

NOTES

Order at the End of Life: Establishing a Clear and Fair Mechanism for the Resolution of Futility Disputes

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INTRODUCTION

On January 22, 2008, Ruben Betancourt was admitted to Trinitas Regional Medical Center in New Jersey for surgery for malignant thymoma, a cancer of the thymus gland (a small organ underneath the breastbone).¹ Following surgery, the patient developed brain damage due to lack of oxygen and, as a result, lapsed into unconsciousness.² For the next five months, Mr. Betancourt was admitted to various medical facilities and readmitted finally to Trinitas in July 2008 for renal failure.³ For six more months, the unconscious patient remained in the hospital on an artificial ventilator, receiving renal dialysis and nutrition through tube feeding.⁴

1. *Betancourt v. Trinitas Reg'l Med. Hosp.*, No. C-12-09, slip op. at 1 (N.J. Super. Ct. Mar. 4, 2009), *available at* http://thaddeuspope.com/images/Betancourt_v_trinitas_3-4_2_.pdf; *see also* National Cancer Institute, *Thymoma and Thymic Carcinoma*, <http://www.cancer.gov/cancertopics/types/thymoma> (last visited Jan. 22, 2010) (defining thymoma).

2. *Betancourt*, slip op. at 1.

3. *Id.* at 1–2.

4. *Id.*

The medical staff at Trinitas determined that Mr. Betancourt was in an unresponsive, irreversible vegetative state and that further treatment would be futile.⁵ As such, they recommended to the patient's family that life-sustaining treatment be discontinued.⁶ The family disputed the hospital's findings, claiming that the patient responded to certain stimuli.⁷ Namely, they insisted that the patient recoiled when approached by medical providers, responded by opening his eyes, and turned his head in response to certain voices.⁸ The family further described Mr. Betancourt as a "strong willed person who would not give up," thus leading them to believe that he would want to continue to receive treatment. As a result, the family insisted that the healthcare provider uphold this choice.⁹ What should the healthcare provider do in this scenario? If disagreement persists, how should the surrogate decisionmaker respond?

The above example illustrates a futility dispute, which arises when a patient's surrogate decisionmaker wishes to prolong treatment that the healthcare provider has deemed medically ineffective.¹⁰ A futility dispute differs from a traditional end-of-life dispute, in which the surrogate seeks to withhold or withdraw life-sustaining treatment while the physician believes that treatment should be continued.¹¹ In this context, the law recognizes a patient's constitutional and common law right to *refuse* treatment.¹² By contrast, a futility dispute, also known as a "reverse" end-of-life dispute, occurs when a patient or surrogate wants to *compel* a physician to provide treatment that the physician deems medically inappropriate.¹³ Most futility disputes involve situations in which the treatment definitely or probably affords the patient some physiologic benefit but offers no reasonable prospect of recovery.¹⁴ The fundamental disagreement of a medical futility dispute is whether to forgo life-sustaining treatment.

5. *Id.* at 2.

6. *Id.*

7. *Id.* at 2–3.

8. *Id.* at 3.

9. *Id.*

10. See ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 13.01[A]–[B] (3d. ed. 2004) (in a futility case, "the physician recommends to the patient, or more likely to the surrogate of an incompetent patient, that treatment be withheld or withdrawn because the physician has concluded that further treatment is futile").

11. *Id.* § 13.01.

12. CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TOYEN A. BRENNAN, *HEALTHCARE LAW AND POLICY* 1103 (2d ed. 1998); MEISEL & CERMINARA, *supra* note 10, § 2.06.

13. MEISEL & CERMINARA, *supra* note 10, § 13.01.

14. *Id.*

Even when life-sustaining treatment is withdrawn, physicians remain obligated by ethical¹⁵ and legal standards of care¹⁶ to continue palliative care, which relieves pain and helps comfort the patient.¹⁷ Some states have even codified the requirement that palliative care be provided when life-sustaining treatment is withdrawn.¹⁸ In addition to providing care to relieve pain and suffering, healthcare providers generally will make short-term accommodation of the surrogate's wishes in order to facilitate the grief process, to allow family members to say goodbye, and to respect the family's personal values.¹⁹ Yet, surrogates often are not satisfied with a doctor's decision to provide these forms of care instead of life-sustaining treatment, resulting in a futility dispute.²⁰

15. See AM. MED. ASS'N, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 2.20 (2008), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml> ("Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."); Sandra H. Johnson, *The Social, Professional, and Legal Framework for the Problem of Pain Management in Emergency Medicine*, 33 J.L. MED. & ETHICS 741, 748 (2005) ("Physicians have a well established legal duty to treat pain as a part of their medical treatment of a patient. The doctor's legal duty to relieve pain is generally supported by policy statements and standards of professional organizations and by the standards enforced by state licensing boards.").

16. See Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J.L. MED. & ETHICS 28, 29 (2001) ("Failure to properly manage pain—to assess, treat, and manage it—is professional negligence"); Bergman v. Chin, No. H205732-1 (Cal. Super. Ct. June 13, 2001), as discussed in Gilah R. Mayer, Bergman v. Chin: *Why an Elder Abuse Case is a Stride in the Direction of Civil Culpability for Physicians Who Undertreat Patients Suffering from Terminal Pain*, 37 NEW ENG. L. REV. 313, 327–30, 341 (2003) (finding that failure to treat the pain of terminally ill patient dying of lung cancer constituted elder abuse and awarding damages).

17. WHO, WHO Definition of Palliative Care, <http://www.who.int/cancer/palliative/definition/en/> (last visited Jan. 22, 2010).

18. See, e.g., CONN. GEN. STAT. § 19a-573(a) (2008) (notwithstanding provisions providing for withdrawal of life-sustaining treatment, "comfort care and pain alleviation shall be provided in all cases"); MINN. STAT. § 145B.13(1) (2009) ("[A] decision to administer, withhold, or withdraw medical treatment after the patient has been diagnosed by the attending physician to be in a terminal condition must always be based on reasonable medical practice, including . . . continuation of appropriate care to maintain the patient's comfort, hygiene, and human dignity and to alleviate pain.").

19. Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 20 (2007).

20. For a recent real life example of a futility dispute, consider the case of Emilio Gonzales. Emilio was born with Leigh disease, a rare inherited neurometabolic disorder characterized by rapid degeneration of the central nervous system. Due to this disease, Emilio was deaf, blind, and ventilator dependent. His healthcare provider claimed that further life-sustaining treatment would be futile, but his mother insisted on continued treatment. Although Ms. Gonzalez acknowledged that her son was terminally ill, she nevertheless wanted him to receive a tracheotomy, a gastrostomy tube, and a bed in a long-term care facility. She urged, "I just want to spend time with my son . . . [;] I want to let him die naturally without someone coming up and saying we're going to cut off on a certain day." The disagreement between Emilio's mother (the

Currently, no legal consensus exists regarding the proper resolution of futility disputes.²¹ However, courts, commentators, and healthcare providers generally agree that the courtroom is *not* the appropriate venue to resolve these disputes.²² The Betancourt futility dispute, in which the patient's daughter eventually initiated court proceedings to prevent the withdrawal of treatment, demonstrates this consensus.²³ In support of the position that treatment should be discontinued, several treating physicians testified that Mr. Betancourt was "actively dying," that his body was "decomposing and often septic," and that dialysis treatment was "medically and ethically inappropriate and inhumane."²⁴ The physicians further explained that the patient's movements, which the family believed demonstrated Mr. Betancourt's responsiveness, were entirely reflexive.²⁵ Nonetheless, the court held that "the decision to continue or terminate life support systems is not left to the courts," and instead appointed the plaintiff as the legal guardian and granted her request for injunctive relief to restrain the hospital from discontinuing treatment.²⁶

If the resolution of futility disputes "is not left to the courts," as the Superior Court of New Jersey and many other courts have held, then who must make these decisions? Lacking a legislative or judicial answer to this question, most healthcare institutions have established internal mechanisms to resolve ethical disputes that arise at the end of life.²⁷ In over 90 percent of the hospitals providing ethics

surrogate) and the healthcare institution represents a medical futility dispute. Jeffrey P. Burns & Robert D. Truog, *Futility: A Concept in Evolution*, 132 CHEST 1987, 1990 (2007).

21. See Elena N. Cohen, *Refusing & Forgoing Treatment*, in 3 TREATISE ON HEALTHCARE LAW § 18.06 (Alexander M. Capron & Irwin M. Birnbaum eds., Matthew Bender rev. ed. 2008) (discussing judicial and non-judicial mechanisms for resolving futility disputes and explaining that non-judicial dispute resolution may be desirable because court proceedings can be time-consuming and emotionally and financially costly for both patients and providers citing several decisions that support this conclusion).

22. See *infra* notes 94–105 and accompanying text.

23. *Betancourt v. Trinitas Reg'l Med. Hosp.*, No. C-12-09, slip op. at 3–4, 7 (N.J. Super. Ct. Mar. 4, 2009) ("The decision to continue or terminate life support systems is not left to the courts.").

24. *Id.*

25. *Id.* The physicians further stated that the patient "does not respond to pain or spontaneously move his extremities." *Id.*

26. *Id.* at 7–8. The hospital appealed the decision, and even though the patient died (while on the ventilator), the appeal appears to still be going forward. Rebecca Dube, 'Death Panels' Obscure Real End-of-Life Challenges, JEWISH DAILY FORWARD, Oct. 9, 2009, available at <http://www.forward.com/articles/115597/>.

27. Ellen Fox et al., *Ethics Consultation in United States Hospitals: A National Survey*, AM. J. BIOETHICS, Feb. 2007, at 13, 23 (finding that 81 percent of general hospitals and 100 percent of hospitals with 400 beds or more provide ethics consultations services); see also Cohen, *supra* note 21, § 18.06 ("To avoid some of the negative aspects of judicial intervention, institutional dispute resolution mechanisms have been created One mechanism for resolving disputes that

consultation, a full ethics committee or a small team of individuals performs ethics consultation.²⁸ Accordingly, this Note will focus on the group model of consulting, using the term “ethics committee” to refer to any group of individuals designated by a healthcare institution to address ethical issues involved in a specific, active clinical case.

Even though ethics committees are typically considered advisory bodies that make only recommendations, they often provide the effective forum of last resort in the context of a futility dispute.²⁹ One would assume that impartiality would be a defining quality of a group vested with such authority to render life-or-death decisions, yet ethics committees are actually internal bodies comprised primarily of hospital staff.³⁰ This relationship creates a substantial risk that inappropriate considerations will influence ethics committee decisions to continue or withdraw life-sustaining treatment.³¹ For example, committee members may be improperly influenced by the financial effects of their decisions, fear of liability, or inherent professional relationships.³² Yet despite these risks, ethics committees in almost all states remain free from any substantive or procedural regulation.³³

deserves special attention is the institutional ethics committee.”). Although ethics committees are the most common forum for addressing ethical issues, ethics consultations may utilize an individual ethicist rather than a committee.

28. Fox et al., *supra* note 27, at 23.

29. See Alexander M. Capron, *Legal Perspectives on Institutional Ethics Committees*, 11 J.C. & U.L. 417, 427 (1985) (noting that “[p]eople frequently assert that an ethics committee should be ‘advisory,’” but that “[t]o call it a committee suggests that the group will come to some kind of closure on the issues that it addresses”).

30. See Dianne E. Hoffmann, *Does Legislating Hospital Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia*, 19 LAW MED. & HEALTHCARE 105, 108 (1991) [hereinafter Hoffmann, *Does Legislating Hospital Ethics Committees Make Sense?*] (describing the typical composition of ethics committees in Maryland, the District of Columbia, and Virginia); cf. Diane E. Hoffmann, *Regulating Ethics Committees in Healthcare Institutions – Is It Time?*, 50 MD. L. REV. 746, 763–68, 782 (1991) [hereinafter Hoffman, *Regulating Ethics Committees*] (examining the relative institutional predispositions of ethics committees to reasoned decisionmaking and noting that “[a] committee that is heavily dominated by medical professionals may not share the same values as the patients that come before it”).

31. See Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 275–84 (2009) (discussing institutional ethics committees conflicts of interest and concluding that “[s]ince, in many treatment disputes, the interest of the institution may not align with that of the patient, [institutional ethics committees] cannot act as sufficiently impartial, independent decision makers”).

32. See *infra* Part II.

33. See, e.g., Bethany Spielman, *Has Faith in Healthcare Ethics Consultants Gone Too Far? Risks of an Unregulated Practice and a Model Act to Contain Them*, 85 MARQ. L. REV. 161, 180 (2001) (“[T]he field of ethics consultation remains free of any internal or external regulation. There is no self-regulation, no registry, no certification, no licensure, and no accreditation of

Any solution to this problem must uphold the patient's right to make autonomous medical decisions while at the same time respecting the physician's right to refuse to provide treatment that is medically ineffective.³⁴ Furthermore, it must provide a clear, statutory procedure for resolving futility disputes that incorporates fundamental due process protections.³⁵ Most importantly, the mechanism for resolving futility disputes must not only prohibit those who have conflicts of interest from making medical decisions on behalf of incompetent patients; it also must bar improper considerations, including financial, legal, or professional concerns, from shading the final decision.³⁶

Fortunately, Iowa has provided a model for such a solution through the development of substitute medical decisionmaking boards ("SMDBs").³⁷ These serve as substitute decisionmakers for incompetent patients who lack a surrogate to make medical decisions on their behalf.³⁸ In contrast to internal ethics committees, any individual with a conflict of interest is precluded from sitting on the board for that case.³⁹ Moreover, SMDBs must comply with specific procedural and decisionmaking regulations that further ensure that the board will fully evaluate all sides of the dispute and that improper considerations will not influence their decisions.⁴⁰ While the Iowa

training programs."). Maryland is the one exception, which regulates only the composition and some procedures of the committees. MD. CODE ANN., HEALTH-GEN. §§ 19-370 to -374.

34. See *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1075 (La. Ct. App. 1998) (holding that a physician would not be compelled to "provide interventions that in his view would be harmful, without effect or 'medically inappropriate'"); *In re Jobes*, 529 A.2d 434, 436 (N.J. 1987) (noting that "the patients' right to self-determination is the guiding principle" in cases regarding the withdrawal of life-sustaining treatment).

35. Cf. Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 844-47 (1991) (discussing the gaps in procedural protections for patients in the Maryland statutory scheme spelling out ethics committee process).

36. See Mark P. Aulisio et al., *Healthcare Ethics Consultation: Nature, Goals, and Competencies*, 133 ANNALS INTERNAL MED. 59, 65 (2000) (summarizing the American Society for Bioethics and Humanities Task Force's report on the core competencies for healthcare ethics consultation, which includes the conclusion that "Conflicts of Interest Must Be Avoided[.] . . . If ethics consultants have important personal or professional relationships with one or more parties that could lead to bias . . . the consultants should . . . remove themselves from the case.").

