members . . . .”).

151 Heitman 1995, supra note __, at 420 (diverse age, gender, ethnicity, socioeconomic); Hoffman, supra note __, at 792 (“[A] significant percentage of the members [should] be from outside of the hospital [and reflect] the patient population with respect to “race, age, gender, income, education, and religion”); id. at 793 (If simple majority vote, outsiders could get outvoted); Pinnock & Crosthwaite, supra note __ (“[S]ome health professional members should be external to the institution to avoid parochialism.”); Jeffrey Spike & Jane Greenlaw, Ethics Consultation: High Ideas or Unrealistic Expectations, 133 ANNALS INTERNAL MED. 56 (2000) (arguing that at least one member “should not be employed by the institution’s administration or malpractice office”).

152 45 C.F.R. § 46.107(d); 21 C.F.R. § 56.107(d) (“Each IRB shall include at least one member who is not otherwise affiliated with the institution.”); PROTECTING HUMAN RESEARCH SUBJECTS: IRB GUIDEBOOK (1993) (diverse background including racial and cultural heritage).


154 Shergold, supra note __, at 18.

155 Andrew L. Merritt, The Tort Liability of Hospital Ethics Committees, 60 S. CAL. L. REV. 1239, 1247 (1987) (citing Fleischman & Murray, Ethics Committees for Infant Does?
HEC serves much the same role as a jury. And just as it is important for a jury to have diverse representation from a cross-section of the community, so too is important for the HEC.

But most HECs have few outside members. Many have zero unaffiliated members. Nearly half have only one unaffiliated member. Moreover, even the few HECs with community members on the roster may not benefit from their participation. Given the laxity or absence of quorum or voting requirements, community members may neither attend nor participate in HEC activities. The picture is much the same for IRBs, the close cousin of HECs, but IRBs at least have a floor.

HASTINGS CENTER REP., Dec. 1983, at 5, 8); Tex. DADS (“Using a multidisciplinary ethics group helps to guard against the tendency to create policies that are based solely on a single perspective...[and] is better able to reflect the richness and diversity of moral life in a pluralistic society.”).

156 Capron, supra note __, at 182; Hoffman & Tarzian, supra note __, at 48.

157 Cf. 21 C.F.R. § 46.107(d) (“The IRB shall be sufficiently qualified through the experience and expertise of its members and the diversity of members, including consideration of race, gender, and cultural backgrounds...”); see also 45 C.F.R. § 46.107(d).

158 This is not surprising since there is little motivation to serve. HECs almost never provider compensation, and participating creates social tension and bad feelings. See Spaeth, __, ANNALS HEALTH L. (2003).

159 Milmore, supra note __, at 227-28 (13% of upstate New York facilities surveyed had zero unaffiliated members)

160 Milmore, supra note __, at 228 (45% of upstate New York facilities surveyed had zero or one unaffiliated members). See also Hoffman 1991, supra note __, at 108 (finding that one-half of surveyed DC-area ethics committees reported no community representative); Hoffman 1991, supra note __, at 767 (lack broad representation); Powell 1998, supra note __ (finding 2/3 of committees had no community member); Mary Beth West & Joan McIver Gibson, Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from mediation and Facilitation Techniques, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 63, 66 (1992).

161 See Cho & Billings, supra note __, at 155 (observing that lay members “may not feel competent or empowered to comment critically”); DeVries & Forsberg, supra note __, at 253-55; Glantz, supra note __, at 132; C.A. Schuppli & D. Fraser, Factors Influencing the Effectiveness of Research Ethics Committees, 32 J. MED. ETHICS 294 (2007) (reporting community members being outnumbered, intimidated, and underappreciated; and reporting the impact on the decision process of variable attendance); RICHARD E. THOMPSON, SO YOU’re ON THE ETHICS COMMITTEE? 52-53 (ACPE 2007) (“Often, the committee member needed for a specific agenda item can’t make it to a meeting.”); id. at 59 (“[W]e [doctors] are very to ignore, however inadvertently, the concerns of co-workers like nurses, technicians, and therapists.”).

162 See Saver, supra note __, at 2 (“[O]nly a token number of nonaffiliated members serve on most IRBs.”).

163 21 C.F.R. § 46.107(a) (“Each IRB shall have...diversity of the members,
In sum, since most HECs are comprised entirely or almost entirely of healthcare professionals, HECs are upper middle class and homogenous, across a range of relevant values. They are aligned with the powerful and not constituted to mitigate bias.

One of the earliest expressions of judicial skepticism toward ethics committees is perhaps the most eloquent. The Massachusetts Supreme Judicial Court explained: “Detached but passionate investigation and decision . . . forms the ideal on which the judicial branch of the government was created.” This is “not to be entrusted to any other group – no matter how highly motivated or impressively constituted.” In fact, HECs are neither highly motivated nor impressively constituted.

C. Intramural HECs Make Careless Decisions.

Not only do intramural HECs make corrupt and biased decisions but they also lack adequate expertise or training to make those decisions. It has been widely recognized that HECs should have a diverse membership to best assure expertise on the medical, ethical, social, religious, and philosophical issues surrounding complex medical decisions.

including consideration of race, gender, cultural backgrounds . . . ”); id. (“If an IRB regularly reviews research that involves a vulnerable category of subjects [like children prisoners, pregnant women, or the handicapped], consideration shall be given to inclusion of one or more individuals who are knowledgeable about and experienced in working with those subjects.”); 21 C.F.R. § 56.107(c) (“Each IRB shall include at least one member whose primary concerns are in the scientific area and at least one member whose primary concerns are in nonscientific areas.”); 21 C.F.R. § 56.107(d) (“Each IRB shall include at least one member who is not otherwise affiliated with the institution . . . .”); see also 45 C.F.R. § 46.107(a), (c) & (d).


165 Milmore 2006, supra note __; see also DeVries & Forsberg, supra note __, at 256 (describing the “over-representation of certain voices”).


167 O’Reilly 2008, supra note __ (“[T]oo many ethics committees are bare-bones efforts . . . .”).

168 IOWA ADMIN. CODE § 641-85.3(1); MD. HEALTH-GEN. CODE § 19-372(a)(1) (requiring a physician, an RN, and a social worker); N.J. ADMIN. CODE § 10:48B-2.1 & 10:48B-3.1; American Academy of Pediatrics: Committee on Bioethics, Institutional Ethics Committees, 107 PEDIATRICS 205, 208 (2001) (“Ideally, the members of an IEC encompass a wide range of clinical experiences, personal backgrounds, and professional
A diverse committee “can identify a greater range of value and options.” Accordingly, the committee should include representatives from different disciplines. It should ideally include: physicians (including specialists in critical care and palliative care), hospital administrators, clergy, attorneys, social workers, nurses, psychiatrists, psychologists, patient advocates, philosophers, and representatives of a disability group.

While some HECs include a broad array of disciplinary perspectives, many other, especially rural HECs, lack multidisciplinary professionals.
Many recommend that the optimal number of members is around fifteen.\textsuperscript{174} A recent survey of upstate New York facilities shows the average ethics committee has thirteen members.\textsuperscript{175} But elsewhere, many HECs have three or fewer members.\textsuperscript{176}

HEC composition varies dramatically from institution to institution. In 1980, the New York Court of Appeals derogatorily described the ethics committee as an “ill-defined, amorphous body.”\textsuperscript{177} During the subsequent three decades, HECs have acquired no additional definition or shape.

Commentators have long observed that the quality of HECs varies tremendously.\textsuperscript{178} This is to be expected as HECs “have no established training curriculum . . . [or] fixed job descriptions.”\textsuperscript{179} One recent survey

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\textsuperscript{174} L. Vasvar et al., \textit{Hospital Ethics Case Consultation Practical Guidelines}, 31 COMP. THER. 35 (2005); Jeffrey Spike & J. Greenlaw, \textit{Ethics Consultation: High Ideals or Unrealistic Expectations?} 133 ARCHIVES INTERNAL MED. 55 (2000).

\textsuperscript{175} Milmore 2006, \textit{supra} note __, at 227-28.

\textsuperscript{176} Hoffman & Tarzian, \textit{supra} note __, at 48. \textit{Id.} at 227-28. \textit{See also} Martin L. Smith et al., \textit{Texas Hospitals’ Experience with the Texas Advance Directives Act}, 35 CRITICAL CARE MED. 1271, 1272 (2007) (56% of surveyed hospitals had a “medical appropriateness review committee distinct from their ethics committee” and “the number of members was most frequently 1-5”). \textit{Compare} MD. HEALTH-GEN. CODE § 19-372(a)(1) (requiring only four members), \textit{with} TEX. ADMIN. CODE tit. 25 § 405.60(b) (requiring seven members, two of whom must be unaffiliated). Another survey in the Washington, DC area showed pretty much the same thing. Hoffman, \textit{supra} note __, 1991 at 107 (finding that the size of surveyed DC-area ethics committees ranged from four to 30, with an average around thirteen). \textit{See also} Csikai, \textit{supra} note __, at 105; JOANN STARR, \textbf{THE ETHICAL IMPLICATIONS OF THE USE OF POWER BY HOSPITAL ETHICS COMMITTEES} 35 (unpublished dissertation for Graduate Theological Union 2002) (finding 75% of surveyed hospitals “have between ten and twenty members with half of the committees having exactly fifteen members”).

\textsuperscript{177} In re Eichner, 426 N.Y.S.2d 517, 549 (1980).

\textsuperscript{178} George J. Annas, \textit{At Law: Ethics Committees: From Ethical Comfort to Ethical Cover}, HASTINGS CENTER REP., May-June 1991, at 18, 19 (Institutional ethics committees “vary widely in terms of purpose, composition, authority, and resources . . . .”); Apel, \textit{supra} note __, at 43 (“[W]hether or not an ethics committee consultation adds anything of value to the deliberations concerning access issues appears to depend on the luck of the draw.”); DeVries & Forsberg, \textit{supra} note __, at 253-55; Fleetwood & Unger, \textit{supra} note __, at 321; Fox, \textit{supra} note __, at 20 (“[T]here appear to be wide variations in practice . . . .”); Hoffman 1991, \textit{supra} note __, at 762 (“The ‘quality’ of ethics committees is likely to vary considerably . . . . Not all ‘institutions have the resources and ‘expertise’ necessary to operate a committee . . . .’”); Laura Williamson, \textit{The Quality of Bioethics Debate: Implications for Clinical Ethics Committees}, 34 J. MED. ETHICS 357 (2008); Wilson 1998, \textit{supra} note __, at 371; Wilson 2002, \textit{supra} note __, at 177; Wolf 1992, \textit{supra} note __, at 94 (“[C]ommittees vary enormously in quality . . . .”); Wolf 1991, \textit{supra} note __, at 808 (“[A]n ethics committee is not an ethics committee is not an ethics committee.”).

\textsuperscript{179} James M. Dubois, \textit{The Varieties of Clinical Consulting Experience}, 15 HEC FORUM
\end{footnotesize}
shows fewer than 20% of ethics committee members have formal training in bioethics. Fully one-third of HECs, especially in rural institutions,\textsuperscript{180} have zero trained members.\textsuperscript{181} Nancy Dubler is “horrified at the number of people out there who don’t have appropriate training” and wishes she could just “stamp her foot and make them go away.”\textsuperscript{182} There is a lot of “half-baked ethics analysis”\textsuperscript{183} conducted without reference to or reliance on settled bioethics principles.\textsuperscript{184}

The situation is no better in the research context with respect to IRBs, the close cousins of HECs.\textsuperscript{185} Indeed, IRBs are both better developed and better regulated than HECs.\textsuperscript{186} Just as HECs mediate and adjudicate treatment disputes in the clinical context, IRBs mediate and adjudicate between investigators and human subjects in the research context. IRBs are more often, more clearly, and more formally empowered to serve a

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\textsuperscript{180} See also Fleming, supra note __, at 251 (2007) (“Presently, there are no unified standards of clinical ethics education, training, or practice.”); Giles R. Scofield, \textit{What Is Medical Ethics Consultation?} \textit{J. L. Med. & Ethics} 95 (2008) (severely criticizing the field and concluding that “the field of medical ethics consultation is, if not an ethics disaster, a disaster waiting to happen”).

\textsuperscript{181} Id; see also Nelson, supra note __, at 30; Denise Niemira et al., \textit{Multi-Institutional Ethics Committees}, 1 HEC FORUM 77, 77 (1989).

\textsuperscript{182} Ruth Shalit, \textit{When We Were Philosopher Kings}, NEW REPUBLIC, Apr. 29, 1997. See also Aulisio & Arnold, supra note __, at 419 (“[E]thics committees are staffed primarily by health professionals and others who have had little or no formal training in either clinical ethics or conflict resolution.”); Nancy Neveloff Dubler & Jeffrey Blustein, \textit{Credentialing Ethics Consultants: An Invitation to Collaboration}, 7(2) AM. J. BIOETHICS 35, 35 (2007) (“It has been a quietly growing scandal . . . [that m]any who now participate or direct bioethics consultation have little if any formal training.”); Dubler, supra note __, at 37 (“[C]linical ethics consultation is a field without adequate standards, training, or quality review.”); Laura Landro, \textit{Life and Death: Helping Families on Big Questions}, WALL ST. J., June 25, 2008, at D1 (quoting Dubler).

\textsuperscript{183} E.G. Derenzo, \textit{The Imperative of Training for Ethics Consultations}, MID-ATLANTIC ETHICS COMMITTEE NEWSL., Summer 2000, at 1.

\textsuperscript{184} While necessary, substantive bioethics knowledge is not sufficient. HEC members should also have expertise in: (i) information gathering, (ii) conceptual clarification/analysis, (iii) normative analysis, and (iv) facilitation or mediation. See Aulisio & Arnold, supra note __, at 421; Vasvar, supra note __, at 280.


\textsuperscript{186} See, e.g., 21 C.F.R. § 56.107(a) (“Each IRB shall . . . be sufficiently qualified through the experience and expertise of its members . . . .”).
gatekeeping role. Yet, the IRB members often have no more training than HEC members. 187

Courts have noted the lack of ethics committee training. For example, in In re Edna MF, the Chief Justice of Wisconsin wrote a concurring opinion specifically to call out that the ethics committee in that case “functioned without either a shared body of rules or training in ethics.” 188

In In re Gianelli, the parents of a seriously ill fourteen-year old boy asked to stop his life-sustaining treatment. 189 The boy had Hunter’s Syndrome, a serious genetic disorder that would be fatal within two years. 190 He was dependent on a ventilator and PEG tube, but was alert and could sense his surroundings. 191 “The members of the ethics committee independently came to the conclusion that the mother’s decision was an ethical one.” 192 Nevertheless, the court refused to credit the HEC’s opinion because the only physician on the committee “did not have experience with Hunter’s syndrome and was not well versed in [the patient’s] care and condition.” 193

Of course, not every member of an HEC needs bioethics or mediation training. 194 Sometimes an HEC needs leaders, people who are respected and create a sense of enthusiasm. 195 It needs people “to enhance the credibility” of the committee and its “standing within the institution.” 196 And the HEC needs community members. 197 But we are nowhere near 100% training. The overwhelming majority of HEC members have zero bioethics or mediation training. 198

188 Edna M.F., 563 N.W.2d at 495.
190 Id.
191 Id. at 626.
192 Id. at 629-30; see also id. at 625 (noting that the physician was “serving in an administrative position at the hospital” and the “nurse on the team was not a pediatric nurse”).
193 Fry-Revere, supra note __, at 95.
194 Heitman, supra note __, at 420; William A. Nelson, Evaluating Your Ethics Committees, HEALTHCARE EXECUTIVE, Jan.-Feb. 2000, at 48, 49 (leadership).
195 Buchanan et al., supra note __, at 201; Jaffe, supra note __, at 411
196 See supra notes __ to and accompanying text.
197 Milmore 2006, supra note __ (only 19% of ethics committee members in upstate New York facilities surveyed had training and 29% of committees had no trained members).
D. Intramural HECs Make Arbitrary Decisions.

We have now seen that HEC decisions are often corrupt, biased, and careless. In addition, HEC decisions are frequently arbitrary. Some ethics committees operate in a formal manner pursuant to detailed bylaws. For example, Maryland law requires that each HEC have a written procedure by which it is convened. But even those requirements are quite thin. A Maryland ethics director explained that how a vote turns out “may depend on a number of “highly arbitrary” factors such as “who happens to be present at a given meeting.”

Outside Maryland, HECs operate in an even more informal and casual manner. In *Edna MF*, for example, Chief Justice Shirley Abrahamson criticized a La Crosse, Wisconsin ethics committee for failing to prepare formal minutes, for having no shared body of rules and for failing to prepare a report. Similarly, in *Rideout*, some ethics committee members at the Hershey Medical Center could not even recall a recent discussion of a case to unilaterally withdraw a ventilator from a three-year old girl over her parents’ objections.

In *In re Martin*, a wife wanted to withdraw life-sustaining medical treatment from her husband, Michael Martin, who was in a minimally conscious state. The HEC agreed with her that withdrawal was the appropriate action. Aware that HEC opinions have historically been

200 MD. HEALTH-GEN. CODE § 19-372(a)(3) (requiring consultation of specific parties); id. § 19-372(b) (allowing petitioner to be accompanied).
202 Fry-Revere, *supra* note __, at 100 (observing that many HECs operate “without knowledge of the key decision makers such as the patient, the attending physician, or the patient’s surrogate”); Hoffman 1991, *supra* note __, at 111 (reporting that of surveyed DC-area ethics committees, 90% operate by consensus and 7% by majority); Wilson 2002, *supra* note __, at 177 (no written opinions, notification, and immunity makes lax – contrast open hearings 181). Cf. Hunter 2006, *supra* note __, at n.62 (observing that HECs suffer from process deficiencies); Shergold, *supra* note __, at 23 (observing that IRB “internal processes of decision making have been likened to a ‘black box’ and the soundness of judgments has been questioned.”).
203 Edna M.F., 563 N.W.2d at 495.
206 Martin v. Major, No. 95-821, 1995 WL 17035828, at *3 (petition for writ of certiorari to the U.S. Supreme Court).
quite persuasive evidence, she offered the HEC recommendation to the court. But the court placed little weight on the recommendation where it never consulted other members of Michael’s family.207

Courts are good at observing procedural regularities.208 They offer a principled, full exposition.209 If HECs purport to substitute for courts, then they must also follow guidelines.210 HECs must base their decisions on reasonable rationales that appeal to relevant evidence, reasons, and principles.211

Lamenting this procedural laxity, commentators warned that courts would start looking more closely at the, HEC minutes to see carefully their meetings were conducted.212 Courts are more carefully scrutinizing the basis for HEC recommendations. Consequently, the courts, which had long deferred to ethics committees, have become increasingly less willing to do so.213


208 Hoffman 1991, supra note __, at 765 (“[E]thics committees often lack substantive guidelines for decisionmaking . . . .”); Wolf 1992, supra note __, at 94 (“[E]thics committees now wield sufficient influence over the fate of real patients that they must do so responsibly, accountably, and with some guiding rules.”); id. at 94 (“Committees . . . are bound by no commonly, accepted rules of reasoning or system of precedent . . . .”).

209 PRESIDENT’S COMMISSION, supra note __, at 160

210 Jaffe, supra note __, at 427 (“The more uniform and formal the committee procedures and the more open its processes, the more likely that a court will give this evidence substantial weight and deference.”). See generally Fleetwood & Unger, supra note __, at 321.


212 Drane, Ethics Committees and the Law, in CLINICAL BIOETHICS 99, 117 (qualification of ethics committees, at their longevity, their preparation, their grounding in ethics). See also Hoffman & Tarzian, supra note __, at 63 (“Courts may wish to give different weight to committee recommendations as ethics committees vary significantly in composition, experience, expertise, and procedures.”).