37. IOWA CODE §§ 135.28-29 (2009).

38. See *id.* § 135.29(2) (providing that "the local [SDMB] may act as a substitute decision maker for patients incapable of making their own medical care decisions if no other substitute decision maker is available to act"); IOWA ADMIN. CODE r. 641-85 (2009).

39. See IOWA ADMIN. CODE r. 641-85.6(1) ("A person shall not participate on a panel for a case when that person has a conflict of interest."); *id.* at r. 641-85.2(1) (defining "conflict of interest" as "a standard which precludes the participation of a panel member in the proceedings with regard to a patient whenever the panel member is a relative of the patient, is a direct care provider of the patient or has a financial interest in the patient").

40. See *id.* at r. 641-85.3 to .6, 641-85.8 to .12.

SMDBs only come into play when there is no surrogate available,⁴¹ their concept can be adapted to resolving futility disputes between surrogates and healthcare providers in an impartial and humane manner.

In order to ensure that incompetent patients are adequately protected as they are nearing the end of life, this Note argues that states should establish state and local medical decisionmaking boards to resolve futility disputes. Modeled after the Iowa SMDBs, these boards would have procedural and substantive requirements that would prevent improper interests from affecting decisions regarding medical treatment. Part I of this Note describes the background of futility dispute resolution. Part II then considers the conflicts of interests inherent in institutional ethics committees, which many healthcare institutions, courts, and states have vested with considerable decisionmaking power. Because of the internal nature of these committees, they cannot and should not be expected to render impartial decisions. Thus, Part III proposes that the proper response to this futility dispute problem lies in creating independent medical boards that would operate under procedural and substantive regulations to ensure their impartiality.

I. HOW ARE FUTILITY DISPUTES RESOLVED?

This Part summarizes the current state of futility dispute resolution. Part I.A illustrates how healthcare decisions are made on behalf of incompetent patients. Next, Part I.B describes both the history and failures of the legislative and judicial treatment of end-of-life disputes. Finally, Part I.C explains the rise of healthcare ethics committees in the late 1970s and early 1980s.

A. Healthcare Decisionmaking for Incompetent Patients

In order to fully comprehend a futility dispute scenario, one must first understand the notion of “competence.”⁴² Despite the

41. *Id.* at r. 641-85.1.

42. The terms “competence” and “capacity” are often used interchangeably in discussions of medical decisionmaking, leading to confusion over the exact meaning of these terms. Traditionally, the term “incompetent” has been used to describe a *judicial* determination that an individual lacks the degree of “capacity” legally required to do a particular task. However, many state statutes require that physicians make a capacity determination in the clinical setting, and this determination results in the person being treated as if they had been adjudicated “incompetent.” Instead of dwelling on the technical distinctions between these terms, this Note will use the word “incompetent” to refer to an individual who lacks decisionmaking capacity to make a treatment decision, whether this determination is made in a judicial or clinical setting.

importance of this concept in medical decisionmaking, courts often fail to provide specific guidance on determining competence.⁴³ Nevertheless, scholarly writing and judicial decisions have established a general standard: a person is competent for purposes of medical decisionmaking when she can (1) understand the consequences of accepting or rejecting a particular treatment, (2) comprehend the benefits and risks of the treatment and alternatives to the proposed treatment, and (3) communicate that decision to another.⁴⁴ Adults are generally presumed to be legally competent to make treatment decisions, so healthcare providers may assume that the patient has capacity to make treatment decisions unless there is reason to question this presumption.⁴⁵ When a patient lacks decisionmaking capacity, as determined judicially or clinically, someone else must make the decision on the patient's behalf.⁴⁶ Legislatures have responded to the problem of determining who will make these medical decisions in two ways: (1) by recognizing advance directives and (2) by enacting surrogacy statutes. Under either approach, however, futility disputes remain an ever-present concern.

1. The Promise and Pitfalls of Advance Directives

An individual can ensure that her wishes will be upheld by completing an advance healthcare directive.⁴⁷ Advance healthcare directives are “personal contingency plan[s]” regarding how medical decisions are to be made in the event of decisional or communicative

See MEISEL & CERMINARA, *supra* note 10, § 3.05 (citing the more widespread usage of “competence” and “incompetence” due to their simplicity as well as the potential for confusing “capacity” with a patient’s health status). For example, a patient may be physically incapacitated but still possess decision making capacity.

43. *Id.*; see, e.g., *Lane v. Candura*, 376 N.E.2d 1232, 1233 (Mass. App. Ct. 1978) (noting that the trial court decision did not include a clear-cut decision that the patient lacked the requisite legal competence). This omission may occur because in many end-of-life cases, the patient’s incompetence is undisputable (e.g. the patient is comatose or in a vegetative state). MEISEL & CERMINARA, *supra* note 10, § 3.06.

44. Cohen, *supra* note 21, § 18.02. For decisions using this standard or a close variation, see *In re Martin*, 504 N.W.2d 917, 924 (Mich. Ct. App. 1993), *In re Hier*, 464 N.E.2d 959, 965 (Mass. App. Ct. 1984), and *State Dep’t of Human Res. v. Northern*, 563 S.W.2d 197, 209 (Tenn. Ct. App. 1978).

45. TENN. CODE ANN. § 68-11-1812(b) (2009); *Saunders v. State*, 492 N.Y.S.2d 510, 516 (N.Y. Sup. Ct. 1985) (“Competency is presumed as the normal condition of a person until the contrary is shown.”); *In re K.K.B.*, 609 P.2d 747 (Okla. 1980) (competency presumed even for psychiatric patients).

46. Cohen, *supra* note 21, § 18.04[1].

47. CAROL KROHM & SCOTT SUMMERS, *ADVANCE HEALTHCARE DIRECTIVES* xix (4th ed. 2002).

incapacity.⁴⁸ There are two types of healthcare directives. A treatment directive, commonly known as a living will, provides direct instructions to doctors about end-of-life care.⁴⁹ A proxy directive, often referred to as a “durable healthcare power of attorney,” names an agent to make medical decisions on a patient’s behalf if the patient becomes incompetent.⁵⁰ Not only have most courts encouraged the use of advance directives, but every state also has legislation authorizing physicians to follow directives without fear of liability.⁵¹ Moreover, Congress enacted the Patient Self-Determination Act of 1991, which requires that hospitals and other healthcare organizations notify patients of their right to make a directive.⁵²

Despite several decades of statutory and judicial endorsement,⁵³ these instruments have been largely unsuccessful. Research indicates that less than 25 percent of individuals enact advance directives.⁵⁴ Many experts blame these results on a patient’s preference of leaving end-of-life decisions to family members, the difficulty of executing a legal document, or a patient’s denial that conditions could worsen such that an advance directive is needed.⁵⁵ Congress has introduced recent legislation to help address these problems. For example, the Senior Navigation and Planning Act would require hospitals to include end-of-life planning as part of patient discharge.⁵⁶ In addition, the Life Sustaining Treatment Preferences Act would allow Medicare to reimburse physicians who consult patients on decisions regarding life-sustaining treatment.⁵⁷ Finally, the Advance Planning and Compassionate Care Act would establish a consumer hotline and a national clearinghouse on advance-care planning and offer state grants to educate the public on the topic.⁵⁸

48. *Id.*

49. *Id.*

50. *Id.*

51. Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1828–29 (2003).

52. 42 U.S.C. §§ 1395cc(a)(1)(Q), (f) (2008).

53. Dresser, *supra* note 51, at 1828–29.

54. See Dallas M. High, *Advance Directives and the Elderly*, 33 GERONTOLOGIST 342, 342–48 (1993) (finding that between 0 to 20 percent of elders had completed an advance directive); Joan M. Teno et al., *Do Advance Directives Provide Instructions that Direct Care?*, 45 J. AM. GERIATRICS SOC’Y 508, 509 (1997) (citing a comprehensive study of 4,804 hospitalized, seriously ill patients during the two years after the PSDA was enacted, which revealed that only 14 percent of the patients had an advance directive in their medical record).

55. Victor G. Cicirelli, *Healthy Elders’ Early Decisions for End-of-Life Living and Dying*, in 20 ANN. REV. GERONTOLOGY & GERIATRICS 163, 181 (2000).

56. S. 1263, 111th Cong. (2009).

57. H.R. 1898, 111th Cong. (2009).

58. S. 1150, 111th Cong. (2009).

Although efforts to facilitate advance healthcare planning may help eliminate uncertainty when a patient becomes incompetent, these instructions cannot realistically address all issues that will arise regarding future treatment.⁵⁹ As one physician explained, “Medical crises cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading.”⁶⁰ For instance, a treatment directive may provide that the patient does not want life-sustaining treatment if the patient is “terminally ill and there is no hope of recovery,” but a debate may arise as to whether this condition is met.⁶¹ Similarly, a decisionmaker appointed through a proxy directive may have difficulty making end-of-life decisions if the patient verbally communicated vague instructions or failed to express her wishes clearly.

2. Delegating Decisionmaking through Surrogacy Statutes

Recognizing the infrequent execution and inherent limitations of advance directives, twenty-eight states and the District of Columbia have statutory surrogate laws.⁶² These laws authorize certain individuals to make treatment decisions on behalf of incompetent patients who have not left written instructions.⁶³ Many surrogacy laws provide a hierarchy of the patient’s family members from which to select a surrogate.⁶⁴

59. See KENNETH A. FISHER, IN DEFIANCE OF DEATH: EXPOSING THE REAL COSTS OF END-OF-LIFE CARE 13 (2008) (explaining that the concept of advance directives is inherently problematic because it presupposes more control over future treatment than is realistic).

60. *Id.* (quoting Dr. Henry S. Perkins).

61. Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 831 (1994).

62. CLAIRE C. OBADE, PATIENT CARE DECISIONMAKING: A LEGAL GUIDE FOR PROVIDERS § 11.3 (current through Dec. 2008). These are also referred to as family decisionmaking laws. *Id.* See also KROHM & SUMMERS, *supra* note 47, at 136 (stating that a majority of states have enacted surrogacy statutes).

63. OBADE, *supra* note 62, § 11.3.

64. KROHM & SUMMERS, *supra* note 47, at 136. For example, the Uniform Healthcare Decisions Act (discussed *infra* Part I.B.1) provides that consideration may be given, in order of descending preference to the patient’s (1) spouse, unless legally separated; (2) adult child; (3) parent; or (4) adult sibling. If none of these individuals are reasonably available, an “adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal value” may act as surrogate. UNIF. HEALTHCARE DECISIONS ACT § 5(b)–(c), 9 U.L.A. 93 (1993), *reprinted in* 22 ISSUES L. & MED. 83 (2006) [hereinafter “UHCDA”].

In general, judicial proceedings are not required to determine incompetence and to appoint a surrogate. MEISEL & CERMINARA, *supra* note 10, § 3.16. If a patient is judicially determined to be incompetent to make medical decisions, the court appoints a guardian who is empowered to make decisions about the patient’s medical care. *Id.* § 3.10. Alternatively, if a patient is clinically determined to lack decisionmaking capacity, the designation of a surrogate usually occurs in the clinical setting without recourse to judicial proceedings. *Id.*

Most of these laws provide a general framework within which surrogates should make decisions on behalf of incompetent patients. Under the substituted-judgment standard, surrogates should attempt to determine what the patient would have decided about a specific medical treatment from any evidence indicating the wishes of the patient before she lost capacity.⁶⁵ If the patient's intent is not evident, the surrogate should then turn to the "best interest" standard, under which the surrogate objectively determines the course of treatment that is in the best interest of the patient.⁶⁶ Even if a surrogate carries out this mode of analysis in good faith, the surrogate's conclusion can conflict with the physician's recommendation regarding the appropriate course of treatment. Such a futility dispute highlights the need for a comprehensive, clear, and unbiased framework for resolving futility disputes that will balance the rights of both the patient and the physician.

*B. Insufficient Legislative and Judicial Approaches to Resolving
Futility Disputes*

1. Vague State Legislation Regarding End-of-Life Decisionmaking

While every state authorizes some form of advance healthcare directive and a majority of states allow surrogates to make medical decisions on behalf of incompetent patients, these statutes have resulted in a fragmented and incomplete set of rules governing healthcare decisionmaking.⁶⁷ In response, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Health Care Decisions Act ("UHCDA" or "the Act") in 1993, which has now been adopted in eight states.⁶⁸ Although the Act is intended to address

65. Matthew Bierlein, *Seeing the Face of the Patient: Considerations in Applying Bioethics Mediation to Non-Competent End-of-Life Decisionmaking*, 23 OHIO ST. J. ON DISP. RESOL. 61, 66 (2007).

66. *Id.*

67. UHCDA, *supra* note 64, at prefatory note ¶¶ 1-2.

68. MEISEL & CERMINARA, *supra* note 10, § 7.04[A]. Two other states have modeled legislation after this. See Pope, *supra* note 19, at 53 n.294 (noting that the legislative history of California and Tennessee statutes confirms that the statutes were largely derived from the UHCDA) (citing *Healthcare Decisions for Adults Without Decisionmaking Capacity, Bill Analysis of A.B. 891 Before the Assem. Comm. on the Judiciary*, 106th Cong., at 5 (Apr. 15, 1999) (noting that the bill is "[d]rawing heavily on the [UHCDA]"); *Healthcare Decisions: Durable Power of Attorney, Bill Analysis of A.B. 891 Before the S. Comm. on the Judiciary*, 106th Cong., at 2 (July 13, 1999) ("The provisions of the proposed Healthcare Decisions Law (HCDL) are drawn heavily from the Uniform Healthcare Decisions Act (1993), and implement major parts of the Commission's recommendation[s]."); Charles M. Key & Gary D. Miller, *The Tennessee Healthcare Decisions Act A Major Advance in the Law of Critical Care Decision Making*, 40 TENN. B.J. 25, 28 (2004).

procedural aspects of all medical decisionmaking for incompetent patients and supplant existing state-specific laws,⁶⁹ it fails to provide a clear and effective futility dispute resolution procedure. The UHCDA generally provides that a “health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective healthcare.”⁷⁰ In addition, the statute attempts to carve out a procedure for resolving futility disputes that, if followed by the healthcare provider or institution, will result in civil and criminal immunity.⁷¹ First, a healthcare provider or institution must communicate its desire to withdraw treatment to the surrogate.⁷² Then, the healthcare provider or institution must make “all reasonable efforts” to assist in the transfer of the patient to another facility that is willing to comply with the surrogate’s request.⁷³ Meanwhile, life-sustaining treatment must be continued until a transfer can be affected.”⁷⁴

Although a step forward in providing structured guidance in resolving futility disputes, the UHCDA fails to answer three major questions: (1) Who, practically, has the authority to make the final decision to withdraw treatment? (2) What should a healthcare provider or institution do if no other institution is willing to admit the patient and to comply with the surrogate’s request? (3) Can a healthcare provider or institution face liability for forgoing treatment after determining that treatment is “medically ineffective”?

First, regarding who has the authority to render the final decision, the UHCDA authorizes the healthcare provider or institution to withdraw treatment when it is deemed medically ineffective.⁷⁵ Yet the Act fails to adequately define the specific individual or group of individuals who should make this determination. The UHCDA defines “health-care provider” as “an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.”⁷⁶ It further defines “health-care institution” to mean “an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law

69. UHCDA, *supra* note 64, at prefatory note ¶ 4.

70. *Id.* § 7(f).

71. *Id.* §§ 7(g), 9(a).

72. *Id.* § 7(g).

73. *Id.*

74. *Id.*

75. See Pope, *supra* note 19, at 53 (labeling statutes that include similar provisions as “Unilateral Decision Statutes” that permit healthcare providers to unilaterally refuse to provide life-sustaining treatment that they consider to be medically inappropriate).

76. UHCDA, *supra* note 64, § (1)(8).

to provide health care in the ordinary course of business.”⁷⁷ Thus the Act appears not only to authorize any physician treating the patient to withdraw treatment unilaterally; it also vests similar authority in any representative of the institution treating the patient. Such responsibility to forgo treatment, thus ending the life of an incompetent patient in opposition to the surrogate’s decision, should not be left up to one individual. Moreover, it certainly should not be made by just any representative of a healthcare institution (i.e., anyone who is involved in the provision of medical care). Nonetheless, faced with this ambiguity, healthcare institutions alone determine who should hold the ultimate decisionmaking authority to continue or withdraw life-sustaining treatment.

Second, in addition to not identifying the ultimate decisionmaker, the Act does not provide a procedure for forgoing life-sustaining treatment against the wishes of the surrogate. The Act provides that a healthcare provider or institution that declines to comply with a healthcare decision must make “all reasonable efforts” to assist in the transfer of the patient to another facility willing to comply with the instruction.⁷⁸ It further states that such healthcare provider or institution *must* “provide continuing care to the patient until a transfer can be effected.”⁷⁹ Although the former provision appears to allow a provider to decline a surrogate’s request after reasonable efforts fail to produce another hospital willing to comply, this interpretation conflicts with the mandate requiring continued care until a transfer takes place.⁸⁰ Therefore, the Act fails to provide clear instructions for a situation in which no other healthcare facility is willing to comply with the surrogate’s request.⁸¹

77. *Id.* § (1)(7).

78. *Id.* § 7(g)(3).

79. *Id.* § 7(g)(2). It should also be noted that the Act fails to provide the meaning of “continuing care.” *See id.* § 1 (providing a list of definitions applicable to the Act, but omitting “continuing care”). Therefore, it is unclear whether it requires institutions to provide only palliative care or instead more generally requires continued medical care, including life-sustaining treatment, until a patient is transferred. California has addressed this problem by providing that the obligation of the declining facility to provide continuing care does not mean unlimited compliance with the patient request but only that the facility continue pain relief and other palliative care. *See CAL. PROB. CODE* §§ 4735–36 (West 2009) (providing that a healthcare provider or institution may decline to comply with an individual healthcare instruction when the requested care would be ineffective, but that “[i]n all cases, appropriate pain relief and other palliative care shall be continued”).

80. *Compare* UHCDA, *supra* note 64, § 7(g)(3), *with id.* § 7(g)(2).

81. The one state statute that does provide a specific extrajudicial process and definite timetable for terminating a patient’s life-sustaining treatment is the Texas Advance Directives Act. *See* Cynthia S. Marietta, *The Debate Over the Fate of the Texas “Futile-Care” Law*, HEALTH L. PERSP., Apr. 25, 2007, at 1, available at [www.law.uh.edu/healthlaw/perspectives/20077\(CM\)TXFutileCare.pdf](http://www.law.uh.edu/healthlaw/perspectives/20077(CM)TXFutileCare.pdf). The Act authorizes a physician to refuse to honor a surrogate’s

Finally, the UHCDA does not address whether a physician or healthcare institution could be held liable for forgoing treatment against the surrogate's wishes.⁸² The Act generally exempts from liability healthcare providers acting in good faith and in accordance with generally accepted healthcare standards when they (1) comply with a healthcare decision of a person apparently having authority to make a decision for a patient, (2) decline to comply with the decision of a person based on a belief that the person lacks authority, or (3) comply with a healthcare directive and assume that the directive was valid when made and has not been revoked or terminated.⁸³ However, the Act does not explicitly provide protection from liability to a provider or institution declining to provide life-sustaining treatment as authorized by the Act.⁸⁴ As will be discussed in Part II.A.3, the potential for liability left possible by the UHCDA is likely to lead physicians to continue ineffective treatment in order to avoid the risk of a lawsuit.⁸⁵

decision to continue life-sustaining treatment if the physician believes the continued treatment would be medically hopeless or futile. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (Vernon Supp. 2009). However, a hospital ethics committee must first review this decision. *Id.* § 106.046(a). If the committee agrees with the physician and determines that the case is futile, the patient's family then has ten days to transfer the patient to a facility willing to continue the treatment. *Id.* §§ 166.046 (d)–(e). During the ten day waiting period, treatment is continued but the hospital has no obligation to continue treatment after ten days. *Id.* The patient's family or surrogate may seek court intervention to extend the waiting period; however, a court must find by a preponderance of the evidence that there is a reasonable expectation that another facility will honor the surrogate's decision in order to grant the extension. *Id.* § 166.046(g).

82. By synthesizing two sections of the UHCDA, it may be possible to argue that the Act grants immunity to a healthcare provider or institution that, in good faith and in accordance with generally accepted healthcare standards, relies on a healthcare provider's decision to forgo "medically ineffective" treatment. Section 9(a)(1) provides that "[a] healthcare provider or institution acting in good faith and in accordance with generally accepted healthcare standards applicable to the healthcare provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for . . . complying with a healthcare decision of a person apparently having authority to make a healthcare decision for a patient, including a decision to withhold or withdraw healthcare." UHCDA, *supra* note 64, §9(a)(1). The healthcare decision upon which a healthcare provider may rely may be the provider's authority to decline to comply with an individual instruction requiring "medically ineffective healthcare," which is authorized by § 7(f). *Id.* § 7(f). However, this interpretation is a stretch and is certainly not clear from the statute.

83. *Id.* § 9.

84. See David M. English, *The Uniform Health-Care Decisions Act and Its Progress in the States*, 15 PROB. & PROP., May/June 2001, at 19, 23 available at <http://www.abanet.org/rppt/publications/magazine/2001/01mj/01mjenglish.html> (highlighting this omission). California, Delaware and New Mexico have tried to fix this gap in the immunities section of the UHCDA by providing protection from liability to a provider or institution declining to provide care as authorized by the Act. *Id.*

85. See *infra* Part II.A.3.

This problem is illustrated by the results of a recent study of ethics consultations at the University of California San Diego Medical Center.⁸⁶ The co-chair of the commission conducting the study explained that

[t]he nearly universal consensus has been that when faced with cases where physicians have determined treatment is non-beneficial, but the patient or surrogate continues to insist on treatment, most physicians continue treatment. Physicians tend to default to continuation of treatment even if their institution's policies support withdrawal of non-beneficial treatment.⁸⁷

Significantly, these findings came from a hospital in California, a state that has adopted a close version of the UHCDA.⁸⁸

Those states that have not adopted statutes similar to the UHCDA provide even less guidance on healthcare decisionmaking. For example, many states generally authorize healthcare providers to decline to comply with treatment requests that are “outside of their professional medical judgment” or “contrary to reasonable medical standards.”⁸⁹ Alternatively, a few states have enacted narrower statutes that permit providers to refuse surrogate requests to continue treatment under very limited circumstances.⁹⁰ For example, when a futility dispute arises in New York, the provider is authorized to refuse to provide cardiopulmonary resuscitation—but not other types of treatment.⁹¹ Other states authorize healthcare providers to refuse to provide life-sustaining treatment only when no other decisionmaker is available.⁹² In sum, the UHCDA and the less-comprehensive state statutes have failed to provide a clear and effective procedure for resolving futility disputes.

86. Lynette Cederquist, *Model Policy on Non-Beneficial Treatment*, SAN DIEGO PHYSICIAN, July 2009, at 22, 23.

87. *Id.*

88. See CAL. PROB. CODE §§ 4600–4805 (West 2009) (“Many provisions in Parts 1, 2, and 3 are the same as or drawn from the Uniform Healthcare Decisions Act (1993).”).

89. Variations of this standard include provisions that authorize providers to refuse to comply with requests not considered to be “reasonable medical practice,” e.g., MINN. STAT. ANN. § 145B.13 (West 2005), or “within the bounds of responsible medical practice,” N.H. REV. STAT. ANN. § 137-J:7(I) (Supp. 2009).

90. Pope, *supra* note 19, at 64–65.

91. N.Y. PUB. HEALTH LAW § 2966(1) (McKinney 2007 & Supp. 2009). For examples of similarly limited statutes, see VT. STAT. ANN. tit. 18, § 9708(a) (Supp. 2009); W. VA. CODE ANN § 16-30C-6(e) (LexisNexis 2006).

92. E.g., OR. REV. STAT. § 127.580 (2007); UTAH CODE ANN. § 75-2-1107(1) (1993) (repealed 2007) (current version at UTAH CODE ANN. § 75-2a-115 (Supp. 2009)).

2. Inconsistency and Reluctance in the Judicial Resolution of Futility Disputes

Compared to traditional end-of-life disputes (in which surrogates desire to withhold treatment against the provider's wishes), futility disputes rarely make it to court.⁹³ This is likely because court proceedings are time-consuming, highly emotional, public, and financially costly for both surrogates and healthcare providers.⁹⁴ When a futility dispute does come before a court, the court will apply the substituted-judgment and best-interest standards, as a surrogate is required to do by many state laws.⁹⁵ But the judiciary has struggled to apply these standards consistently.⁹⁶ For example, courts have had difficulty deciding what type of evidence may be considered in determining the patient's substituted judgment, and they have also struggled with appropriately weighing the opinions of different family members.⁹⁷ Furthermore, courts have not established the sufficient evidentiary burden to decide what the patient would have chosen.⁹⁸

The lack of a consistent judicial approach underscores a conclusion that judges themselves acknowledge: courts are not an adequate forum for resolving futility disputes.⁹⁹ Numerous judges have expressed discomfort at being placed in such a role and have

93. MEISEL & CERMINARA, *supra* note 10, § 13.01.

94. Cohen, *supra* note 21, § 18.06.

95. Hoffmann, *supra* note 61, at 840.

96. See, e.g., Thomas L. Hafemeister & Donna M. Robinson, *The Views of the Judiciary Regarding Life-Sustaining Medical Treatment Decisions*, 18 LAW & PSYCHOL. REV. 189, 191, 212–21 (1994) (presenting the results of a survey in which judges described particular difficulty in reconciling conflicting second-hand information about past patient preference, family wishes, and disputed medical evidence particularly in light of uncertain decisional standards); see also J. DONALD SMITH, RIGHT-TO-DIE POLICIES IN THE AMERICAN STATES 169 (2002) (explaining that the Massachusetts Supreme Judicial Court has applied a case-by-case approach in treatment refusal cases by limiting its holdings to the specific facts, thus providing healthcare professionals with very little guidance).

97. Hoffmann, *supra* note 61, at 840 n.81 (“At the trial court level, judges seem to have had particular difficulty in (1) evaluating prior statements of the patient; (2) evaluating the testimony of witnesses reporting prior statements of the patient; (3) deciding what weight to give the opinions of family and friends of the patient; and (4) determining whether the patient's expressed choice had been altered by time or intervening events.”).

98. Cohen, *supra* note 21, § 18.04[2][a]. While many courts require “clear and convincing evidence” that the requested treatment constitutes the “substituted judgment” of the patient, the relationship between the substituted judgment standard and the evidentiary burden of proof is also unclear in many cases. *Id.*

99. *Id.* § 18.06 (“[S]ome courts, while recognizing their responsibility to protect individual rights, have noted that treatment refusal decisions are more appropriately made either in the physician/patient/family context or through legislature.”).

promoted an alternate form of resolution.¹⁰⁰ For example, one judge stated, “Because judgment in [life and death cases] involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment—through legislation or otherwise—of another tribunal to make these decisions”¹⁰¹ Many other experts echo this sentiment, citing the financial expense, time commitment, and psychological strain of these cases.¹⁰² One need only look to the recent case of Terri Schiavo to see the inherent problems with the judicial resolution of these disputes.¹⁰³ The Schiavo case did not present issues of first impression, yet it involved over forty court proceedings and took seven years to resolve.¹⁰⁴ Given the inconsistency and reluctance of courts in addressing futility disputes, many medical and legal scholars recognized the need for an alternative forum. This recognition led to the development of the institutional ethics committee.

C. The Emergence and Proliferation of the Ethics Committee

In 1976, the New Jersey Supreme Court issued an influential decision endorsing the creation of ethics committees as an alternative

100. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674, 678–79 (Ariz. 1987) (“We approach this case . . . with extreme caution and humility, mindful of the profound and overwhelming sense of responsibility that accompanies the power to resolve what . . . are all too often life-and-death issues. . . .”); *Wendland v. Superior Court*, 56 Cal. Rptr. 2d 595, 601 (Cal. Ct. App. 1996) (Raye, J., concurring) (“I write separately to emphasize the complexity of the life and death issues underlying this litigation.”); *In re Guardianship of Browning*, 568 So. 2d 4, 15 (Fla. 1990) (“We are loath to impose a cumbersome legal proceeding at such a delicate time in those many cases where the patient neither needs nor desires additional protection.”); *DeGrella v. Elston*, 858 S.W.2d 698, 712 (Ky. 1993) (Wintersheimer, J., dissenting) (“It is always a struggle for the judicial system to properly resolve such weighty questions.”); *McKay v. Bergstedt*, 801 P.2d 617, 637 (Nev. 1990) (Springer, J., dissenting) (“I have agonized over this case.”).

101. *In re A.C.*, 573 A.2d 1235, 1264 n.2 (D.C. 1990).

102. Wendy K. Mariner, *Decision Making in the Care of Terminally Ill Incompetent Persons: Concerns About the Role of the Courts*, 32 J. AM. GERIATRICS SOC'Y 739, 742 (1984); David M. Shelton, *Keeping End-of-Life Decisions Away From Courts After Thirty Years of Failure: Bioethical Mediation as an Alternative for Resolving End-of-Life Disputes*, 31 HAMLINE L. REV. 103, 110–13 (2008).

103. *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378 (M.D. Fla. 2005); see Shelton, *supra* note 102, at 105 (calling the *Schiavo* case “[t]he most recent and well-known example of the failure of litigation in resolving end-of-life disputes”).