213 In re Gianelli, 834 N.Y.S.2d 623 (N.Y. Sup. 2007); In re Edna M.F., 563 N.W.2d 485 (Wis. 1997); In re Martin, 538 N.W.2d 399, 413 (Mich. 1995) (disagreeing with committee’s recommendation); In re Doe, 418 S.E.2d 3 (Ga. 1992) (see appellant brief); In re Wendland, 28 P.3d 151, 155 (Cal. 2001) (ignoring recommendation of 20-member HEC that agreed with wife but never spoke with patient’s mother or sister before determining appropriateness of withdrawal). Where the process is more careful, courts are more prepared to defer. See, e.g., In re J.H.V., 2008 A.B.O.B. 250 ¶ 31 (2008) (“I am not satisfied that we as judges should be replacing our opinion with that of the medical community that has obtained extensive unbiased third party analysis, including opinions from medical ethicists . . . not associated with this health region . . . .”).
E. The Problems of Intramural HECs Are Worth Fixing.

HEC decisions are often corrupt, biased, careless, and arbitrary. But I write not to bury HECs but to praise them. HECs are ubiquitous. They can and do serve an important role in our healthcare system.\textsuperscript{214} HECs are not inherently flawed; they are the victims of neglect. There are at least three significant reasons that we should repair rather than replace HECs.

First, HECs are recommended by professional medical associations;\textsuperscript{215} practically required by accreditation standards;\textsuperscript{216} and often literally required by regulation and statutes.\textsuperscript{217}

Second, the trend, both in and out of healthcare, is to provide internal systems for conflict management and resolution.\textsuperscript{218} Like other forms of internal dispute resolution (IDR), HECs have significant advantages.\textsuperscript{219} For example, the members are usually concerned about the patient’s welfare and educated about the decision making process.\textsuperscript{220}

Third, for issues such as medical futility, about which we have been unable to achieve consensus, HECs have been the most constructive mechanism yet devised.\textsuperscript{221} When we cannot fruitfully address the substantive issues

\textsuperscript{214} See generally L. Doyal, Clinical Ethics Committees and the Formulation of Health Care Policy, 27 J. MED. ETHICS 44 (2001) (“In North America, CECs have . . . become part of the organizational infrastructure . . . .”); Marshall B. Kapp, Handbook for Health Care Ethics Committees, CARE MANAGEMENT J. 38, 38 (2008) (“[T]he IEC device has become a common and valuable fixture throughout the current American healthcare enterprise . . . . [F]ormal resort to the judicial system for a legally definitive adjudication is very rarely desirable from anyone’s perspective.”); Wilson, supra note __, at 173 (“HECs have become a fixture . . . .”); Wilson, supra note __, at 356 (“[H]ospital ethics committees are so ingrained in American medicine . . . .”).

\textsuperscript{215} AMDA, Resolution D97 (1997).

\textsuperscript{216} See supra notes __ to __ and accompanying text.

\textsuperscript{217} See supra note __.


\textsuperscript{219} Carolynn M. Ryan, Internal Dispute Resolution 2 (IRC Press 1998); Norman Daniels, Just Health Care: Meeting Health Needs Fairly 132 (2008) (“With a well-developed internal dispute resolution procedure, patients or clinicians adversely affected by decisions may be less inclined to seek the help of authorities . . . . Even if litigation and legislation are pursued, however, the presence of strong IDR mechanism can lead to improved external deliberation.”). But see Wilson 1998, supra note __.

\textsuperscript{220} Lynne, supra note __, at 24.

\textsuperscript{221} Fry-Revere, supra note __, at 11; Moreno, supra note __, at 93-96 (“[T]hey promise a politically attractive way for moral controversies to be procedurally
raised by treatment disputes, we can at least address how such conflicts are settled.222

So, while riddled with problems relating to independence, composition, and resources, we should focus not on replacing HECs but on improving them.223 We should not strip them of decision making power but help them exercise that power better.224 Specifically, form must follow function.225 Since the function of HECs has evolved from one of advising, clarifying, and facilitating to one of decision making, the form of HECs must evolve as well.

III. THE MULTI-INSTITUTIONAL ETHICS COMMITTEE

I contend that the corruption, bias, expertise, and procedural problems of intramural committees are largely a byproduct of their intramural nature. In Section Four, I will explain how a multi-institutional ethics committee (MI-HEC) can substantially overcome these problems. But first, in this section, I describe the nature and prevalence of MI-HECs.

There are four basic types of MI-HECs. First, there are regional networks of ethics committees. These operate like professional associations, serving as an educational resource for their intramural HEC members. Second, some institutions follow an extramural model. Because they are either unable or unwilling to form their own intramural HEC, these institutions contract with another (usually larger academic) facility to provide those services. Third, some hospitals retain their own intramural HECs but jointly form a multi-institutional committee to serve in a quasi-appellate

222 NORMAN DANIELS & JAMES E. SABIN, SETTING LIMITS FAIRLY (2002) (“When we lack consensus on principles . . . we may nevertheless find a process or procedures that most can accept as fair to those who are affected by such decisions.”).

223 Hoffman, supra note __, at 761 n.93 (“This article . . . assumes that these committees have the potential to work well and provide some benefit to their users.”); Wolf 1992, supra note __, at 93 (“Instead of offering the more radical proposal to move case review out of the institution . . . my proposal pursues a middle course. . . . In matters of health care the fox always guards the chicken coop . . . .”).

224 McCormick, supra note __, at 153 (“Because these committees are here to stay and are worthwhile, we should face their problems and objections unflinchingly and in their strongest form.”).

225 Robertson, supra note __, at 89.
role to hear particularly difficult cases. Finally, some healthcare institutions join together to create a shared multi-institutional committee that they use instead of their own intramural HECs.226

A. The Network Model

Intramural HECs may feel a sense of isolation and a desire to meet with members of other committees to share experiences and provide encouragement.227 To meet this need and to help institutions develop new HECs, many HEC networks have been established.

Across the United States a number of regional ethics committee networks serve many HEC members.228 Particularly active among these are: (i) the Kansas City Area Ethics Committee Consortium,229 (ii) the West Virginia Network of Ethics Committees,230 (iii) the Maryland Healthcare Ethics Committee Network,231 and the New Hampshire-Vermont Hospital Ethics

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226 In addition, there is “informal, curbstone discussion amongst colleagues from different institutions.” Miller, supra note __, at 207.


229 <http://www.practicalbioethics.org/cpb.aspx?pGLD=936> (“[T]he consortium is the largest and longest operating network of its kind in the nation.”).

230 <http://www.hsc.wvu.edu/chel/wv nec/> (“[T]he WVNEC is considered to be one of the largest and most successful ethics committee networks.”); A.H. Moss, West Virginia Network of Ethics Committees, 2 CAMBRIDGE Q. HEALTH CARE ETHICS 108 (1993).

Committee Network.\textsuperscript{232}

Ethics committee networks primarily provide educational materials and model policies for their member committees.\textsuperscript{233} They hold conferences and distribute materials such as newsletters and videos. Some networks provide an even more “integrated and continuous educational program.”\textsuperscript{234} Thereby, the network may enhance the informational and educational resources of its member HECs. The network enables member HECs to better serve their given institutions “but it never supplants them.”\textsuperscript{235} The individual members “retain an autonomous identity within their institutions.”\textsuperscript{236}

Networks help intramural HECs address their resources and training problems.\textsuperscript{237} But networks do not directly address their independence and composition problems.\textsuperscript{238} Moreover, unlike the extramural, quasi-appellate, and joint MI-HEC models, the network model does not engage with specific cases from member institutions. Consequently, the network model holds comparatively less promise for overcoming the problems of the intramural HEC.\textsuperscript{239}

\textbf{B. The Extramural Model}

Large hospitals and academic medical centers are more likely to have a functioning HEC than are smaller hospitals, nursing homes, and dialysis

\begin{itemize}
\item \textsuperscript{232} <http://dhmc.org> (representing the HECs of 40 hospitals and other healthcare centers).
\item \textsuperscript{233} Hoffman & Tarzian, supra note __, at 50; Miller, supra note __, at 206-07; Nelson, supra note __, at 32; Tarzian et al., supra note __, at 86.
\item \textsuperscript{234} Rosa Lynn Pinkus, The Consortium Ethics Program: An Approach to Establishing a Permanent Regional Ethics Network, 7 HEC FORUM 13, 14 (1995).
\item \textsuperscript{235} Niemira et al., supra note __, at 77.
\item \textsuperscript{236} Id. at 77. Confusingly, some networks, like the Sonoma County Bioethics Network, are referred to as “joint ethics committees.” Tex. DADS, supra note __.
\item \textsuperscript{237} Greg S. Loeben, Networking Health Care Ethics Committees: Benefits and Obstacles, 11 HEC FORUM 226, 227-28 (1999) (“[T]he benefits of HEC networking [include] . . . educational materials and methods . . . policy standardization . . . [and] exposure to problems that other institutions are currently facing, but which have not yet surfaces at one’s own institution.”).
\item \textsuperscript{238} Meece, supra note __, at 130 (envisioning teams “educated jointly” but “meeting individually for consultation on individual cases” “The cooperative would only be an educational and policy-review center.”).
\item \textsuperscript{239} Networks are also useful for non-institutional HECs. For example, in 1993, independent IRBs formed the Consortium of Independent IRBs (CIRB), to provide a central discussion area concerning public policies and issues. Heath, supra note __, at 12.
\end{itemize}
centers. Conversely, small hospitals and other facilities like nursing homes and dialysis centers are less likely to have an HEC. It may be quite challenging for small institutions, each without sufficient resources or organizational experience, to form an intramural committee or to work “horizontally” to form a joint/shared committee. Therefore, it is often easier to work “vertically.” It is often easier for “a recognized ethics center, tertiary care hospital, or state medical society [to] provide the initial leadership.”

Indeed, the Joint Commission specifically suggested using such outsourcing relationships as a way to satisfy the ethics mechanism requirement: “Patient rights mechanisms may include a variety of implementation strategies . . . [including] 24-hour access to an external consulting service . . . or . . . access to the ethics service of a large medical center in a neighboring town.”

240 Ellen Fox et al., Ethics Consultation in United States Hospitals: A National Survey, 7(2) AM. J. BIOETHICS 13, 15 (2007); Hoffman 1991, supra note __, at 116 (“[L]arge hospitals . . . and teaching hospitals are more likely to have ethics committees than small non-teaching hospitals.”); Hoffman 1991, supra note __, at 757 n.70.