104. Cohen, *supra* note 21, § 18.04. In addition, this case generated legislative activity that created interesting legal issues about the role of third parties in end-of-life decisionmaking. Although the early years of the case involved only the patient’s family members, the Florida legislature eventually enacted a statute authorizing the governor to order tube reinsertion. 2003 Fla. Laws ch. 418, *invalidated by* *Bush v. Schiavo*, 885 So. 2d 321 (Fla. 2004). This law was invalidated by the Florida Supreme Court, *Schiavo*, 885 So. 2d at 337, but then the U.S. Congress passed a law specifically permitting Schiavo’s parents to sue in federal court. Judicial Relief for the Parents of Theresa M. Schiavo, Pub. L. No. 109-3, 199 Stat. 15 (2005).

forum for futility dispute resolution.¹⁰⁵ In *In re Quinlin*, the court authorized a father, as guardian of his permanently unconscious daughter Karen, to request termination of her life-sustaining treatment.¹⁰⁶ Significantly, the court suggested that as “a general practice and procedure,” ethics committees should confirm the prognosis of a patient before life-sustaining treatment is withdrawn.¹⁰⁷ Furthermore, it granted civil and criminal immunity for providers who honored treatment refusals after such ethics committee involvement.¹⁰⁸ With its holding, *In re Quinlin* gave credence to a new alternative to the judicial system in order to clarify proper action for healthcare providers.

Several states followed New Jersey’s lead in recognizing a role for healthcare ethics committees.¹⁰⁹ Additionally, a 1983 President’s commission report strongly encouraged the creation of ethics committees to help resolve questions arising at the end of life.¹¹⁰ Following this development, Maryland and New Jersey mandated the establishment of ethics committees by law and by regulation, respectively.¹¹¹ The most important impetus came in 1992, when the Joint Commission on the Accreditation of Healthcare Organizations recommended that hospitals establish a mechanism for ethics consultation.¹¹² Hospitals were certain to heed this recommendation rather than risk losing accreditation.¹¹³ By 2007, 81 percent of all general hospitals and 100 percent of hospitals with more than 400

105. *In re Quinlin*, 355 A.2d 647, 671 (N.J. 1976), *overruled in part on other grounds by In re Conroy*, 486 A.2d 1209 (N.J. 1985). *Quinlin* is also significant because it was the first case to recognize that incompetent patients do not lose the right to reject treatment. Cohen, *supra* note 21, § 18.04.

106. *Quinlin*, 355 A.2d at 647.

107. *Id.* at 667–69.

108. *Id.*

109. For decisions discussing the role of ethics committees, see *Conservatorship of Wendland*, 28 P.3d 151, 155–56 (Cal. 2001); *In re Doe*, 418 S.E.2d 3, 4–5 (Ga. 1992); *In re Lawrance*, 579 N.E.2d 32, 42 (Ind. 1991); *Woods v. Commonwealth*, 142 S.W.3d 24, 49–51 (Ky. 2004); *In re Martin*, 538 N.W.2d 399, 208–10, (Mich. 1995).

110. PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBS. IN MED. & BIOMEDICAL & BEHAVIORAL RES., DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 154–60 (1983), *available at* http://www.bioethics.gov/reports/past_commissions/deciding_to_forego_tx.pdf.

111. MD. CODE. ANN. HEALTH-GEN. § 19-374 (LexisNexis 2009); N.J. ADMIN. CODE § 8:436-5.1 (2009). Since that time, Colorado and Texas have similarly mandated the establishment of ethics committees. COLO. REV. STAT. § 15-18.5-103(6.5) (2008); 25 TEX. ADMIN. CODE § 405.60(a) (2009).

112. Sharon E. Caulfield, *Healthcare Facility Ethics Committees*, 34 HUM. RTS., Fall 2007, at 10, *available at* <http://www.abanet.org/irr/hr/fall07/caulfield07.html>.

113. *Id.* at 11.

beds had established ethics consultation services.¹¹⁴ Indeed, the American Medical Association's model approach for resolving futility disputes includes ethics committee consultation as the final stage of dispute resolution before an attempt to transfer the patient is made.¹¹⁵

Although ethics committees are generally authorized to make recommendations, some states have delegated them considerable decisionmaking power. Several states empower ethics committees to make life and death decisions jointly with one or two physicians when no usual surrogate is available.¹¹⁶ Texas has gone a step further by giving ethics committees the legal authority to render final decisions in disputes between surrogates and physicians.¹¹⁷ Hawaii has statutorily defined "ethics committee" to include the function of decisionmaking regarding life-sustaining treatment.¹¹⁸ In New Jersey, ethics committees are expressly authorized to resolve disputes about the appropriate interpretation and application of the terms of an advance directive.¹¹⁹

Even where the authority to render binding decisions is not granted by state law, ethics committees often serve as the informal forum of last resort.¹²⁰ An influential national study of hospital ethics consultation revealed that, on average, ethics committees recommended a single best course of action in 46 percent of cases.¹²¹ Commentators note that the institutional force of such recommendations is so strong that they often become mandatory in

114. Fox et al., *supra* note 27, at 23.

115. Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281(10) J. AM. MED. ASS'N 937, 939-40 (1999). In the AMA's "process-based" approach, if a resolution cannot be reached after consultation with the ethics committee, and transfer cannot be effected, "the intervention . . . need not be provided, although the legal ramifications of this course of action are uncertain." *Id.*

116. See, e.g., ALA. CODE § 22-8A-11(D)(7) (2006); ARIZ. REV. STAT. ANN. § 36-3231(B) (2009); GA. CODE ANN. § 31-39-2 (2009); FLA. STAT. § 765.404 (2005 & Supp. 2009).

117. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (Vernon Supp. 2009); see *supra* note 81 and accompanying text (providing a brief summary of the Texas Advance Directives Act).

118. HAW. REV. STAT. ANN. § 663-1.7(a) (LexisNexis 2007) (defining "ethics committee" as "a committee that may be an interdisciplinary committee appointed by the administrative staff of a licensed hospital, whose function is to consult, educate, review, and make decisions regarding ethical questions, including decisions on life-sustaining therapy").

119. N.J. STAT. ANN. § 26:2H-53 (West 2007 & Supp. 2009).

120. Sheila A.M. McLean, *Clinical Ethics Committees, Due Process and the Right to a Fair Hearing*, 15 J.L. & MED. 1, 1 (2008) (finding that hospital ethics committees in the United States are "increasingly authoritative"); Sheila A.M. McLean, *Clinical Ethics Committees: A Due Process Wasteland?*, 3 CLINICAL ETHICS 100-01 (2008) (describing several court decisions that cede considerable authority to ethics committee recommendations).

121. Fox et al., *supra* note 27, at 21.

effect.¹²² Moreover, the finality of ethics committee decisions is especially true in medical futility disputes, which rarely make it to court.¹²³ Any decisionmaking body given such tremendous responsibility to render life-or-death decisions must be impartial and fair. Yet, as examined in Part II, ethics committees face distinct conflicts of interests, thus highlighting the need for a different forum for futility dispute resolution.

II. ETHICS COMMITTEE BIAS CONTAMINATES FUTILITY DISPUTE RESOLUTION

Many states have not even attempted to address futility dispute resolution through legislation, instead only allowing healthcare providers to decline to comply with treatment requests that are “outside of their professional medical judgment” or “contrary to reasonable medical standards.”¹²⁴ Although the UHCDA attempts to fix this legislative gap, it still fails to provide a clear procedure to assure that decisions to sustain or forgo treatment will be made in the best interest of the patient. Faced with these gaps in legislation and the judiciary’s reluctance to resolve futility disputes, many healthcare institutions have adopted policies that authorize ethics committees to resolve futility disputes.¹²⁵

Despite this degree of influence over life-and-death decisions, ethics committees operate without any internal or external regulations.¹²⁶ This lack of regulations is particularly problematic in light of the inherent conflicts of interest within ethics committees. Healthcare institutions undoubtedly have an interest in the resolution of end-of-life disputes because the final decision may lead to adverse financial, legal, and reputational consequences. Such considerations may inappropriately influence ethics committee decisions because the

122. George Agich, *Authority in Ethics Consultation*, 23 J.L. MED. & ETHICS 273, 275 (1995) (recommendations have a “practical effect akin to power”); Karen Ritchie, *When It’s Not Optional*, 18 HASTINGS CTR. REP. 25, 25 (1988) (describing some ethics committee recommendations as being mandatory in effect and explaining that committees “may, intentionally or not, place a great deal of pressure on caregivers to conform to ‘optional’ committee determinations”); Susan M. Wolf, *Due Process in Ethics Committee Case Review*, 4(2) H.E.C. FORUM 83, 88 (1992) (noting that “committees, even when they protest that they are merely advisory, can actually wield significant power”).

123. MEISEL & CERMINARA, *supra* note 10, § 13.01.

124. *See supra* notes 89–92 and accompanying text.

125. Susan Carhart, *Process Approach to End-of-Life Care Fails to Eliminate Ethical, Political Issues*, 11 Health L. Rep. (BNA) 1755 (Dec. 19, 2002).

126. Spielman, *supra* note 33, at 180.

majority of committee members are employed by the institution.¹²⁷ As one law professor states, “One need only ask who hires them, who they are accountable to, and what group they wish least to offend to appreciate how easily ethics consultants can lose the critical distance needed to exercise . . . independent, objective judgment.”¹²⁸

The risk of bias is present in all end-of-life decisions; however, this Note focuses specifically on the presence of this risk in futility disputes. Depending on the primary considerations of the specific ethics committee, conflicts of interest can make ethics committees biased toward a physician in a futility dispute (resulting in a decision to inappropriately withdraw treatment) or toward the surrogate (resulting in the prolonging of treatment even though it is futile). In other words, an ethics committee’s ties to the healthcare institution create improper considerations that can bias the final decision in either direction in futility disputes.¹²⁹ This Part will describe multiple ways in which such improper considerations may contaminate ethics committee decisions.

A. Financial Conflicts of Interest Lead to the Improper Consideration of Cost

1. Limiting Expenses by Limiting Treatment

When deciding whether to continue providing life-sustaining treatment, an ethics committee may be tempted to consider whether the financial costs of providing such treatment are covered by Medicare. As the largest public program for financing individuals’ healthcare, Medicare covers inpatient services for persons sixty-five and over “who receive old-age benefits under Social Security or the railroad retirement system—nearly the entire elderly population.”¹³⁰ Under the current payment system, Medicare reimburses hospitals based on calculations of the average cost of treatment for any

127. See Hoffmann, *Regulating Ethics Committees*, *supra* note 30, at 847 (noting the strong concern that ethics committee decisions will exhibit “institutional protectionism” because generally the committees are “composed almost entirely of . . . staff”).

128. Hoffman, *Does Legislating Hospital Ethics Committees Make Sense?*, *supra* note 30, at 185 (citing Giles R. Scofield, *Ethics Consultation: The Least Dangerous Profession?*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 420 (1993)).

129. Furthermore, the sources of bias discussed in this Part can affect futility determinations generally, whether or not the surrogate disputes a physician’s decision to withdraw treatment. In other words, the effects of ethics committee conflicts of interest extend further than futility disputes between a physician and surrogate, as they can influence a physician’s actions even if not challenged by the surrogate.

130. HAVIGHURST ET AL., *supra* note 12, at 110.

particular diagnosis.¹³¹ This prospective payment system, instituted in 1983, completely transformed healthcare reimbursement;¹³² before then, Medicare retrospectively reimbursed physicians and healthcare institutions according to what they charged.¹³³ Under the current system, institutions receive a set fee for the treatment of patients in the same diagnosis-related groups (“DRGs”).¹³⁴ A DRG is a grouping of comparable types of patients and illnesses whose cost of treatment is expected to be similar.¹³⁵

Although Congress created the prospective payment system in order to promote more cost-efficient management of medical care,¹³⁶ the system creates new ways for hospitals to behave opportunistically and to maximize revenue.¹³⁷ In the end-of-life context, the prospective system creates an incentive for physicians and hospitals to limit treatment and transfer patients quickly and efficiently.¹³⁸ When a patient has exhausted the payment received for her DRG, continuing treatment results in a net loss for the institution. A healthcare provider or institution may be more likely to insist upon the withdrawal of treatment if Medicare payments have been exhausted. Upon review of this decision, ethics committee members may be more inclined to discontinue treatment due to these fiscal concerns.¹³⁹

Rideout v. Hershey Medical Center demonstrates the influence that insurance payments may have on ethics committee decisions.¹⁴⁰ This case involved Brianne Rideout, a three-year-old diagnosed with a brain stem glioblastoma that manifested as a malignant tumor in her brain.¹⁴¹ After undergoing surgery, her physicians determined that her illness was incurable and that further life-sustaining treatment would be futile.¹⁴² On May 20, 1992, the hospital’s social services department

131. Medicare Prospective Payment System, American Hospital Directory, <http://www.ahd.com/pps.html> (last visited Jan. 22, 2010).

132. *Id.*

133. John Lantos, *When Parents Request Seemingly Futile Treatment for Their Children*, 73 MOUNT SINAI J. MED. 587, 589 (May 2006).

134. *Id.*

135. *Doctors Hosp., Inc. of Plantation v. Bowen*, 811 F.2d 1448, 1449–50 (11th Cir. 1987). Each DRG is assigned a weight that varies with the severity of the illness. This number is then multiplied by a dollar figure that represents the national average per patient cost of medical treatment. *Id.*

136. *Id.*

137. HAVIGHURST ET AL., *supra* note 12, at 232.

138. Lantos, *supra* note 133, at 589.

139. *Id.*

140. 30 Pa. D. & C.4th 57 (Pa. Com. Pl. 1995); *see also* Frank Bruni, *A Fight Over Baby’s Dignity and Death*, N.Y. TIMES, Mar. 9, 1996, at A6 (recounting the facts of the case).

141. 30 Pa. D. & C.4th at 59.

142. *Id.* at 59–60.

informed Brianne's parents that her health insurance coverage would soon be exhausted.¹⁴³ The very next day, Brianne's attending physician convened the hospital's ethics committee, which decided that a "Do Not Resuscitate" order would be instituted in the event of cardiac arrest.¹⁴⁴ Brianne's parents reacted with vehement opposition and desperation, pleading with the physicians and eventually seeking legal assistance to prevent the cessation of treatment.¹⁴⁵ Nevertheless, the physician and hospital ethics committee decided to remove Brianne's ventilator against her parents' fervent opposition.¹⁴⁶

The ethics committee may have correctly assessed the futility of Brianne's situation;¹⁴⁷ however, the important point here is that the exhaustion of insurance payments appeared to factor prominently into the decision. First, Brianne's physician consulted the ethics committee the very day after insurance was exhausted. Second, the exhaustion of insurance payments seemingly led the provider to rush inappropriately into a decision to withdraw life support. Indeed, the physician removed Brianne from ventilator support while her mother was in another area of the hospital on the phone with her lawyer—an action that the court characterized as sufficient to allege reckless indifference.¹⁴⁸ Brianne's mother drew attention to the apparent influence of monetary concerns by stating, "It's okay for some people who don't regard life and may want their child dead for insurance, but we value Brianne and her life."¹⁴⁹ Even if the withdrawal of insurance was not a factor, the appearance of such an improper influence on ethics committee decisions can be just as damaging to their legitimacy.

Some may respond that economic factors must be considered in healthcare decisions because the resources of medical institutions are limited. However, the legal framework for making healthcare decisions on behalf of incompetent patients does not include monetary considerations as a relevant factor. Both surrogate decisionmakers and courts first apply the substituted-judgment standard, which seeks to ascertain what the patient would have decided about a specific medical treatment before she lost capacity.¹⁵⁰ If the patient's intent is

143. *Id.* at 60.

144. *Id.*

145. *Id.* at 60–63.

146. *Id.* at 62–63.

147. *Id.* at 69 ("[T]he hospital's decision to remove the ventilator support may have been a 'reasoned medical decision.'").

148. *Id.* at 95–96.

149. *Id.* at 61.

150. *See supra* note 98.

not evident, the decisionmaker then applies the “best interest” standard, under which the course of treatment in the best interest of the patient is determined.¹⁵¹ Both of these tests are patient-centered, focusing on the preferences, benefits, and burdens on the patient and excluding considerations such as economic impact on third parties. This decisionmaking framework should be maintained regardless of the entity rendering an end-of-life decision on behalf of incompetent patients.

2. Generating Revenue through Insurance Payments

While the prospective payment system incentivizes hospitals to limit treatment, other healthcare institutions participating in retrospective reimbursement may instead continue life-sustaining treatment in order to increase profit, even though such treatment is not in the patient’s best interest. Even though acute-care hospitals have transitioned to the prospective payment system, Medicare retrospectively reimburses certain institutions (including psychiatric, rehabilitation, children’s, and long-term hospitals and home health agencies) for the reasonable costs of services, determined after the provision of care.¹⁵² This type of reimbursement creates disincentives for cost containment by providers,¹⁵³ possibly resulting in the continuation of futile treatment.

Additionally, states may retrospectively reimburse medical facilities through Medicaid, the major federal entitlement program intended to meet the medical needs of low-income individuals.¹⁵⁴ Federal law does not set specific guidelines for Medicaid reimbursement, instead leaving discretion to the states.¹⁵⁵ The potential for Medicaid reimbursement to impact futility cases is heightened by the program’s coverage of nursing home care.¹⁵⁶ Faced with heavy medical expenses not covered by Medicare, many older persons use up their assets and become eligible for Medicaid.¹⁵⁷ Largely as a result of this trend, over 50 percent of nursing home

151. *Id.*

152. HAVIGHURST ET AL., *supra* note 12, at 227.

153. *Id.* at 226.

154. *Id.* at 113.

155. 42 U.S.C. § 1396a(30)(A) (2006) (requiring states to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”).

156. HAVIGHURST ET AL., *supra* note 12, at 115.

157. *Id.*

patients are supported by state Medicaid programs.¹⁵⁸ Moreover, many for-profit long-term care facilities receive more than 75 percent of their total revenue from Medicare and Medicaid, amounting to over \$87 billion annually.¹⁵⁹ Consequently, for many long-term care facilities, the bottom line greatly depends on government insurance payments.

Simply put, ethics committees at healthcare institutions receiving retrospective reimbursement have a financial incentive to prolong treatment in order to generate revenue through insurance payments, regardless of whether such treatment is in the best interest of the patient. For example, a long-term care facility may receive more reimbursement for attempting life-sustaining treatment for a patient in a critical state than for administering palliative care.¹⁶⁰ Even if the treatment will be futile, the facility has little incentive to withdraw life-sustaining treatment against the wishes of the surrogate in this scenario. Long-term care institutions, whose operation largely depends on federal Medicare and Medicaid funds, may be more heavily influenced by these financial considerations. Consequently, ethics committee members who have a financial interest in the medical facility may feel an obligation to take these costs into consideration when resolving a futility dispute.

Additionally, healthcare institutions may generate revenue by transferring futile patients from one facility to another during the course of treatment, a practice that gives rise to unnecessary physical stress and creates avoidable risks for the patient. This occurs for two reasons. First, under the Medicare prospective payment system, a transferring institution will be paid at a per diem rate (up to the full DRG allowance) based on the average per diem cost to the government of patients in the same DRG.¹⁶¹ By contrast, the transferee-institution receives the usual DRG payment in full.¹⁶² This payment scheme incentivizes healthcare institutions to admit patients transferred from other institutions. It is thus unsurprising that public healthcare

158. *Id.*

159. Carolyn Cartier, *From Home to Hospital and Back Again: Economic Restructuring, End of Life, and the Gendered Problems of Place-Switching Health Services*, 56 SOC. SCI. & MED. 2289, 2293 (2003).

160. See Robert Kaplan & Diane Schneider, *Medical Decision Making Toward the End of Life: Ethical, Economic, and Health Policy Implications*, 20 ANN. REV. GERONTOLOGY & GERIATRICS 39, 576 (2000).

161. HAVIGHURST ET AL., *supra* note 12, at 232.

162. *Id.*

institutions receive more transfers since the implementation of this system.¹⁶³

Second, hospitals may exploit the prospective payment system by transferring patients to nursing homes, which in turn transfer the patient back to the hospital. In this scenario, referred to as the “revolving door” of healthcare provision,¹⁶⁴ a hospital first transfers a futile-care patient to a nursing home. Later, a physician will readmit the patient to the hospital with newly documented symptoms in order to qualify for a new DRG. The transfer of futile-care patients back and forth from hospitals to nursing homes for complications that solely prolong the dying process may generate additional income for the hospital, the physician, and the long-term care facility. Indeed, “[i]n a study of three U.S. west-coast nursing homes, 48% of the residents who were transferred to an acute-care hospital had conditions that ‘could have been definitively diagnosed and treated in the nursing home.’”¹⁶⁵

Although Medicare has attempted to prevent this abuse through oversight,¹⁶⁶ the profit incentive and the potential for abuse will remain if those who profit from the care possess complete discretion to decide whether such care is futile. When an ethics committee is faced with a futility dispute and the institution can profit if the committee sides with the surrogate, then continuing treatment would appear to be the easy choice for the committee. After all, those who may be harmed by the decision are unlikely to cause any real problems in response: the physician depends on the institution for her livelihood, and the patient cannot speak for herself.

3. Avoiding Litigation

Not only may ethics committees be influenced to continue futile treatment improperly in order to gain revenue through insurance payments, but they may also continue treatment to prevent the costs of litigation. Although numerous experts believe that patient protection should be the primary purpose of ethics committees,¹⁶⁷

163. *Id.*

164. Cartier, *supra* note 159, at 2290.

165. Miriam Moss, *End of Life in Nursing Homes*, 20 ANN. REV. GERONTOLOGY & GERIATRICS 224, 226–27 (2000) (quoting Jeanie S. Kayser-Jones et al., *Factors in Contributing to the Hospitalization of Nursing Home Residents*, 29 GERONTOLOGIST 502, 509 (1989)).

166. See HAVIGHURST ET AL., *supra* note 12, at 232 (“[T]he government set up a monitoring system to investigate transfers to ensure that PPS was not being exploited.”).

167. *E.g.*, Robert M. Kliegman et al., *In Our Best Interests: Experience and Workings of an Ethics Review Committee*, 108 J. PEDIATRICS 178, 186 (1986) (“[T]he goal is to promote the best interests of patients.”); Judith Randal, *Are Ethics Committees Alive and Well?*, HASTINGS CTR.

many have asserted that risk management is also a valid committee objective.¹⁶⁸ The Supreme Court has supported this role for ethics committees, explaining that “[t]he committee’s function is protective. It enables the hospital appropriately to be advised that its posture and activities are in accord with legal requirements.”¹⁶⁹ In some cases, the hospital’s interest in avoiding potential lawsuits may be inconsistent with the best interest of the patient.¹⁷⁰ Liability concerns may lead physicians to resort to more aggressive treatment even when such treatment is futile.¹⁷¹ Ethics committees reviewing treatment decisions may similarly err on the “safe side” by recommending the continuation of futile treatment.

Two factors heighten the risk that ethics committees will “over-treat” due to liability concerns. First, the presence of hospital administrators and attorneys on many ethics committees may increase the likelihood that risk-management will be a committee objective.¹⁷² Second, the unequal bargaining power of the surrogate and the healthcare institution may lead ethics committees to continue treatment in accordance with the surrogate’s wishes. Healthcare institutions may incur substantial financial and reputational harm due to litigation, making them risk-averse in futility disputes. By contrast, surrogates may be more risk-tolerant because the costs of their decisions are externalized.¹⁷³ The financial burden is often borne by the insurer, while the emotional burden of treating the patient is

REP., Dec. 1983, at 10, 12 (characterizing the role of ethics committees as that of patient advocate).

168. George J. Annas, *Ethics Committees in Neonatal Care: Substantive Protection or Procedural Diversion?*, 74 AM. J. PUB. HEALTH 843, 843–44 (1984) (“Institutions and their staffs often see the primary function of ethics committees as protecting them against potential legal liability for treating or not treating particular patients.”).

169. *Doe v. Bolton*, 410 U.S. 179, 197 (1973).

170. JUDITH WILSON ROSS ET AL., HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 39 (1986); John A. Robertson, *Committees as Decision Makers: Alternative Structures and Responsibilities*, in INSTITUTIONAL ETHICS COMMITTEES AND HEALTHCARE DECISION MAKING 85, 88–89 (Ronald E. Cranford & A. Edward Doudera eds., 1984) (noting the potential use of an ethics committee as an “ethical risk management team”).

171. HARRIS INTERACTIVE, FEAR OF LITIGATION: THE IMPACT ON MEDICINE 9 (2002), available at <http://commongood.org/attachments/57/Fear+of+Lit+Exec+Rep.pdf> (showing that over half of the respondents stated that they have noticed a physician resorting to aggressive treatments of terminally ill patients because of liability concerns).

172. ROSS, *supra* note 170, at 390 n.194 (citing 1992 survey conducted with the assistance of the American Hospital Association that found that 96.2 percent of all ethics committees contain at least one administrator and explaining: “The concern that the ethics committee will act as a risk management team is heightened by the inclusion on nearly all committees of hospital administrators and in-house counsel, both of whom have probable conflicts of interest.”).

173. Thaddeus M. Pope & Ellen A. Waldman, *Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143, 169 (2007).

borne by the healthcare provider.¹⁷⁴ The resulting relationship is often characterized by unequal bargaining power, as risk-tolerant surrogates have greater leverage than risk-averse institutions.¹⁷⁵

Because the interests of the majority of ethics committee members are inherently intertwined with the interests of the healthcare institution, the committee may reflect the institution's risk aversion. As a result, ethics committees may gloss over difficult cases to avoid courses of action that could work to the institution's disadvantage, thus jeopardizing the patient's right to receive treatment in accordance with her substituted judgment or best interest.¹⁷⁶ At a recent open forum on ethics committees conducted by the American Medical Association Council on Judicial and Ethical Affairs, delegates highlighted this problem by asserting that ethics committees often avoid cases that could pose challenges to the organization.¹⁷⁷ Those committee members who serve risk-management functions within the institution, including hospital legal counsel and administrators, will more strongly advise the committee to take the position on a case that is least likely to cause legal problems for the institution.¹⁷⁸

Legislation in ten states grants immunity from civil or criminal liability to members of ethics committees or healthcare providers who rely on committee advice; however, this legislation leaves unprotected the healthcare institution from other claims relating to the physician's prior decisions in the treatment of the patient.¹⁷⁹ If an ethics committee decides to withdraw life-sustaining treatment against the surrogate's wishes, the surrogate may perceive the decision as evidence that the physician did not value the patient's life. This perception, however irrational, may result in a civil suit for allegedly negligent acts or omissions occurring prior to the ethics committee decision. Alternatively, patients may perceive the withdrawal of treatment as the provider's attempt to "bury a mistake," thus leading to a malpractice or negligence suit. Because a healthcare institution

174. *Id.*

175. *Id.* at 184–85.

176. Cynthia B. Cohen, *The Social Transformation of Some American Ethics Committees*, HASTINGS CTR. REP., Sept.-Oct. 1989, at 21.

177. Kevin B. O'Reilly, *Delegates Weigh Ethics Committee's Role*, AM. MED. NEWS, Dec. 1, 2008, at 17, available at <http://www.ama-assn.org/amednews/2008/images/prhd1201.pdf>.

178. Robert F. Weir, *Pediatric Ethics Committees: Ethical Advisers or Legal Watchdogs?*, 15 LAW MED & HEALTHCARE 99, 106 (1987).

179. ALA. CODE § 22-8A-11 (2006); ARIZ. REV. STAT. ANN. § 36-3231 (2009); FLA. STAT. ANN. § 765.404 (West 2005); GA. CODE ANN. §§ 31-39-4, 31-39-7 (2009); HAW. REV. STAT. ANN. § 663-1.7 (LexisNexis 2007); MD. CODE ANN. HEALTH-GEN. § 19-374 (West 2009); MONT. CODE ANN. § 37-2-201 (2009); TEX. HEALTH & SAFETY CODE ANN. §§ 166.039, 166.044 (Vernon 2001 & Supp. 2009).

could be joined in these lawsuits and held vicariously liable for a physician's acts, ethics committees employed by the institution would be incentivized to side with the surrogate in order to avoid this risk. Ethics committees may also want to continue treatment to shield the institution from reputational consequences, which can result even without litigation. For example, a hospital may attract negative attention from the public if it withdraws life-sustaining treatment, especially if the surrounding community holds strong religious views regarding the end of life.¹⁸⁰

In addition, liability considerations may impact ethics committee decisions in a more subtle way. Consider the following scenario. During a tonsillectomy, a physician makes a mistake in administering the anesthetic.¹⁸¹ The patient, a five-year-old boy, enters into a coma due to hypoxic encephalopathy caused by a lack of oxygen supply to the brain.¹⁸² While the provider recognizes the futility of continuing life-sustaining treatment, the family insists that treatment be continued.¹⁸³ This futility dispute is appropriate for ethics committee review, but both the physician and the institution may wish to delay this case until the expiration of the statute-of-limitations period for malpractice claims.¹⁸⁴ Even though a prompt decision is in the patient's best interest, the ethics committee may instead seek to shield the physician, the institution, or both from liability through delay or avoidance. An independent decisionmaking body lacking any connection to the physician or hospital would not seek to protect these third parties, but would instead step in to protect the patient from such injustice.

180. See, e.g., Arthur E. Kopelman, *Understanding, Avoiding, and Resolving End-of-Life Conflicts in the NICU*, 73 MOUNT SINAI J. MED. 580, 582 (2006) (reproducing a surrogate decisionmaker's explanation that if he or she "agreed to limit or stop life support, members of their church would see them as lacking faith in God's ability to heal"); see also Robert L. Fine, *The Texas Advance Directives Act of 1999: Politics and Reality*, 13 HEC FORUM 59, 64 (2001) (explaining that individuals led by the National Right to Life Committee believed that patient surrogates should have the unlimited right to insist on life-sustaining treatment for the patient).