242 American Medical Director Association, The Role of a Facility Ethics Committee in Decision Making at the End of Life (2008), available at <http://amda.com /governance/whitepapers/ethicscommittee.cfm>; Ken S. Meece, Long-Term Care Bioethics Committees: A Cooperative Model, 2 HEC FORUM 127, 127 (1990); How Regional Long-Term Care Ethics Committees Improve End-of-Life Care, STATE INITIATIVES IN END-OF-LIFE CARE, Jan. 2000, at 1; University of Florida College of Medicine, Community Health and Family Medicine, Clinical Ethics and Organizational Ethics Consultation Services for Hospitals and Nursing Homes, <http://chfn.ufl.edu/programs/blmp/blmp_consult.shtml> (“For many hospitals it is simply not cost-effective to maintain an active ethics committee . . . .”).

243 Niemira et al., supra note __, at 78-79; University of Florida College of Medicine, Community Health and Family Medicine, Clinical Ethics and Organizational Ethics Consultation Service for Hospitals and Nursing Homes, <http://chfn.ufl.edu/programs/blmp/blmp_consult.shtml> (“For many hospitals it is simply not cost effective to maintain an active ethics committee which meets Joint Commission requirements.”).

244 Id.

245 JOINT COMMISSION 1994 MANUAL, supra note __, at 10. In the 1950s, the work of Marin General Hospital’s therapeutic abortion committee became “accepted so widely that the other three hospitals of the [San Rafael] community now refer all their applications for therapeutic abortion to this committee for review- a most unusual arrangement.” Howard Harmond, Therapeutic Abortion: Ten Years Experience with Hospital Committee Control, 89 AM. J. OBSTETRICS & GYNECOLOGY 349, 350-51 (1964).
A typical extramural MI-HEC entails the smaller facility outsourcing its ethics committee work to the larger facility.246 The larger facility has resources and experience that the smaller facility could not sustain on its own. Some large institutions have recognized the smaller facilities’ need, and have created extramural services suited to serving the smaller institutions. For example, the Wake Forest University Medical Center, recognizing its “importance” to the region, anticipates that its Bioethics Committee will assist “other organizations including some smaller hospitals.”247

Florida law specifically anticipates that one healthcare facility might use another healthcare facility’s HEC. When a guardian wants to withdraw life-sustaining treatment from a patient, that decision must be confirmed by the HEC.248 If there is no HEC at the facility, then “the facility must have an arrangement with the medical ethics committee of another facility or with a

246 See, e.g., COLO. REV. STAT. § 15-18.5-103(6.5) (“If there is no medical ethics committee for a health care facility, such facility may provide an outside referral for such assistance or consultation.”); Md. Health-Gen. Code § 19-371(b)(2) (“An advisory committee at a related institution may function jointly with a hospital advisory committee.”); AMDA, supra note __ (“Other options for smaller facilities may include collaboration with local hospital ethics committees”); Texas Department of Aging and Disability Services (DADS), Ethics Committees and Ethics Process, qmweb.dads.state.tx.us/Ethics.htm (“A LTC facility can utilize an external ethics committee (i.e. one that is in a hospital, is community-wide, or part of another LTC facility) . . . .”); Nelson, supra note __, at 32; St. Peter’s Hospital, <http://stpetes.org.html/Patient/patientinformation.php> (“We assist the hospital, home care, and hospice when they have questions or dilemmas.”).
247 Wake Forest University Health Sciences, Main Ethics Committee By-Laws & Procedures, http://www1.wfubmc.edu/bioethics/CommitteeStructure/>. See also University of Pennsylvania Center for Bioethics Mediation Service (“Specific applications at your institution: Using the Service as an alternative or complement to existing ethics mechanisms.”) (“For institutions without existing ethics mechanisms, our Service can provide a complete program.”); Medical College of Wisconsin, http://www.mcw.edu/populationhealth /Services.htm> (“The Center for the Study of Bioethics has established and staffs a clinical consultation service for hospitals and health care institutions in the Milwaukee area.”); Dartmouth Hitchcock Medical Center, <http://dhmc.org> (“The DHMC Bioethics Advisory Committee will consider providing advice if requested by staff of community hospitals and nursing homes.”); Cleveland Clinic Bioethics Department, <http://my.clevelandclinic.org /bioethics/services/consultation.aspx> (“External agencies [may] request a formal analysis or recommendation about a case.”); Columbus Community Hospital, Ethics Committee, <http://www.cch.inc.com/internet/home/columbus.nsf /Documents/532E2> (“The committee . . . addresses relevant issues to the hospital, the nursing home, and the community.”); Bolin 2008, supra note __ (describing program run by Texas A&M Health Science Center).
248 FLA. STAT. ANN. § 765.404(2).
More recently, extramural HECs have been provided not only by another (larger) institution’s HEC but also by an academic unit or by independent organizations formed specifically to provide such services. For example, Kansas Health Ethics, Inc. offers consultation services on a sliding fee scale to help resolve healthcare ethics dilemmas. Other organizations, such as the Health Priorities Group (formerly Bioethics Consultation Group) and The Ethics Practice, consult with healthcare institutions. Bioethics Services of Virginia operates in a similar way. In addition, some networks are planning to move beyond education to “serve as a resources for consultation or mediation” in specific cases.

In Ontario, the Consent and Capacity Board (CCB) operates as an extramural ethics committee. The CCB is a body created by the Ontario government under its Health Care Consent Act. “When ‘in-house’ conflict resolution fails, CCB can mediate. If this mediation fails, CCB adjudicates . . . .” The CCB is, in short, “an independent, quasi-judicial

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249 Id. The University of Florida offers such a service. University of Florida College of Medicine, supra note __. Similarly, Maryland law anticipates that a nursing home ethics committee might function “jointly with a hospital advisory committee.” MD. HEALTH-GEN. CODE § 19-371(b).


252 <http://bioethic.cust.he.net>.

253 __, Berkeley, California.

254 <http://bsvinc.com/services.htm> (BSV “offers a full array of medical ethics programming functions, including: Ethics Committee Development and Support . . . Case Consultation . . . .”).

255 See, e.g., Health Care Ethics Consortium of Georgia, <http://www.hcecg.org/membership>; Baruch, supra note __.


tribunal,” a “neutral, expert board,” that for intractable treatment disputes can make a “legal, binding decision that can only be reversed on appeal through the courts.”

Again, we can gain useful guidance for the HEC from its older cousin, the institutional review board for human subjects research. The extramural model is well-developed in the research context. Over the past decade, there has been an exponential expansion of independent or “central” IRBs.

Independent IRBs review research proposals (to assure adequate protection of human subjects) for entities that are not affiliated with the IRB. Oftentimes, much research is done in smaller facilities and physician’s offices where the economy of scale precludes forming an IRB. Also, multi-center research is more efficiently reviewed by a single IRB than duplicitous review at each participating site. Accordingly, institutions have developed new models of IRB review, including where one institution relies on the review of another institution’s IRB, or where multiple institutions rely on the review of an independent IRB.

In contrast to the network model, the extramural model engages with specific cases from member institutions. Since the decision maker is separate and independent from the facility in which the case arose, the extramural model offers promise for overcoming corruption problems with the intramural HEC. Both with a higher volume of cases and with the incentive to maintain its “customers,” the extramural HEC can achieve efficiencies of scale to also overcome the intramural HEC’s problems of

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258 Id.


260 Heath, supra note ___ , at 2.

261 21 C.F.R. § 56.114 (“[I]nstitutions involved in multi-institutional studies may use joint review, reliance upon the review of another qualified IRB, or similar arrangements aimed at avoidance of duplication of effort.”).

bias, carelessness, and arbitrariness.

C. The Quasi-Appellate Model

Just as ethics committees are a step removed from the treatment team, some have proposed what is, effectively, an ethics committee for the ethics committee.263 Some hospitals retain their own internal ethics committee but join with others to form a separate shared committee that hears only particularly complicated cases.264 Each institution sends representatives to serve on a panel that serves all the member institutions. On this model, disputes first go to the intramural HEC. If the dispute is not resolved intramurally, then it goes to the MI-HEC.265

263 JAMES F. DRANE, CLINICAL BIOETHICS: THEORY AND PRACTICE IN MEDICAL ETHICAL DECISION MAKING 163 (1994) (“If conflict remains intractable and the decision preferred by the surrogate or patient conflicts with institutional policy, then the health care ethics committee should move the case to a more authoritative/regional committee . . . .”); George P. Smith, Restructuring the Principle of Medical Futility, 11(3) J. PALLIATIVE CARE __ (1995) (proposing a three-tier decisional structure in which the third tier recognizes a right of limited appeal to the courts); Truog, supra note __, at 2 (“Some have suggested setting up ad hoc ethics committees with a membership . . . without any financial or social ties to the hospitals they serve, specifically to offer a more legitimate sounding board for difficult cases in which the hospital ethics committee could be seen as having a conflict of interests or biased perspective.”).

264 Michelle Hey, Shared Corporate Ethics Committee: Two Systems Collaborate to Enhance Ethical Decision Making, HEALTH PROGRESS, Sept. 1994 (“Cincinnati-based Mercy Health System and Radnor, PA-based Eastern Mercy Health System have formed a Shared Corporate Ethics Committee (SCEC). . . . Local facilities will retain their own ethics committees but benefit from the [system] guidance of the shared committee.”). See also Allan R. Fleischman, An Infant Bioethical Review Committee in an Urban Medical Center, HASTINGS CENTER REP., June 1986, at __ (describing “interlocking committees” among four related New York City hospitals in which “members from all four hospitals meet monthly to develop general guidelines and procedures and to review all cases that have been discussed by the individual committees”); M. Fukuyama et al., A Report on Small Team Clinical Ethics Consultation Programmes in Japan, 34 J. MED. ETHICS __ (2008) (describing requests to the “Clinical Ethics Support and Education Project” from “the ethics committees of medical institutions, suggesting that even ethics boards were finding difficulty”) (Still, the authors would “never consider it appropriate to replace local consultation services with our distance team consultants. . . . Our activities should be regarded as supplementary.”). A quasi-appellate panel could also serve as an extramural committee. Cf: Email from Dr. David Fleming, University of Missouri Center for Health Ethics (June 2008) (on file with law review) (“Most, if not all, of the outlying hospitals that we serve do have ethics committees, and we serve to support their efforts with the most difficult cases.”).

265 Miller, supra note __, at 210-13 (including a flow chart illustrating the operation of what I refer to as the quasi-appellate model). See also KENNETH A. FISHER, IN DEFIANCE OF DEATH: EXPOSING THE REAL COSTS OF END-OF-LIFE CARE 30-31 (2008) (proposing a “three-tiered (local, state, and national) Appropriate Care Committee System”).
Unaffiliated private hospitals have experimented with quasi-appellate HECs. At least one has been formed and implemented. In Fort Wayne, Indiana, three separate institutions formed a “community ethics consensus panel” to handle disputes that cannot be resolved by an institution’s intramural HEC. Each institution sent three representatives who are joined by a local philosophy professor and a local attorney. The panel provides another level of review when a conflict cannot be resolved internally.

Perhaps the most notable example of the quasi-appellate model is found in the Veterans Health Administration. Each VA facility has its own ethics committee. But there is also a central, national ethics committee available to provide consultation to “field-based ethics programs on request.” However, unlike the Ft. Wayne MI-HEC, the VA central committee only advises and does not approve or reject a recommendation or decision made by a HEC.

As with the extramural model, the quasi-appellate model has an analog in the research context. For research on vulnerable populations, a local IRB must seek second level review. Similarly, in New Zealand, the 1990 Research Council Act established the Health Research Council Ethics Committee, a national ethics committee “to review the independent ethical assessment made . . . by an approved ethics committee.”

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266 Susan Fox Buchanan et al., A Mediation/Medical Advisory Panel Model for Resolving Disputes about End-of-Life, 13 J. CLINICAL ETHICS 188 (2002) (describing the The Colorado Collective for Medical Decisions). See also Scannell, supra note ___ (describing a proposal for the “creation of an independent organization composed of diverse community and professional representatives who would advise hospitals or help make decisions for their friendless incompetent patients.”)


268 Phillips, supra note __; see also Denver Community Bioethics Committee, supra note __ (“The DCBC can also serve as a resource to other institutional ethics committees, providing ‘second opinions’ and additional review of cases.”); University of Florida, supra note __ (“Even hospitals which maintain an ethics committee may benefit from the consultation services we offer . . .”).


270 AAMC TASK FORCE ON FINANCIAL CONFLICTS OF INTEREST IN CLINICAL RESEARCH (Dec. 2001) (“When the ICOI has determined that compelling circumstances exist . . . the institution should consider the desirability of contracting with an external IRB to provide a second level of review.”). Cf. DHHS, Standards for Institutional Review Boards for Clinical Investigators, 43 Fed. Reg. 35,186, 35,191 (Aug. 8, 1978) (permitting the creation of an “appellate IRB”).

271 Act § 25.
HRCEC currently provides only “nonbinding second opinions,” the Minister of Health is “attempting to establish an appellate committee.”

**D. The Joint Committee Model**

While a quasi-appellate HEC serves member institutions that each still retains its own intramural HEC, a joint committee serves institutions that do not each have their own internal ethics committee. On this model, the joint (or “shared”) committee is the “principal ethics forum for its participating institutions,” each of which sends representatives to the joint committee. Institutions form joint committees for two basic reasons: either they cannot form an intramural HEC, or it would be more convenient to use a joint committee.

1. **Joint Committees for Institutions Unable to Form their Own Intramural HECs.**

Healthcare facilities such as freestanding dialysis clinics, nursing homes, and rural hospitals are unlikely to have their own intramural HECs. These facilities are too thinly staffed. To address this problem, the American Medical Association advises these healthcare facilities “without ethics committees” to “develop flexible, efficient mechanisms of ethics review that divide the burden of committee functioning among collaborating health care facilities.”

Similarly, Maryland encourages non-hospital institutions to operate joint committees. A 1990 statute specifically anticipates that a nursing home

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273 Nelson, *supra* note __, at 33 (“Each participating facility would identify one or two professionals to serve on the committee . . . .”); Niemira, *supra* note __ at 78; MD. HEALTH-GEN CODE § 19-372(a)(1)(iv) (“Each advisory committee shall [include] the CEO or a designee from each hospital and each related institution represented on that advisory committee.”).

274 AMDA, *supra* note __ (“Smaller facilities may not have the personnel or the volume to maintain an ethics committee.”).

275 AMA CODE OF MEDICAL ETHICS § E-9.1115. See also AMDA, *supra* note __ (“Other options for smaller facilities may include collaboration with other nursing homes . . . .”); Levine, *supra* note __, at 11 (“[S]everal such . . . small community . . . hospitals might together form a committee . . . .”)

276 MD. HEALTH-GEN. CODE § 19-371(b); see also TEX. ADMIN. CODE tit. 25 § 405.60 (“The committee may be established multi-institutionally in cooperation with other health care providers, e.g. local hospitals serving the same geographic area.”); 45 § C.F.R. 84.55(f)(1)(i) (“The hospital establishes an Infant Care Review Committee (ICRC) or joins
ethics committee may function: “jointly with an advisory committee representing no more than 30 other related institutions.” 277 Pursuant to this statute, the Health Facilities Association helped establish eight joint committees, each composed of four to six facilities. 278

Other cooperative regional ethics committees have been created for institutions unable to create one individually. 279 For example, the National Kidney Foundation of Kansas and Western Missouri and the Center for Practical Bioethics created a “standing ethics committee” that functioned to provide “individual consultations” among other services. 280 The Dubuque Regional Healthcare Ethics Committee established “a service for facilities and agencies in the tri-state area [Iowa, Wisconsin, Illinois] which do not have their own ethics committee.” 281

Perhaps most impressive is the even broader system of joint committees established in New Jersey. While New Jersey law mandated a “dispute resolution mechanism” like an ethics committee, 282 as early as 1990, the “[s]taff of long-term care facilities often do not have the knowledge and experience to address complex ethical issues.” 283 So, starting in 1996, under the Direction of the Office of the Ombudsman for the Institutionalized Elderly, New Jersey formed and trained a statewide network of fifteen “Regional Long Term Care Ethics Committees” to serve the state’s nearly 400 long-term care facilities. 284 Most of these regional committees consult

with one or more other hospitals to create a joint ICRC.”). 277 MD. HEALTH-GEN. CODE § 19-371(b).

278 Tex. DADS, supra note ___; see also Ethics Advisory Committee of Levindale and Jewish Convalescent Nursing Home, <http://lifebridgehealth.org/physdir.cfm/levindalebodidy.cfm?id=3577>.

279 Heitman, supra note __, at 43 (1995).

280 E.C. Grochowski & E. Blacksher, Collaborative Ethics: A Standing Renal Dialysis Ethics Committee, 7 ADVANCES RENAL REPLACEMENT THERAPY 355, 355 (2000). While, the Kansas City committee is still the only one among the 52 NKF affiliates, other committees could be “linked together under the national umbrella.” Id. at 357. While the committee may not have actually done much consultation, it was certainly positioned to do so. Email from Terrence Rosell to Thaddeus Pope, May __, 2008 (on file with law review).

281 Loras College, supra note __. See also IOWA ADMIN. CODE § 641-85.3(2) (allowing the formation of “multi-county local substitute medical decision-making boards”).

282 ___


284 Id. See also STATE OF NEW JERSEY OFFICE OF THE OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY, 2006 ANNUAL REPORT 10 (2006). The facilities in each
on a regular basis.285

2. Joint Committees for Convenience

While the most common motivation for joint ethics committees is necessity, some are formed for convenience. For example, in Chico, California providers formed a joint committee serving both Enloe and Chico Community Hospital.286 Since most physicians had staff privileges at both institutions, this was motivated by a concern to avoid duplication of effort.

Again, there is an analogy in the research context. Centers engaged in multi-site research sometimes form a consortium by which each agrees to accept review by the IRB of any other participating institution.287 Notable examples include Biomedical Research Alliance of New York (BRANY),288 the Multicenter Academic Conical Research Organization (MACRO),289 and the Michigan State University Community Research IRB (CRIRB).290 It is important to distinguish one type of joint committee. Often committees that are part of the same corporate health entity may establish committees that serve more than one facility. For example, the HEC of the Pittsburgh Mercy Health System in Pittsburgh serves three hospitals.291 There are

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286 Email from Becky White to Thaddeus Pope, May 5, 1998 (on file with law review). There were four outside members and other members unique to each hospital. The larger of the two hospitals subsequently purchased the smaller. Id.

287 Meeker-O’connell, supra note __.


289 <http://med.upenn.edu/ohr/aboutmacro.html>.


291 Pittsburgh Mercy Health System, <http://mercylink.org>; see also Mercy Health Partners of Northwest Ohio, <http://www.ehealthconnection.com/regions/toledo>; Health Progress __ (joint committee between eastern Mercy and Mercy Health Partners, separate corporations under the broader Sisters of Mercy umbrella); MedCentral Health System, <http://www.medcentral.org/default.cfm?id=123> (one HEC for a system of two hospitals and other facilities); Kendra Rosencrans, God, Medicine, Money: Religious Secular Union Raises Ethical Issues, DULUTH NEWS TRIBUNE, Apr. 28, 1996, at 1A.
many other examples. But it is unclear whether such joint committees of
entity-related institutions achieve the same degree of independence as the
joint committees of unaffiliated institutions.

Since some facilities lack the resources to support an intramural HEC, a
quasi-appellate MI-HEC is not a realistic option. For these institutions, the
joint MI-HEC model offers promise for overcoming problems with the
intramural HEC.

IV. THE MULTI-INSTITUTIONAL ETHICS COMMITTEE CAN MITIGATE THE PROBLEMS OF INTRAMURAL HECs.

While a MI-HEC cannot solve all the problems of the HEC, it goes a
substantial way. The MI-HEC can significantly ameliorate deficiencies
regarding resources, competence, and independence. Indeed, this was
suggested by the Joint Commission in its influential accreditation
standards. Encouragingly, multi-institutional committees appear to be
working to address similar problems in IRBs. Given the affinity between
HECs and IRBs, MI-HECs should be able to replicate this success. We
should, therefore, chart a course for HECs based on prior voyage of IRBs.