181. This illustration is modeled after a scenario documented by Kevin Simpson, *Anesthesia Cited in B-N Boy's Death*, PANTAGRAPH (Bloomington, Ill.), Mar. 16, 1996, at A1. In the real case, the young boy died soon after the surgery. *Id.*

182. *Id.*

183. *Id.*

184. See, e.g., TENN. CODE ANN. § 29-26-116 (2009) (declaring that the statute of limitations in medical malpractice actions is one year following the date of the event or incident giving rise to the injury, or one year from the date of the discovery of the injury).

B. Professional Conflicts of Interests Create Improper Allegiance

Ethics committees are composed primarily of physicians and nurses.¹⁸⁵ As a result, physicians and other medical staff on the ethics committee are likely to give added weight to the opinion of the treating physician and to dismiss the surrogate's position in a futility dispute more quickly. One physician noted that he has "seen the concerns of some individuals ignored because they are old, young, women, or health care personnel *other than physicians*."¹⁸⁶ In fact, committee members may believe that their primary constituency is the physician, rather than the patient.¹⁸⁷ A patient's surrogate who recognizes the professional relationship between ethics committee members and the treating physician would be justifiably suspicious of the committee's neutrality, leading the surrogate not to consult the committee if she disputes a physician's recommendation to forgo treatment.¹⁸⁸

Moreover, preexisting social and professional relationships with the treating physician may cause overreliance in the treating physician's opinion regarding the futility of continuing treatment.¹⁸⁹ This bias may help explain the findings of a national study that discovered that 87 percent of ethics committees "usually" or "always" gathered information by examining the patient's record (composed by the patient's physician), while only 48 percent consulted the patient's family members.¹⁹⁰ In addition to professional relationships, the institutional process of medical peer review further threatens ethics committee objectivity. A treating physician involved in a futility dispute may later participate in peer review of other physicians

185. Fox et al., *supra* note 27, at 23 (finding that of individuals performing ethics consultation, 34 percent were physicians and 31 percent were nurses); *see also* Burns & Truog, *supra* note 20, at 1990–91 ("[T]he delicate task of adjudicating futility disputes between families and [physicians] is done by a group that is virtually indistinguishable from the clinicians themselves.").

186. SIGRID FRY-REVERE, *THE ACCOUNTABILITY OF BIOETHICS COMMITTEES AND CONSULTANTS* 100 (1992) (emphasis added).

187. Andrew L. Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1292 (1987) ("It is unlikely that many committees identify whether their primary constituency is doctors or patients. Indeed, few of the participants may consciously think in advance of defining their roles in these terms.").

188. *See* Robert D. Truog, *Tackling Medical Futility in Texas*, 357 NEW ENG. J. MED. 1, 2 (2007) (recognizing that members of ethics committees are "insiders," and that this is "hardly a 'jury of peers' for a low-income woman of color and her infant son").

189. *See* Don Milmore, *Hospital Ethics Committees: A Survey in Upstate New York*, 18 HEC FORUM 222, 235, 239 (2006) (noting that ethics committees constituted of hospital staff may exhibit both institutional biases toward 'groupthink' as well as feel an obligation of loyalty that may color their views of the actions of those with whom they work).

190. Fox et al., *supra* note 27, at 20.

serving on an ethics committee. By siding with the surrogate decisionmaker, ethics committee members risk later retaliation by the treating physician in peer review.¹⁹¹

Although committee members influenced by professional connections may be prone to side with the physician in a futility dispute and thus decide to withdraw treatment, this risk is lessened by the ethics committee's fear of liability resulting from stopping treatment.¹⁹² Accordingly, the risk of professional bias is greatest in jurisdictions granting immunity to ethics committee members.¹⁹³ Empirical research conducted at the Baylor Health Care System in Texas, a state where ethics committees are immune from liability, indicates that this risk may be a reality.¹⁹⁴ During a two-year period, Baylor's ethics committee agreed with the clinical team's futility assessment in forty-three of forty-seven cases.¹⁹⁵ This statistic may signal that internal ethics committees that are immunized from liability serve merely as a rubber-stamp mechanism for consistently overriding surrogate requests for maintaining treatment.¹⁹⁶

III. A FAIR AND IMPARTIAL FUTILITY DISPUTE RESOLUTION MECHANISM

The above discussion reveals that both public and private policies have failed to adequately safeguard incompetent patients in the midst of a dispute regarding whether to forgo or continue life-sustaining treatment. Most states have not addressed futility disputes through legislation, and the model act intended to address this issue, the UHCDA, fails to answer fundamental questions regarding its procedure. Furthermore, judges have expressed consistently that courts are not the proper venue for the resolution of futility disputes. As a result, ethics committees have emerged as an alternative forum, yet it is a forum plagued by conflicts of interest that can lead to biased and unfair medical decisions.

Any solution to this legal problem must balance several competing interests. First, patient autonomy is a fundamental

191. See, e.g., Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993) (in which interviewed respondents expressed discomfort with withdrawing treatments due to fear of sanction by peer review boards).

192. See *supra* Part II.A.3.

193. See *supra* note 179 for a list of states.

194. Robert D. Truog & Christine Mitchell, *Futility – From Hospital Policies to State Laws*, AM. J. OF BIOETHICS, Sept.-Oct. 2006, at 19, 19–21.

195. *Id.*

196. *Id.*

principle of American common law. Judge Benjamin Cardozo, then of the New York Court of Appeals, explained long ago that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body”¹⁹⁷ Advance directives and surrogacy statutes are an effort to protect and extend the autonomy principle for those not of “sound mind” such as the incompetent, mentally disabled, or underage. Under most surrogacy statutes, a surrogate must make medical decisions according to the surrogate’s knowledge of the patient’s wishes, to the extent that these are known. Thus, a physician’s disagreement with a surrogate’s request for continued life-sustaining treatment, albeit futile in the physician’s opinion, may be seen as denying respect for patient autonomy.

Yet the law simultaneously embraces the physician’s right to refuse treatment that she deems medically ineffective.¹⁹⁸ This right is well-established among members of the medical field,¹⁹⁹ as captured by the American Medical Association Code of Medical Ethics.²⁰⁰ By facilitating a surrogate’s request for unnecessary or harmful intervention out of respect for patient autonomy, the physician reciprocally undermines her own professional autonomy²⁰¹ as well as her fiduciary obligation to the patient.²⁰² Therefore, any solution to resolving futility disputes must provide a channel for the opinions and concerns of the competing autonomies of the patient and the physician to be expressed.

Furthermore, futility dispute resolution must incorporate elements of procedural due process to ensure that patients’ interests receive adequate protection.²⁰³ Although some commentators argue that due process procedures may make ethics committee case review unnecessarily adversarial, minimum procedural protections must be afforded in the context of life-and-death decisions. The existence of

197. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

198. MEISEL & CERMINARA, *supra* note 10, § 13.01.

199. Cohen, *supra* note 21, § 18.04[5][b] (“Until the end of the 20th century, there was little legal or medical dispute over the general proposition that there is no legal obligation to provide “medically futile” treatment, even if a patient or a patient’s surrogate demands the treatment and can pay for it.”).

200. “[P]hysicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefitting their patients.” AM. MED. ASS’N, *supra* note 15, §§ 2.035, 2.17, 2.20.

201. Allan S. Brett & Laurence B. McCullough, *When Patients Request Specific Interventions—Defining the Limits of the Physician’s Obligation*, 315 NEW ENG. J. MED 1347, 1347–51 (1986).

202. Philip G. Peters, *When Physicians Balk at Futile Care*, 91 NW. U. L. REV. 798, 841 (1997).

203. Wolf, *supra* note 35, at 818–19.

procedural rights in these decisions bolsters confidence in the accuracy of the decision, permits an orderly and reliable method for fact-finding and rule application, and symbolizes the parties' rights to have official acts explained and justified.²⁰⁴ Due process norms demand that institutions exercising control over the lives of others, such as ethics committees, "channel their authority in a way that is morally and ethically justifiable."²⁰⁵ In that vein, the Supreme Court has held that when a jury must decide whether to sentence a criminal defendant to death, due process requires procedures to protect against arbitrariness and capriciousness.²⁰⁶

With these principles in mind, this Note proposes a solution that provides a clear, statutory procedure for resolving futility disputes. This solution is adapted from Iowa's innovative establishment of State and Local Substitute Medical Decision-Making Boards ("SMDBs"). This Part first discusses the background of the Iowa SMDB program. It then describes each element of this program and its application to futility dispute resolution.

A. Background of Iowa Substitute Decisionmaking Boards

In 1989, Iowa enacted legislation establishing the State Substitute Medical Decision-Making Board and authorizing counties to establish local substitute medical decisionmaking boards.²⁰⁷ These boards were created in order to make medical decisions for incompetent patients who have no other surrogate decisionmaker available.²⁰⁸ Iowa's program expands upon New York's Surrogate Decision Making Committee Program,²⁰⁹ which makes decisions for persons with mental disabilities who reside in state-operated or state-

204. Nora O'Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 BAYLOR L. REV. 527, 561 (2008).

205. *Id.* at 561-62.

206. *Gregg v. Georgia*, 428 U.S.153, 189 (1976) ("[W]here discretion is afforded . . . on a matter so grave as the determination of whether a human life should be taken or spared, that discretion must be suitably directed and limited so as to minimize the risk of wholly arbitrary and capricious action.").

207. IOWA CODE § 135.28-29 (2009); SUBSTITUTE DECISION MAKERS TASK FORCE FOR THE IOWA DEPT. OF ELDER AFFAIRS, ALTERNATIVES TO GUARDIANSHIP AND CONSERVATORSHIP FOR ADULTS IN IOWA 14 (2006), available at <http://www.state.ia.us/elderaffairs/Documents/Ombudsman/AlternativesBooklet.pdf>.

208. IOWA ADMIN. CODE r. 641-85.3(1) (2009).

209. Ronald D. Eckoff, Letter to the Editor, *State Plans for Surrogate Decision Making*, 272 J. AM. MED. ASS'N 849, 850 (1994) (explaining that the Iowa SMDB's were established "using the New York rules as a guide").

licensed facilities.²¹⁰ Unlike the New York program, the Iowa SMDBs may make healthcare decisions for any individual who is medically incompetent and who does not have a guardian or family members to make medical decisions.²¹¹ However, they are not authorized to make decisions regarding the discontinuance of life-sustaining medical treatment.²¹²

Even though the Iowa SMDBs are utilized as a substitute mechanism when surrogates are not available and lack the authority to make decisions regarding life-sustaining treatment, these independent boards, along with their requirements and procedures, provide the ideal mechanism for resolving futility disputes. Therefore, this Part proposes the establishment of Futility Dispute Resolution Boards (“FDRBs”) by building upon the Iowa program. These policy provisions would help ensure that those charged with resolving futility disputes fully consider both positions in the dispute and are not influenced by the financial, legal, or professional considerations that currently undermine the neutrality of ethics committee decisions. Even though this solution is focused on resolving futility disputes, it could easily be broadened to encompass all end-of-life disputes.

B. Hashing Out the Solution Details

1. Board Structure and Composition

As in Iowa, FDRBs would be structured as a two-tier program that creates a state board and authorizes each county to establish and fund a local board.²¹³ Where there is no local board, the state board would have jurisdiction.²¹⁴ The state board would consist of at least fifteen members, at least four of whom are licensed as medical doctors by the state.²¹⁵ The two-tier nature of this program will provide the

210. See NY COMP. CODES R. & REGS. tit. 14, § 710.1 (2009); Stanley S. Herr & Barbara L. Hopkins, *Healthcare Decision Making for Persons With Disabilities: An Alternative to Guardianship*, 271 J. AM. MED. ASS'N 1017, 1017 (1994).

211. Eckoff, *supra* note 209, at 850.

212. IOWA ADMIN. CODE r. 641-85.2(5) (2009) (explicitly providing that the board does not have the authority to make a decision regarding the “discontinuance of medical treatment which is sustaining life functions”).

213. IOWA CODE § 135.28 (2009) (“A state substitute medical decisionmaking board is established to formulate policy and guidelines for the operations of local substitute medical decisionmaking boards, and to act if a local substitute medical decisionmaking board does not exist.”).

214. IOWA ADMIN. CODE r. 641-85.10.

215. *Id.* at r. -84.2 (“The state [SMDB] shall consist of 15 members at least 4 of whom shall be licensed in Iowa as doctors of medicine and surgery or as osteopathic physicians and surgeons, as defined by law.”).

flexibility needed to ensure participation by counties with varying amounts of human and financial resources. Some counties might establish their own boards, which would have the obvious advantage of local accessibility. However, counties lacking adequate resources could take advantage of a state board without sacrificing limited resources. The lack of resources has been cited by rural healthcare providers as one factor inhibiting the development and maintenance of institutional ethics committees.²¹⁶ Providing institutions access to a state- or county-funded decisionmaking board would alleviate this burden. Furthermore, by creating a uniform mechanism of resolving futility disputes in each state, this program would replace the current system, in which ethics committees vary in quality and function across healthcare institutions.²¹⁷

In addition, FDRBs would have standard composition requirements. Each board, whether at the state or local level, would have at least one member in each of the following categories: (1) physicians; (2) bioethicists; (3) nurses or social workers; (4) psychologists or counselors; and (5) other individuals (who do not fall into the first four categories) with recognized expertise and interest in persons unable to make their own health decisions.²¹⁸ These guidelines recognize the expertise needed to resolve the complex and technical medical and ethical issues involved in end-of-life disputes.²¹⁹ Courts have cited the lack of medical and ethical expertise in calling for an alternative forum for resolving these disputes;²²⁰ therefore, such an alternative forum must consist of individuals with the requisite training.

In addition to providing expertise, the guidelines would acknowledge the importance of diversity in a healthcare decisionmaking body. A nurse's or social worker's perspective likely

216. Ann Cook & Helena Hoas, *Are Healthcare Ethics Committees Necessary in Rural Hospitals?*, 11 HEC FORUM 134, 135 (1999).

217. Hoffmann, *Regulating Ethics Committees*, *supra* note 30, at 762 ("The 'quality' of ethics committees is likely to vary considerably. Large teaching hospitals in urban centers, for example, are much more likely to have the resources and access to individuals with expertise in medical ethics that are necessary to operate a successful committee, whereas small hospitals and nursing homes in rural areas may have difficulty finding these ingredients.").

218. IOWA ADMIN. CODE r. 641-85.3(1) (requiring local boards to consist of one or more representatives from each of the following categories: (1) physicians, nurses, or psychologists licensed by Iowa; (2) attorneys admitted to practice in Iowa or social workers; and (3) "other individuals with recognized expertise or interest in persons unable to make their own medical care decisions" not included in the first two categories).

219. The Iowa regulations require diversity but fail to require expertise. *Id.* Interpreting the plain meaning of the regulatory text, it appears as though a board could be composed of only a nurse, a social worker, and a clergyman. *Id.*

220. *In re A.C.*, 573 A.2d 1235, 1237 n.2 (D.C. 1990) (en banc).

would differ from that of a physician on a particular case, given the nature of their day-to-day interaction with patients and their families. Furthermore, psychologists or counselors would assist the ethics committee in understanding the emotional and psychological dimensions of a futility dispute, and would help to resolve misunderstandings between surrogate decisionmakers and hospital staff. Lastly, the final category would give boards the flexibility to include another individual with valuable expertise or interest in end-of-life medical decisions. For example, a chaplain would contribute a theological perspective, helping the committee to better understand the religious or spiritual beliefs of the patient, the surrogate, or both, and the impact of these beliefs on the futility dispute. Placing this type of composition requirement on each hospital ethics committee might be unrealistic in areas with fewer resources and limited staffing levels;²²¹ however, the FDRB program would allow a county to pool its resources to meet the standard or, alternatively, use the state's board.

2. Universal Access and Clear Application Procedure

While most hospitals have established ethics committees, surrogates may be unaware of their presence or may not be granted access to consultations.²²² Even if they are granted access, surrogates may feel intimidated by an ethics committee's close ties with the healthcare institution and the physician treating the patient. As one commentator explains, committee members are "unavoidably 'insiders,' completely acculturated to the clinical world and its attendant values. This is hardly a 'jury of peers' for a low-income woman of color and her infant son."²²³ Thus, a board reviewing a futility dispute must be accessible to any person who has knowledge and concern of a particular case.²²⁴ In addition to requiring broad access, hospitals would be required to provide information about the FDRB program to surrogate decisionmakers, family members, and hospital staff.

221. Cook & Hoas, *supra* note 216, at 135; *cf.* N.J. ADMIN. CODE § 8:43G-5.1(h) (2009) (requiring that hospitals assure participation by individuals with medical, nursing, legal, social work, and clergy backgrounds in ethics committees).

222. See Fox et al., *supra* note 27, at 23 (noting a small percentage of hospitals responding to the survey place restrictions on who could request consultations).

223. Truog, *supra* note 188, at 1.

224. IOWA ADMIN. CODE r. 641-85.4(1) (2009); see Hoffmann, *Regulating Ethics Committees*, *supra* note 30, at 761 ("A likely goal of legislation mandating the establishment of ethics committees is to provide access for all patients and healthcare providers to a multidisciplinary group that can provide them with sound advice on ethical dilemmas involved in the treatment of patients.").

Furthermore, the application procedure must be clear and expeditious. Importantly, the application requirements must be comprehensible by those with and without medical knowledge.²²⁵ The application thus would include (1) the relationship of the person filing the application; (2) the patient's preferred course of treatment, if known, as expressed to the person filing the application; (3) if the patient's preference is not known, a stated opinion by the applicant of the treatment decision that is in the best interest of the patient; and (4) any other information that may be necessary in determining the appropriate course of treatment, such as a second medical opinion.²²⁶

3. Panel Appointment and Conflicts of Interest

When an application is filed with a state or local FDRB, the chairperson would appoint a panel to handle the case.²²⁷ The panel would consist of a minimum of three members, including at least one member from each category provided in the regulation governing the composition of boards.²²⁸ Most significantly, an individual would be prohibited from participating on a panel for a case when that person has a conflict of interest.²²⁹ A "conflict of interest" is defined as

a standard which precludes participation of a panel member in the proceedings with regard to a patient whenever the panel member is a relative or friend of the patient, is a health care provider of the patient, has a professional or personal relationship with the health care provider, or has a direct or indirect financial interest in the patient.²³⁰

Thus, an employee, officer, director, or owner of the healthcare institution treating the patient would be prohibited from serving on the panel resolving a futility dispute. As a result, the panel would not

225. Iowa requires the application to include a written statement by a physician or dentist describing the proposed medical care, the patient's medical condition, and the risks and benefits of the proposed care and any alternative treatments (including non-treatment). IOWA ADMIN. CODE. r. 641-85.4(3)(g). This requirement is not appropriate in the futility context because the patient's family or surrogate may not be able to meet it.

226. *See id.* at r. -85.4(3) (including these requirements but adding others that are inapplicable or unnecessary in the futility dispute context, e.g. a statement that the patient does not have any family member, guardian, or attorney-in-fact who is reasonably available and willing to make the medical care decision; the reasons for believing that the patient is medically incompetent; and a physician's statement).

227. *Id.* at r. -85.6(1).

228. *Id.* at r. -85.3, -85.6(1).

229. *Id.* at r. -85.6(1).

230. IOWA ADMIN. CODE. r. -85.2(1) provides a similar definition of "conflict of interest," but it does not exclude a friend of the patient, anyone who has a professional or personal relationship with the healthcare provider, or anyone with an *direct or indirect* financial interest in the patient.

have a financial interest in the decision and would not even be privy to the monetary considerations of the healthcare institution.

Critics may respond that although panels composed from FDRBs might not be motivated by the healthcare institution's financial interest, these governmental bodies would be incentivized to terminate treatment as a cost-cutting measure.²³¹ In other words, FDRBs could use their authority as a way of "rationing" end-of-life care.²³² To the contrary, this mechanism would prevent forms of rationing used by insurance companies from affecting medical decisions for the terminally ill. In contrast to institutional ethics committees in private healthcare institutions, FDRBs would not be motivated by profit and thus would not be driven by insurance reimbursement. Additionally, FDRBs would be legally required to follow substantive decisionmaking criteria, which further ensure that their decisions remain patient-centered.²³³ Finally, states have an indisputable interest in safeguarding the patient's individual right to make medical decisions at the end of life, as evidenced by advance directive and surrogacy statutes. States also have an indisputable interest in the preservation of human life, as demonstrated by the criminalization of, for example, homicide and euthanasia.²³⁴ Thus, even more than ethics committees who have a financial interest in the institution, public officials have an overwhelming interest in protecting incompetent patients, which cuts in favor of establishing the FDRB program.

In addition to eliminating financial conflicts of interest, severing the ties between the dispute resolution mechanism and the healthcare institution will remove other ethics committee biases. First, independent medical decisionmaking boards would not be

231. See Sarah Palin, Opinion, *Obama and the Bureaucratization of Healthcare*, WALL ST. J., Sept. 9, 2009, at A23 (claiming that the president's proposals to create an Independent Medicare Advisory Council and to reimburse doctors for end-of-life counseling would lead to the rationing of healthcare by "death panels").

232. *Id.*

233. This includes the requirement that board members may not consider potential financial costs associated with life-sustaining treatment, including coverage by insurance providers.

234. *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) ("The state's interest in preserving life is commonly considered the most significant of the four state interests."); see also *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 282 (1990) (discussing Missouri's interest in safeguarding the personal element of the choice between life and death through the imposition of heightened evidentiary standards and explaining that a state may simply assert an "unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual").

affected by the risk-aversion of healthcare institutions.²³⁵ Furthermore, board members would not possess the professional bias that currently may lead ethics committee members to side with the physician. Even though the physician on the board might still be more trusting of a fellow physician involved in the futility dispute, the absence of any personal relationship will greatly lessen the potential for professional bias. This solution will further remove any personal biases of hospital staff, who might have become frustrated and fatigued by the surrogate over time and consequently be less open to reaching a fair decision. Those directly involved with the patient's treatment might hold strong opinions about the case; therefore, these individuals might be especially domineering and persistent in committee discussions.²³⁶ Lastly, the establishment of independent boards will help to preserve the relationship between the surrogate and the treating physician by placing ultimate decisionmaking authority in the hands of a completely separate entity. When the process is specified in the law, both surrogates and physicians will accept that they are not being singled out and, in fact, likely will be relieved that the decision does not rest on their shoulders alone.²³⁷

4. Notification of Patient and Scheduling of Hearing

In order for the dispute resolution procedure to be effective in the futility context, a case must be reviewed and a decision made in a speedy, but thorough, manner. By contrast, court involvement in futility disputes causes critical delay, during which the patient often dies.²³⁸ When an application is received, the panel would notify the patient's surrogate as well as the treating physician of the submission

235. Decisionmaking criteria prohibiting the consideration of liability as well as qualified immunity, discussed in Part III.B.7 *infra*, further ensure that liability concerns will not contaminate the decisionmaking process.

236. Samuel L. Tilden, *Ethical and Legal Aspects of Using an Identical Twin as a Skin Transplant Donor for a Severely Burned Minor*, 1 AM. J.L. & MED. 87, 112–13 (2005) (describing a committee in which the opinion of the “lone surgeon” “carried great weight with the committee”).

237. Fine, *supra* note 180, at 71 (observing that many decisionmakers “show guilt” and say something like, “I know my dad wouldn’t want to go on like this, but we just have to keep going because I could never live with myself if I agreed to stop” but that with a clearer statutory process, accept that they are not being singled out); Robert L. Fine & Thomas W. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANN. INTERNAL MED. 743, 745 (2003) (explaining that after Texas adopted a clearer process for resolving futility disputes, patients were often relieved that they did not have to make end-of-life medical decisions on their own).

238. Thaddeus Mason Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQ. ELDER’S ADVISOR 229, 237 (2008).

within forty-eight hours from receipt.²³⁹ Additionally, the notification would state that a hearing has been scheduled and that the parties have the rights to be present, to testify orally or in writing, and to have a lawyer present.²⁴⁰ These procedural requirements will prevent the boards from relying too heavily on a patient's medical record, as many ethics committees currently do, and instead will provide a more-balanced method of case review.²⁴¹ Again, because of the patient's critical state, the hearing would be set within forty-eight hours after the parties have received notice.²⁴²

5. Information Gathering and Confidentiality

In order to ensure the panel's comprehensive assessment of the case during the hearing, the panel chairperson would review the application preliminarily to ascertain whether additional information might be necessary to resolve the issues presented in the case.²⁴³ The chairperson, if necessary, would request from any healthcare provider or institution any information relevant to the patient's medical care.²⁴⁴ Some might be concerned with releasing private medical information to a state board; however, the panel would be legally required to maintain the confidentiality of these records.²⁴⁵ Currently, no uniform confidentiality exists for institutional ethics committees, even though they regularly access confidential patient records.²⁴⁶ Confidentiality also makes the FDRB forum preferable to a court proceeding, in which highly emotional and personal information could be made public.²⁴⁷ On the other hand, some might respond that the boards could abuse their power if they are allowed to operate behind closed doors under

239. Although the Iowa regulations require notification of these parties, they do not provide a designated time frame. IOWA ADMIN. CODE r. 641-85.5(1) (2009).

240. *Id.*

241. See Fox et al., *supra* note 27, at 23 ("Whereas 87 of ECSs 'usually' or 'always' gathered information through direct examination of the patient's medical record, only 54% 'usually' or 'always' gathered information through direct examination of the patient.'").

242. See IOWA ADMIN. CODE r. 641-85.5(1) ("The hearing shall be held no less than 48 hours after the patient receives this notification.").

243. *Id.* at r. -85.5(2).

244. *Id.* at r. -85.5(2)(a).

245. *Id.*

246. See Fox et al., *supra* note 27, at 23 (finding a variety of practices for record-keeping and reporting by ethics consultation services).

247. For example, litigation of the Terri Schiavo and Emilio Gonzalez cases received widespread media coverage. Transcript of Jim Lehrer's Interview of Media Correspondent Terrence Smith, *NewsHour: Schiavo: Talk of the Nation* (PBS television broadcast Mar. 24, 2005), available at http://www.pbs.org/newshour/bb/media/jan-june05/schiavo_3-24.html.

the guise of protecting the patient's confidentiality.²⁴⁸ However, the provisions requiring review by the state health agency assuage this concern. Such a review procedure will allow the boards to keep proceedings confidential while at the same time monitoring their quality and content.²⁴⁹

6. Hearing Procedures

The FDRB would follow an adjudicatory model of process, in which the board would hear from both of the relevant parties and then would render a decision.²⁵⁰ Under this model, the panel would be authorized to administer oaths and to take testimony from any person who might assist the panel in making its decision.²⁵¹ In order to facilitate the maximum amount of fact-finding, the hearing could be conducted via telephone conference if deemed appropriate by the chairperson, unless a party requests an in-person hearing.²⁵² A record of the deliberations and proceedings of the panel would be made and retained for ten years.²⁵³ More specifically, this record would include any information submitted to or considered by the panel, and it would be held confidential.²⁵⁴

The surrogate and the treating physician, or a representative for either, would have the rights to be present at the hearing and to express feelings orally or in writing.²⁵⁵ Involving the surrogate in the hearing might clarify any misunderstandings that she may have of the patient's prognosis.²⁵⁶ To render a valid determination to consent to or refuse life-sustaining treatment on behalf of the patient, a majority of

248. Hoffmann, *Regulating Ethics Committees*, *supra* note 30, at 793 (citing this as a possible concern).

249. *Id.* ("A provision that keeps the proceedings confidential with some exceptions for monitoring of quality might satisfy both concerns.")

250. See generally Dianne E. Hoffmann, *Evaluating Ethics Committees: A View from the Outside*, 71 MILBANK Q. 677, 690-94 (1993) (asserting that to provide the greatest amount of patient protection, ethics committees should operate based on an adjudicatory model, which is similar to a court proceeding in the sense that the committee will hear from the relevant parties).

251. IOWA ADMIN. CODE r. 641-85.6(3)(a) (2009); Hoffmann, *supra* note 250, at 691.

252. IOWA ADMIN. CODE r. -85.6(3)(a).

253. *Id.* at r. -85.6(3)(b).

254. *Id.* at r. -85.6(3)(b)-(c).

255. Iowa gives only the patient the right to be present at the hearing. *Id.* at r. -85.6(3)(d). This clearly would be an unfair requirement in the futility dispute context.

256. See Kopelman, *supra* note 180, at 582 ("[S]tudies have shown that it is quite common for families to misunderstand the information provided to them by physicians."); Shelton, *supra* note 102, at 121 (explaining that family members may seek an understanding of the patient's prognosis and that a method of clarifying misunderstandings would be extremely beneficial in resolving end-of-life disputes).

the panel would be required to vote in the affirmative.²⁵⁷ The panel would be required to issue its written decision within twenty-four hours of concluding the hearing and to send the decision to the surrogate, the treating physician, and the institution involved in the futility dispute.²⁵⁸ The decision would describe the board's reasoning in forgoing or continuing life-sustaining treatment.²⁵⁹ This requirement will assure both the parties to the dispute and the reviewing state agency that the board followed a substantive decisionmaking standard.