A. MI-HECs Mitigate the Risk of Corrupted Decisions.

If a decision maker’s deliberation is distorted by pressure and biases, then
the typical solution is to get another decision maker. An MI-HEC is just

292 Tex. DADS (“Mt. St. Vincent Nursing Home in Holyoke, Massachusetts
established an ethics committee that served three LTC facilities . . . under the ownership
of Sisters of Providence Health System.”); Diane E. Hoffman, Does Legislating Hospital
Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in
Maryland, the District of Columbia, and Virginia, 19 L. MED. & HEALTH CARE 105, 107
(1991) (“In two cases, two hospitals shared the same committee . . . .”); <http://www.smdc.org>
(share committee with Duluth Clinic after merger); Joanne Davidson, Children’s Future Will
Reap Reward of ‘Planting’ Dinner, DENVER POST, Apr. 7, 1996, at E07 (Dr. Maxine Glaz
co-chair of six-hospital joint ethics committee); cite (Dr. Dennis A. Ruff. Chaired a joint St.
Lukes and Methodist bioethics committee in 1988-89).

293 Most significantly, HECs need additional procedural due process protections. See
generally Wilson, supra note __; Wolf, supra note __.

294 See Thaddeus Mason Pope, Multi-Institutional Ethics Committees for Rural
Hospitals, and Urban Ones Too, 8(4) AM. J. BIOETHICS 69 (2008).

295 JOINT COMMISSION, supra note __. See also Banerjee & Kuschner, supra note __,
at 143 (“Consideration should be given to an external reviewing mechanism for the
oversight of HEC . . . .”).

296 ABA MODEL CODE OF JUDICIAL CONDUCT (2008); JAMES SAMPLE ET AL., FAIR
McDERMOTT & A.E. BERKELEY, ADR IN THE WORKPLACE: CONCEPTS AND TECHNIQUES
such a source of independent evaluation. With respect to independence, the MI-HEC will be less beholden to the peculiar social relationships at any one institution.\textsuperscript{297} Indeed, sometimes an external HEC is sought specifically because of its independence.\textsuperscript{298}

For example, Cook and Hoas describe several futility cases in which the provider’s decision about whether to accede to the surrogate’s request for continued treatment was materially influenced by the family’s money and influence.\textsuperscript{299} In contrast, a MI-HEC would presumably be less willing to accede to an 86-year-old terminal cancer patient’s request for surgery because he “was influential, well-known, and respected in the

\textsuperscript{297} Cho & Billings, supra note __, at 157 (suggesting “independence from any single institution, i.e. regional or non-institutional review boards” to “minimize individual and institutional conflicts of interest”); Denver Community Bioethics Committee, supra note ___ (“Because the DCBC is not attached to any particular institution . . . it offers objective, thoughtful consideration of tough issues.”); Frazier, supra note __ (“Airing a case before a community panel might help alleviate concerns that a hospital’s recommendation that life support be removed is being made in its own self-interest . . . “)); Glantz, supra note __, at 133 (“One objective in encouraging diversity in the composition of committees, both IRBs and IECs, is to keep the committees honest.”); Hoffman 1991, supra note __, at 763 (“Less susceptible to the criticism that it is representing the interests of the institution rather than those of the patient”); id. at 785 (arguing that “includ[ing] members from outside the health care institution” having the committee “represent more than one institution” can help overcome the puppet problem); Kimberlee K. Kovatch, Neonatology Life and Death Decisions: Can Mediation Help? 28 CAP. U. L. REV. 251 (2000) (recommending outside mediators); Smith et al., supra note __, at 1274 (“A review committee with significant membership from outside the hospital where the patient in question has been admitted could potentially diminish institutional bias (or its appearance) . . . ”); Schluppi & Faser, supra note __, at 297 (“Other possible solutions are to move to greater independence from the institution – for example by using a regional committee . . . “)); Spielman, supra note __, at 192 (describing problems with in-house dispute resolution programs).

\textsuperscript{298} Before stopping its selling of ethics services for tax reasons, the University of Pennsylvania offered its mediation service as “truly independent.” Penn Center for Bioethics Mediation Service, <http://bioethics.upenn.edu/mediation>. So, if another Philadelphia-area hospital referred a case to Penn, the Penn ethics committee would be substantially free from any incentive to appease the medical staff or administration of the referring hospital.

\textsuperscript{299} Cook & Hoas 2008, supra note __. See also Cook & Hoas 1999, supra note __, at 136 (“The costs associated with a complicated, un-insured case can compromise the health of an entire community.”).
community.” 300 And it might be more circumspect about denying “recommended vaccinations” to a premature infant “because his less influential family lacked funds to pay for the procedure.” 301

Since at least a majority of a MI-HEC’s members would come from other institutions, the MI-HEC would not be swayed by these factors. 302 A major criticism of intramural HECs is that they cannot “procure an extra-institutional professional appraisal of the medical facts.” 303 But that is precisely what a MI-HEC offers. As bioethicist Art Caplan observed twenty-five years ago, a more diverse HEC is less likely to fall captive to one person or perspective. 304 It better ensures a more unbiased, impartial review. 305

This is perhaps best illustrated by In re Torres. 306 Rudolfo Torres was a patient at the Hennepin County Medical Center. Mr. Torres became comatose likely as the result of medical malpractice. His providers determined that the appropriate course of action was to remove his ventilator. The chair of the HCMC HEC recognized its inability to make an independent judgment in Torres because the negligent incident occurred there. 307 So, it declined to review the case. 308 Instead, HEC chair Ronald

300 Cook & Hoas 2008, supra note __.
301 Id.
302 Bolin 2008, supra note __, at 65 (“The virtual ethics committee model allows . . . a neutral committee unlikely to be affected by small town politics.”); Fukuyama et al., supra note __ (“The consultation service offered by our project was . . . independent of any specific medical institution. There was no conflict of interest between the consultants and the clients, and thus we could freely provide candid advice.”); Penn Center for Bioethics Mediation Service (“Our Service is designed to avoid problems associated with traditional in-house ethics mechanisms . . . . Our Service has a number of advantages: . . . *Preservation of integrity . . . where staff might be compromised via association with outcomes desired by powerful clinicians or hospital administrators. *Enhancement of integrity when the institution acknowledges and manages its potential, perceived, or actual conflicts of interest.”). The Quinlan court anticipated an HEC would “screen out” cases “which might be contaminated by less than worthy motivations of family or physician.” Quinlan, 355 A.2d at 669. Similarly, a MI-HEC can screen out cases contaminated by less than worthy motivations of an intramural HEC.
303 Wilson, supra note __, at 379
304 Arthur Caplan, ___, in CRANFORD & DOUDERA, supra note __, at __, __. Cook & Hoas 1999, supra note __, at 136 (suggesting a shift to “inter-institutional activities” would “facilitate the inclusion of more voices and perspectives”).
305 Jaffe, supra note __, at 428
306 357 N.W.2d 332 (Minn. 1984).
307 ___ Contrast Memorial Hermann Hospital in Houston, which had its own HEC review the treating physician’s decision to withdraw LSMT under similar circumstances. See supra note __ to __ and accompanying text.
308 Torres (Amicus brief by Minnesota Hospital Association).
Cranford employed the extramural model. He asked the ethics committees of three other hospitals to determine whether the withdrawal of life-sustaining medical treatment was appropriate.\textsuperscript{309} The Minnesota Supreme Court found these reports very useful.\textsuperscript{310}

Again, the experience with IRBs provides guidance. While many institutions outsource review to independent IRBs for the sake of efficiency, many also do so to avoid the logistical problems of staffing the IRB in a way to mitigate conflict of interest.\textsuperscript{311} For example, New Zealand has employed regional committees for nearly twenty years, since a scandalous Tuskegee-like study involving cervical cancer.\textsuperscript{312} In New Zealand “[i]ndependence from the providers of care and researchers [came] to be seen [as a] sine qua non.”\textsuperscript{313}

But perhaps I have too readily concluded that MI-HECs can achieve the requisite independence. Commentators have made to objections to the use of MI-HECs to address independence and bias problems. First, Richard Saver\textsuperscript{314} argues that experience with corporate boards of directors suggests that the MI-HEC will not improve HEC performance. Just as adding more independent directors (i.e. directors not otherwise affiliated with a company) to a corporate board does not improve board director performance, adding committee members will not ameliorate similar problems in HECs.\textsuperscript{315}

\textsuperscript{309} Wolf, \textit{supra} note __, at 13.
\textsuperscript{310} In re Torres, 357 N.W.2d 332, 336 n.2 (Minn. 1984) (“[T]hese committees are uniquely situated to provide guidance to physicians, families, and guardians when ethical dilemmas arise.”).
\textsuperscript{311} OFFICE OF INSPECTOR GENERAL, DEPT. OF HEALTH & HUMAN SERVICES, IRBS: THE EMERGENCY OF INDEPENDENT BOARDS ii (June 1998) (“They provide a detached source of expertise . . . .”); \textit{id.} at 6 (“[D]etachment leads to greater objectivity.”); \textit{id.} (“[T]he independent IRBs can operate without being influenced by concerns about the financial well-being or prestige of the institution that employs them or the career interests of colleagues.”).
\textsuperscript{312} CARTWRIGHT, REPORT OF THE COMMISSION OF INQUIRY INTO ALLEGATIONS CONCERNING THE TREATMENT OF CERVICAL CANCER AT NATIONAL WOMEN’S HOSPITAL AND INTO RELATED MATTERS 151 (1988) (attacking HECs as “too closely attached . . . to be entrusted . . . . [T]he Auckland Hospital Board must establish an ethics committee which is able to be more detached . . . .”).
\textsuperscript{313} Donald Evans, \textit{Ethical Review of Innovative Treatment}, 14 HEC FORUM 53, 53-54 (2002). \textit{See also} Soren Holm, \textit{Ethics Committees in Europe}, 18(67) NOTIZIE DI POLITEIA RIVISTA DI ETICA E SELCETE PUBBLICHE 54, 55 (2002) (In most Nordic countries research ethics committees are established regionally to “make them independent of institutional interests,” though clinical ethics committees “are linked to specific institutions”).
\textsuperscript{314} Richard Saver is a law professor at the University of Houston.
\textsuperscript{315} This is the position of the Singapore Health Minister Khaw Boon Win. While the
But Saver’s argument is inapposite here. The MI-HEC entails a more significant organizational upheaval than making mere “numerical changes in the insider/outside mix.” The MI-HEC entails a more dramatic change in the very organization of the HEC, delegating the deliberation and decision making to a wholly separate committee.

The second objection, from Susan Wolf, is that MI-HECs are just like HECs in that they are still “dominated by health care professionals employed at the cooperating institutions.” While a HEC looks out for its sponsoring institution, a MI-HEC is not much better. It looks out for the joint and several interests of its member institutions.

While MI-HECs draw from much the same “pool” as intramural HECs, available data do not suggest that professional comraderie corrupts or biases MI-HEC decisions. While corporations are repeat players, “statistics of favoritism within ADR processes have yet to be documented.” Independent review has been endorsed by the FDA, the OHRP, and the National Cancer Institute. Moreover, even if Wolf is correct that MI-HECs cannot eliminate corruption, they materially mitigate it in the first instance.

### B. MI-HECs Mitigate the Risk of Biased Decisions.

To address the risk of biased decisions, the MI-HEC can draw from a...
broader diversity of voices and perspective. This is analogous to broadening the roster of arbitrators so that the pool does not favor either party. Just as the HEC was proposed as a check on the idiosyncrasies of individual providers, the MI-HEC serves as a check on the idiosyncrasies of an intramural HEC.

C. MI-HECs Mitigate the Risk of Careless Decisions.

To address the risk of careless issues, the MI-HEC can draw from a broader pool of professional and community representatives. It can harness more disciplinary expertise, include more disciplinary perspectives, and support more formal training than an individual intramural ethics committee.

An individual institution may not have the time, money, or expertise for an adequate HEC. The MI-HEC can help an individual institution overcome its lack of adequate ethics resources in that each hospital benefits from the input and deliberation of a large multidisciplinary body, yet must contribute only a fraction of the membership and a fraction of the cost. “This model has the potential to be efficient and effective by sharing ethics expertise and financial support.” Support could be pooled without overly taxing any individual institution, allowing more resources to be spent on educating members.

322 Cook & Hoas, supra note __, at 137.
324 M. BRAZIER & E. CAVE, MEDICINE, PATIENTS, AND THE LAW (2007) (“Given a sufficiently large and diverse committee, there will always be people who represent different ethical viewpoints present and each perspective will, at least, get a chance to make its case.”).
325 Cf. Heath, supra note __, at 13 (“Recruitment of members for an independent IRB is usually from a broader pool.”).
326 Cf. Cartwright, supra note __, at 151 (“National Women’s Hospital is too small an institution . . . lacks the broad scientific and ethical bases needed . . . .”); Glantz, supra note __, at 130 (arguing the fact that “[d]ifferent groups have different primary concerns, . . . seems to be a good argument for having people from different fields on each IRB . . . .”); Nelson 2007, supra note __.
327 Cook & Hoas, supra note __, at 135.
328 Cook & Hoas 1999, supra note __, at 137 (“It would also allow hospitals to share training and technical assistance resources.”); Hoffman, supra note __, at 763 (observing that a joint committee is “likely to be better educated,” and “could spend more resources on workshops”); Nelson, supra note __, at 32 (“When there are limited resources at one facility to support an ethics committee, another option is a multi-facility ethics committee (MFEC).”).
329 Nelson, supra note __, at 33.
330 Hoffman, supra note __, at 762 (arguing it would be more efficient to have
For example, if each of three rural Montana hospitals were individually too small to support its own ethics committee, they could pool their efforts. Each could contribute one-third of the committee’s members and pay one-third of library materials, CME, clerical support, and other costs.\textsuperscript{331} In short, shifting to “inter-institutional activities” can achieve “economies of scale.”\textsuperscript{332}

**D. MI-HECs Mitigate the Risk of Arbitrary Decisions.**

MI-HECs not only mitigate the risk of corrupt, biased, and careless decisions, but they also address the lack of procedures and methods in intramural HECs. Since the MI-HEC serves several institutions, it must operate with greater transparency and accountability. The higher volume of referrals gives the MI-HEC more experience.\textsuperscript{333} And with a greater caseload, the MI-HEC will work more formally.\textsuperscript{334} More uniformity creates consistency and reliability in decision making.

**E. Summary of MI-HEC Advantages**

[Summarize the problems in section II, the nature of the MI-HEC in section III, and especially how it solves those section II problems in IV.A-C]

**V. OVERCOMING CHALLENGES TO THE FORMATION OF MI-HECs**

There is not much debate that MI-HECs can eliminate or at least substantially mitigate the independence, composition, and resources problems of intramural HECs. Yet, there remains an utter dearth of MI-

\textsuperscript{331} Berkowitz & Dubler, \textit{supra} note __, at 143; Niemira, \textit{supra} note __, at 80 (arguing that MI-HECs “hold the promise of consolidating resources”).

\textsuperscript{332} Cook and Hoas 1999, \textit{supra} note __, at 138.


HECs across the United States. So, it seems the real challenge is not proving the benefit offered by MI-HECs, but proving that these benefits outweigh the costs.

MI-HECs present their own problems and challenges. They take time and effort to form and operate. They may be too detached from the institutional context in which cases arise. And there are liability, confidentiality, and communication logistics problems.

But these challenges can be readily overcome. Indeed, these challenges demonstrably already are overcome by existing MI-HECs. In the end, the greatest challenge may not be convincing institutions that MI-HECs are a viable solution to the intramural HEC problems, but convincing them that those problems exist and are worth addressing.

A. Classic Obstacles to MI-HECs

1. Transaction Costs

Some have argued that institutions are “unlikely to come together to plan joint committees because of the transaction costs.” “It takes time and expert personnel to develop and implement a single ethical policy.” Intramural HECs often do not have the “necessary money [to] find and allocate time in order to resolve present and evolving ethical issues.” But an MI-HEC does not obviously produce a net savings. Each institution must invest time and resources simply to coordinate with the other member institutions.

But the organizational costs may not be too onerous. There are organizations already in place, like county medical societies, that can

335 The primary exception is where MI-HECs for long-term care facilities in states like Maryland and New Jersey, where they are an appealing vehicle for satisfying regulatory requirements.

336 Hoffman, supra note __, at 769; Smith et al., supra note __, at 1274-75 (“[T]his procedural change would then raise concerns about . . . administrative burden.”); see also Cook & Hoas 1999, supra note __, at 135 (expertise, resources, not think need); Nelson, supra note __, at 30 (explaining that staff in rural hospitals “have little time to participate on a committee and the facility has limited economic resources to support the committee”); Scannell, supra note __ (“[N]o financial . . . support is available for such an undertaking and structure.”). Cf. Caroline McNeil, Debate over IRBs Continues as Alternative Options Emerge, 99 J. NAT’L CANCER INST. 502, 503 (2007). (“Another barrier to the use of central IRBs is confusion over how local and nonlocal boards can work together.”).

337 Monagle & West, supra note __, at 260.

338 Id.
help. Costs can be defrayed by each institution that requests consultation. Moreover, any costs would be a prudent investment because an effective ethics committee can reduce operational costs, legal costs, and marketing costs. Ethics committee “costs would be minor compared with the cost of litigation (which hopefully would be avoided).”

2. Locality

It has long been considered important for HECs to be “local.” Similarly, has long been considered important for IRBs to be local. For either committee to be effective, it must be familiar with the cultural milieu of the institution and the local community. Therefore, “[a]t least one argument against joint committees, however, is that health care institutions are unique and need to be attuned to the unique characteristics of each institution and to its staff.”

While this argument has some force against extramural model in which an

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339 Miller, supra note __, at 211.
341 Caulfield 2007, supra note __; Miller, supra note __, at 211; Nelson, supra note __, at 30 (“[E]thics committees can be economically beneficial for the organization.”); DEPARTMENT OF VETERANS AFFAIRS, A BRIEF CASE FOR ETHICS (2007). See also Banerjee & Kuschner, supra note __, at 143 (reviewing literature showing “measurable benefits” from ethics committees).
342 An early version of the patient Self Determination Act required ethics committees. S. 1766, 101st Cong. (1989). But the requirement was dropped because of a desire for local control. Fletcher, supra note __, at 871; Hoffman, supra note __, at 753. Some significant opposition to 1983 Baby Doe rules rested “on the grounds that local ethics review would be more valuable.” Heitman, supra note __, at 411.
343 21 C.F.R. § 56.107(a) (“The IRB shall have . . . sensitivity to such issues as community attitudes . . . .”); 45 C.F.R. § 46.107(a). In the IRB context local review is desirable because local members know: (i) the research, (ii) the resources, (iii) the reputation of the investigators, (iv) the capabilities of the investigators, and (v) the attitudes of the community. And local members can build a culture of trust. Steven Peckman, Local Institutional Review Boards, in 2 ETHICAL AND POLICY ISSUES INVOLVING HUMAN PARTICIPANTS (NBAC 2001). Local review committees have traditionally been considered better than national ones or regional ones because they are more familiar with actual conditions surrounding the conduct of the research and can work closely with investigators. See NATIONAL COMMISSION, REPORT AND RECOMMENDATIONS IRBs (1978).
344 OIG, supra note __, at ii, 6; OHRP, IRB KNOWLEDGE OF LOCAL RESEARCH CONTEXT (July 21, 2000). Some objected to even intramural HECs as “undesirable bureaucracy not sufficiently close to the clinical situation.” AMDA, supra note __.
345 Hoffman 1991, supra note __, at 762.
institution may have no representation on the MI-HEC, it has little against the quasi-appellate or joint models because each hospital has representation. The quasi-appellate model is independent from each member institution that refers a case. Yet, since each institution has representation, the MI-HEC panel is still in touch with local institutional culture and possesses “relevant local knowledge.” At the same time, since the committee’s functions are not entirely outsourced and the referring institution has some representation on the committee, relevant community norms and values can still be considered.

This was specifically suggested as a solution in the IRB context. For example, the largest independent IRB “has regular representatives who take the pulse of the local community to determine attitudes and customs.” “Routine visits to sites and videos and teleconferences provide the Board with additional information about local conditions.”

3. Liability

Lawsuits against ethics committees are rare; but they do occur. It is just such a threat that may corrupt an intramural HEC’s decisions and

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346 Even the extramural MI-HEC can overcome the locality objection. Through a regular, ongoing relationship, the MI-HEC will acquire substantial local knowledge. And since physicians are on staff at several hospitals, some MI-HEC members will have direct local knowledge. Hoffman 1991, supra note __, at 762 n.97

347 However, on some MI-HEC proposals, the treating facility would have no representation. See, e.g., Buchanan, supra note __, at 191 (“Individuals who had a financial conflict of interest with the patient’s ‘home’ facility or managed care plan could not participate on that patient’s panel, and every effort was made to avoid institutional affiliation between panel members and the patient’s site of care.”).


349 Povar 1991, supra note __, at 910 (emphasizing the importance of attending to “the individual culture of an institution”).

350 FDA, Guidance for Industry: Using a Centralized IRB Review Process in Multicenter Clinical Trials 4-5 (Mar. 2006) (suggesting as “a sufficient mechanism to ensure meaningful consideration” the participation of an institution in the deliberations of or the provision of information to the central IRB).

351 <http://wirb.com/context/institution.aspx>. See also Heath, supra note __, at 17 (describing alternative approaches “for assuring accurate and up-to-date knowledge of local issues and attitudes”).

352 Fletcher & Spencer, supra note __, at 270-75; Susan B. Rubin & Laurie Zoloth, Margin of Error 355-60 (2000) (5 lawsuits against HEC). See also S.M. Staubach, What Legal Protection Should a Hospital Provide, If Any, to Its Ethics Committee, 1 HEC FORUM 209 (1989).
recommendations. The reduced risk of corruption with MI-HECs stems from the fact that no single institution has control over the MI-HEC. But this lack of control can have a chilling effect on the willingness of a healthcare institution to participate in a MI-HEC. The fear of lawsuits “makes some institutions reluctant to relinquish control.” Moreover, a MI-HEC could increase an institution’s exposure to liability, if it makes the institution more likely to make controversial decisions.

But an MI-HEC substantially mitigates liability concerns in four ways. First, MI-HECs are often accorded, by statute, with civil, criminal, and disciplinary immunity. Second, MI-HECs can carry insurance. Third, MI-HECs increase chance for resolution of treatment conflicts, thus reducing the risk of litigation. Finally, in the unlikely event of litigation, the MI-HEC serves a protective role. The original attraction of HECs was the reassurance that they could provide in the face of adverse legal consequences. MI-HECs can do the same job better, since courts are more likely to defer to a broader, more independent committee.

4. Confidentiality

Some argue that MI-HECs are problematic because they require institutions to share their problem cases with competitors. Some have argued that institutions are “unlikely to come together to plan joint committees because of . . . the insular views of most institutions.”

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353 See supra notes __ to __ and accompanying text.
354 Miller, supra note __, at 211; see also Scannell, supra note __ (“[N]o legal . . . support is available for such an undertaking and structure.”).
355 McNeil, supra note __, at 502. Cf. Peter Winn & Jacque Cook, Ethics Committees in Long Term Care, 8 ANNALS LONG TERM CARE 35, 37 (2000) (“[F]acility officials may believe that an institutional ethics committee may actually increase the risk of liability.”).
356 See, e.g., FLA. STAT ANN. § 765.404(2); HAW. REV. STAT. § 663-1.7(b); MD. HEALTH-GEN. CODE § 19-374(c).
358 Monagle & West, supra note __, at 258 (“Bioethics committees reduce, not increase, legal exposure.”).
359 See Panel Discussion: Implementing and Utilizing an IEC, in CRANFORD & DOUDERA, supra note __, at 226, 237 (Peter McShannon) (“The looser the committee, as far as the courts are concerned, the less value and the less deference they would give . . . .”).
360 Loeben, supra note __, at 230 (“HECs are relatively used to the idea of operating behind closed doors.”); Smith et al., supra note __, at 1274-75 (“[T]his procedural change would then raise concerns about patient confidentiality . . . .”)
361 Hoffman, supra note __, at 769
[There must be an exception – see treatise] But this is not an issue of whether open or closed. Many intramural HECs already have outside members.362

5. Distance

Some have argued that since rural facilities are separated by great distance, a cooperative venture like a MI-HEC would be impractical. It would, the objection states, be very difficult for the members from the different constituent institutions to get together for ethics education, policy development, or case consultation.363

This may have been true just a decade ago. But it is not true today.364 Technology already available or soon available in rural healthcare institutions can effectively facilitate the necessary communication. Telemedicine is proving its feasibility and usefulness in the clinical context, for example, allowing a rural family physician to instantly consult with an urban specialist through live interactive videoconferencing.365

Just as telemedicine is addressing the lack of rural physicians, “teleethics” can address deficiencies in rural bioethics.366 For example, nearly fifteen years ago, the University of Missouri developed the Missouri Telehealth Network to enhance access to care to more than forty underserved Missouri counties. More recently, over the past three and one-half years, the University of Missouri Center for Health Care Ethics has incorporated this

362 State Initiatives, supra note __, at 2 ("There was initial concern . . . about hanging out our dirty laundry for competitors to see, but . . . the concern didn’t bloom.") (quoting William Isele); Bayley, supra note __, at 362 ("Although neighboring hospitals are often in competition, ethics committees have traditionally been natural allies since many of their goals are not zero sum games . . . .")

363 Niemira, supra note __, at 78 ("Distances between institutions . . . are obvious obstacles that must be overcome."); id. at 80 (arguing that "practical issues" such as "distances between members" may limit the usefulness of MI-HECs).

364 Bayley, supra note __, at 362 ("Telephone and email make . . . possible . . . an ongoing, if geographically distant, buddy relationship."); Pinnock & Crosthwaite, supra note __ (observing that smaller centres could gain access to ethicists/clinical ethics committees via teleconferencing").


366 Fleming, supra note __, at 250-51, 257; Fukuyama et al., supra note __, at __ ("E-mail was used as the primary means of consultation . . . . Advantages of our method . . . included the ability to request consultation anonymously from anywhere in Japan."); Nelson, supra note __, at 32-33.
very same telemedicine technology for use by ethics consultants to provide services to ethics committees and providers at rural health facilities where such ethics consultation services are not available.\textsuperscript{367}

In a very recent futility dispute in the remote Northern Territory of Australia, the court recommended establishing “a clinical ethics committee” that is “independent of the treating doctors and the family.” The court noted “that given the small population of the Northern Territory, for the committee to have any independence at all from the treating doctors it would probably need to have interstate members (who would need to be available on short notice by telephone or videoconferencing).”\textsuperscript{368}

\section*{B. Big Obstacle: Lack of Motivation}

Perhaps the biggest challenge to the expanded use of MI-HECs is getting HEC members to recognize and care about the problems with intramural HECs.\textsuperscript{369} I address problems assuming people want an ethics committee.\textsuperscript{370} One reason not care is not being used.\textsuperscript{371} So, chicken-egg because need to make think valuable so will fix.

Importantly, the MI-HEC can improve not only the quality of rural ethics but also the perception of that quality by both providers and the public. Many have “little idea of what to expect.”\textsuperscript{372} If rural healthcare providers were confident that the MI-HEC could handle an issue and effect positive change, they would be more likely to use the committee.\textsuperscript{373} More positive

\textsuperscript{367} At the 2007 annual meeting of the American Society of Bioethics and Humanities (ASBH), David Fleming and Donald Reynolds reported that the accessibility and feasibility of providing teleethics services have proven to be very effective. See also Jane N. Bolin et al., An Alternative Strategy for Resolving Ethical Dilemmas in Rural Healthcare, 8(4) AM. J. BIOETHICS 63 (2008) (describing a “virtual ethics committee program”).

\textsuperscript{368} Inquest into the Death of Paulo Melo, 2008 N.T.M.C. 080 ¶¶ 107-08, 110 (Dec. 18, 2008).

\textsuperscript{369} Miller, supra note __, at 214 (“These proposals, though long overdue in terms of need, may even now be premature in terms of acceptance.”).

\textsuperscript{370} Hoffman 1991, supra note __, at 114-15, 118.

\textsuperscript{371} Fox 2007, supra note __, at 13; Pinnock & Crosthwaite 2004, supra note __. See also Cook & Hoas 2008, supra note __; J. Gacki-Smith & E. Gordon, Resident’s Access to Ethics Consultations: Knowledge, Use, and Perceptions, 80 ACAD. MED. 168 (2005); Kevin B. O’Reilly, Willing, But Waiting: Hospital Ethics Committees, AM. MED. NEWS, Jan. 28, 2008; J.P. Orlowski et al., Why Doctors Do Not Use Ethics Consultants, 32 J. MED. ETHICS 499 (2006).


\textsuperscript{373} Sigrid Fry-Revere, Some Suggestions for Holding Bioethics Committees and Consultants Accountable, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 449, 451 (1993).
experiences will lead to more usage and more usage will lead to more positive experiences. Unitedly, MI-HECs create consistency among institutions, increasing public understanding and trust in committee functions.

Education has not worked. The problems of HECs have been widely publicized for decades at conferences and in the professional literature such as HEC Forum and the Cambridge Quarterly of Health Care Ethics. Litigation is not a good way to develop standards. Plus it is tough because HECs often have immunity and plaintiffs have easier defendants. Best is legislation or accreditation. As HECs look more like gatekeepers must be more accountable. Overcome obstacles with incentives.

**CONCLUSION**

Since the function of HECs has evolved from one of advising, clarifying, and facilitating to one of decision making, the form of HECs must evolve as well. Today, most HECs are intramural committees whose decisions are subject to material risks of corruption, bias, arbitrariness, and carelessness. Reconstituting intramural HECs as extramural, quasi-appellate, or joint/shared multi-institutional committees (MI-HECs) can significantly mitigate these risks.

Unfortunately, material advances in bioethics are often made only in response to crises. Since rural healthcare facilities may most acutely feel the need to fix problems with their ethics mechanisms, they may serve a sort of sentinel or bellweather function. Rural healthcare facilities may serve as the spark to the Joint Commission, state regulators, or others to give definition to the composition and operation of HECs. And they may serve as the laboratory in which to test solutions that may later be adapted more broadly.

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375 [PDP cites]

376 Hoffman, supra note __, at 769, 789-90 (education, grants, immunity)