Opponents might argue that the mediation model, in the futility context, provides a better form of dispute resolution than the adjudicatory model.²⁶⁰ Instead of rendering a decision based on the information provided by the parties, a mediator would act as a facilitator, assisting the parties to arrive at a mutually agreeable solution.²⁶¹ A mediator often uses non-judicial techniques to help the parties understand each other's interests, such as allowing parties to discuss their emotions openly, summarizing or rewording statements to ensure comprehension, and bridging any cultural gaps between the parties.²⁶²

Despite these potential advantages, mediation does not adequately protect patient interests because there is no party whose sole motive is to protect the patient.²⁶³ Instead, each party has its own individual interests at stake; for example, the physician may be concerned with liability, finances, reputation, or workload, while the surrogate may be affected by emotional, familial, religious, and monetary concerns. By contrast, the adjudicatory model provides an impartial panel of individuals whose only goal is to protect the patient. Moreover, one party may be intimidated and effectively silenced by the other during mediation.²⁶⁴ By contrast, adjudication does not

257. This is a variation of IOWA ADMIN. CODE r. 641-85.8(3), which requires a majority vote for consent or refusal of "medical care." As previously mentioned, the definition of "medical care" explicitly excludes the discontinuance of life-sustaining treatment, thus the Iowa SMDBs are not authorized to make futility decisions. *Id.* at r. -85.2(5).

258. *Id.* at r. -85.6(3)(f).

259. No similar provision exists for the Iowa SMDBs.

260. See generally Bierlein, *supra* note 65, at 62-64 (proposing an approach to bioethics mediation); Shelton, *supra* note 102 ("Mediation of end-of-life treatment disputes provides a forum to counterbalance the coercive nature of the right to terminate treatment.").

261. Shelton, *supra* note 102, at 134.

262. *Id.* at 134-35.

263. Hoffmann, *supra* note 250, at 693.

264. Pope & Waldman, *supra* note 173, at 149 (arguing that ethics committee mediations are currently just "one-sided negotiations in which surrogates are sure to prevail" because healthcare decisions law gives surrogates disproportionate power).

depend solely on the bargaining power of the parties and instead requires a majority of panel members to reach a decision independently, thus leveling the playing field between the surrogate and the physician.

7. Decisionmaking and Evidentiary Standards

The panel's decisionmaking standard would mirror the substituted-judgment and best-interest framework, the common law standard for making medical decisions for incompetent patients.²⁶⁵ In making a determination regarding the patient's medical care, the panel would presume the past and present expression of the patient's wishes to be valid unless clearly overcome by the evidence.²⁶⁶ In this way, the patient's autonomy will be the central principle of decisionmaking.²⁶⁷ If there is no clear preference by the patient, the panel then would determine whether the proposed medical care is in the best interest of the patient based upon clear and convincing evidence.²⁶⁸ This standard is also designed to promote the patient's autonomy, because the assumption is that the patient would have chosen what was in his or her best interest.²⁶⁹

In order to further prevent contamination of the decisionmaking process, FDRBs would be explicitly prohibited from considering the benefits or burdens to any third party.²⁷⁰ Therefore, panel members would be prohibited from considering the emotional needs or religious beliefs of the patient's family. Furthermore, the committee would be prohibited from discussing potential liability for forgoing treatment. Instead, the board could consult an attorney only after a medical and ethical decision has been reached for advice on the appropriate procedure to follow to execute the committee's decision. Finally, panel members would be prohibited from considering

265. Hoffmann, *supra* note 61, at 839–41.

266. IOWA ADMIN. CODE r. 641-85.8(1) (2009).

267. *Id.* (“The patient's autonomy should always be respected.”); see Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431–34 (Mass. 1977) (defining the actual, autonomously determined interests of the patient as the paramount guiding principle under both the substituted judgment standard and the best interest standard).

268. IOWA ADMIN. CODE r. 641-85.8(2) requires only a preponderance of the evidence. However, courts have mandated the higher standard of clear and convincing evidence when the individual interests at stake in the proceeding are particularly important and more substantial than the mere loss of money. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 282 (1990). Because the individual and societal interests at stake in the resolution of a futility dispute are quite substantial, this higher evidentiary standard is more appropriate.

269. O'Callaghan, *supra* note 204, at 578.

270. The provisions proposed in this paragraph are not included in the Iowa SMDB regulations.

potential financial costs associated with life-sustaining treatment, including coverage by insurance providers.

By explicitly defining the decisionmaking framework, FDRBs would be given a clear purpose: to protect the patient.²⁷¹ By contrast, ethics committees are often confused about their role, stating that their goals include not only protecting the patient, but also reducing the risk of legal liability, providing moral support to staff, and increasing patient and family satisfaction.²⁷² This patient-centered standard will further protect the physician's autonomy, as any decision focused on protecting the patient will not require the physician to provide harmful or non-beneficial treatment. To be sure, boards would consider the following factors in determining the best interest of the patient: (1) whether the benefits of treatment outweigh the burdens in terms of pain and suffering; (2) the degree, expected duration, and constancy of pain with and without treatment; (3) whether any pain could be mitigated by less intrusive forms of medical treatment; (4) an evaluation of treatment options and their risks and benefits; and (5) the likely prognosis and expectant level of functioning with or without the proposed medical care.²⁷³ An FDRB evaluating these factors thus would render patient-centered decisions in futility disputes, necessarily safeguarding the physician's right not to provide treatment that is futile or harmful.

Some might question why these standards could not be applied merely to ethics committees instead of creating a new state-operated mechanism for resolving futility disputes. Indeed, many have advocated creating formal standards for clinical ethics consultation.²⁷⁴ In fact, on June 16, 2009, the American Society for Bioethics and

271. Hoffmann, *Regulating Ethics Committees*, *supra* note 30, at 767 (“[T]he stated purpose of ethics committees since their inception has been to protect the patient . . .”).

272. Robert Klitzman, *Additional Implications of a National Survey on Ethics Consultation in United States Hospitals*, AM. J. BIOETHICS, Feb. 2007, at 47.

273. IOWA ADMIN. CODE. r. 641-85.8(2)(a)–(d) (slightly reworded to achieve better balance of interests).

274. *E.g.*, Mark P. Aulisio et al., *supra* note 36, at 59–66 (summarizing the conclusions of the American Society for Bioethics and Humanities Task Force report on the core competencies for healthcare ethics consultation); Nancy N. Dubler & Jeffrey Blustein, *Credentialing Ethics Consultants: An Invitation to Collaboration*, AM. J. BIOETHICS, Feb. 2007, at 35 (“It has been clear for some time that there is a need for substantive standards for—and a clear nation of process to direct—clinical ethics consultation. It should not be the case that a service this common proceeds with no precise idea of who is qualified to do these consultations, what educational background and skills are needed, and how consultations should be conducted, documented, and reviewed for quality.”). *But see* Jeffrey P. Bishop et al., *Of Goals and Goods and Floundering About: A Dissensus Report on Clinical Ethics Consultation*, 21 HEC FORUM 275, 278 (2009) (contending that the standardization of clinical ethics consultation obscures the “goods” that are fundamental to the field (e.g., listening, interpretative skills, moral inquiry), which inherently resist standardization).

Humanities announced its decision to create a standing committee that will develop ethics consultation standards and methods of implementation.²⁷⁵ However, applying standards to internal ethics committees will not eliminate the conflicts of interest that arise out of their employment by the healthcare institution. Even though ethics committee members may attempt to follow procedural and substantive rules, other financial, legal, and professional considerations necessarily will factor into their decisions so long as they have an employment relationship with the healthcare institution involved in the futility dispute.²⁷⁶ Such conflicts place ethics committee members in the position of shading an opinion to avoid personal risks, a goal that may be adverse to the patient's best interest.²⁷⁷ The only way to remove the bias that currently affects the resolution of futility disputes in ethics committees is to sever the relationship between the individuals resolving the dispute and the healthcare institution. Independent state and county decisionmaking boards, operating with uniform requirements and procedures, would promote impartial decisions to forgo or continue life-sustaining treatment.

8. Qualified Immunity from Liability

The FDRB, its members, and anyone acting in good-faith reliance on an FDRB decision would be immunized from civil and criminal liability for any actions taken or omissions made in the official discharge of their duties, except those acts committed in bad faith or with malicious purpose.²⁷⁸ Without providing this immunity, individuals would be deterred from serving on the board. Furthermore, the fear of lawsuits would hinder the board members' ability to do their job, as they may be reluctant to discuss cases fully and openly if they fear liability for themselves or others. Immunity is typically granted when an important public interest necessitates that a function be performed carefully and free from the concern of potential liability.²⁷⁹ The general public has a compelling interest in a board's careful determination of whether an incompetent patient's life-

275. Bishop et al., *supra* note 274, at 278.

276. See Linda T. Powell, *Hospital Ethics Committees and the Future of Healthcare Decision Making*, 20 HOSP. MATERIEL MGMT. Q., Aug. 1998, at 82, 83 ("It is likely that committee members will act from a sense of duty to the institution, their fellow professionals, and the preservation of health resources.").

277. Aulisio et al., *supra* note 36, at 66.

278. IOWA ADMIN. CODE r. 641-85.12 provides qualified immunity for Iowa SMDBs, except for those acts or omissions "constituting willful or wanton misconduct." An exception for actions taken in bad faith or with malicious purpose appeared to create a clearer standard.

279. O'Callaghan, *supra* note 204, at 572.

sustaining treatment should be continued; therefore, FDRBs would appear deserving of such immunity.

Importantly, FDRBs members would be granted *qualified* immunity, whereby an individual is insulated from liability unless she violates an objective standard of care.²⁸⁰ It is difficult to imagine that a group of public officials serving on an independent medical decisionmaking board would endorse a decision in bad faith or with a malevolent intent. Nonetheless, this exception to the grant of immunity would protect the patient from such a possibility. In addition, the qualified immunity provision would encourage healthcare institutions to consult FDRBs. Board members and anyone relying in good faith on a board's decision would be protected from liability. Due to vague legislation regarding the appropriate way to deal with a futility dispute, healthcare providers currently are uncertain of whether their actions will lead to liability—even if they consult an ethics committee. For that reason, it seems obvious that healthcare providers would want to utilize an independent dispute resolution mechanism that makes decisions under legally imposed standards, resulting in immunity for anyone relying on this decision in good faith.

9. Review of State and Local Board Decisions

To ensure that these regulations are followed, an oversight mechanism is needed. Both state and local FDRBs would be required to file records of the presentation of evidence, the discussion, and the decision in every case with the state's appropriate health department.²⁸¹ These records would be filed within five business days of the final decision. A healthcare institution would be authorized to act on a board's decision before it has been reviewed by the state agency. However, if the state agency finds that a board has not complied with the above requirements, the institution may be subject to sanctions. Additionally, the boards would submit an annual report to the state health department. This report would include summary information regarding the number, nature, and disposition of

280. *See id.* at 571 (defining qualified immunity as “a standard by which an official is insulated from liability unless he violates clearly established rights of which a reasonable person would know” and contrasting this with absolute immunity).

281. IOWA ADMIN. CODE r. 641-84.8 and -85.11 require only that the local board submit an annual report to the state board for review, and that the report must contain a summary of information regarding the number, nature, and disposition of applications filed with the local board in the preceding year. This proposal places oversight authority in the state's department of health, requires review of the state board, provides more detailed reporting requirements, and provides the possibility of sanctions for noncompliance.

applications filed with the local board in the preceding year. This comprehensive report would allow evaluators to ensure that decisions are being made consistently and without bias, with particular attention to patients in traditionally vulnerable or disadvantaged groups (e.g., minorities, women, the poor, the homeless, or individuals without family members).²⁸²

CONCLUSION

Many sources predict the increasing prevalence of disputes regarding the medical futility of life-sustaining treatment.²⁸³ As the costs of healthcare continue to become a more significant social and political issue, healthcare institutions and third-party payers will come under increased pressure to cut costs.²⁸⁴ As the public gains awareness of this danger, patients and families are likely to resist a physician's recommendation to withdraw life-sustaining treatment out of fear that financial pressures, rather than the best interest of the patient, are motivating the assessment.²⁸⁵ In addition, advances in medical technology that can sustain life—but not necessarily cure illness—will make end-of-life decisions more complex and contentious.²⁸⁶ Finally, the rising percentage of the elderly population in the United States, predicted to be 17.7 percent by 2020, will cause a corresponding increase in difficult medical decisions regarding end-of-life treatment.²⁸⁷

282. See Hoffmann, *supra* note 250, at 695 (providing that evaluators of ethics committees must try to assure that there is no statistically significant difference in ethics committee recommendations for certain vulnerable or traditionally disadvantaged groups).

283. See, e.g., MEISEL & CERMINARA, *supra* note 10, §§ 13.01, 13.09 (describing the current state of futility disputes, how they are likely to change in the future, and likely future legal and extra-legal means to resolve them); Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at A1 (“About 15 years ago, at least 80 percent of the cases were right-to-die kinds of cases . . . Today, it’s more like at least 80 percent of the cases are the other direction: family members who are pushing for continued or more aggressive life support and doctors and nurses who think that that’s wrong.” (quoting Dr. Lachlan Forrow, Dir., Ethics Program, Beth Israel Deaconess Med. Ctr., Boston, MA)).

284. MEISEL & CERMINARA, *supra* note 10, § 13.09.

285. *Id.*

286. Fine, *supra* note 180, at 60. An example of a so-called “halfway technology” is a machine that supplants the function of failed organs. *Id.*; see also *Partners CEO Addresses Ethical Challenges*, (New England Cable News television broadcast Mar. 3, 2009), available at <http://www.necn.com/Boston/Business/2009/03/03/Partners-CEO-addresses-ethical/1236125930.html> (quoting an executive of a large Boston healthcare corporation as stating “End-of-life issues will become even more significant as medicine advances and society ages.”).

287. See Elizabeth B. Herrington, *Strengthening the Older Americans Act's Long-Term Care Protection Provisions: A Call for Further Improvement of Important State Ombudsman Programs*, 5 ELDER L.J. 321, 325–326 (1997) (citing the Population Reference Bureau's

It is therefore becoming increasingly vital that states develop a fair, impartial, and patient-centered method of resolving futility disputes. Legislation such as the UHCDA has failed to provide a clear dispute resolution procedure, and most agree that the judicial resolution of these disputes is not preferable due to the complexity of medical and ethical issues involved, the highly emotional nature of these disputes, the length of time required by court proceedings, and the financial costs to both families and healthcare institutions.²⁸⁸ To avoid these obstacles, many commentators, courts, and healthcare institutions have endorsed an alternative forum for resolving end-of-life disputes: the institutional ethics committee.²⁸⁹ Even though ethics committees are normally authorized to give recommendations to the healthcare institution, these recommendations often have the practical import of a final and authoritative decision in the futility dispute context.²⁹⁰

Despite this degree of influence over life-and-death decisions, ethics committees operate free from any form of regulation whatsoever,²⁹¹ which is particularly troubling given that these committees are comprised almost entirely of hospital staff.²⁹² Because most ethics committee members are employed by the healthcare institution, these individuals are likely to be influenced by the financial, legal, and professional benefits or burdens of their decisions on that institution.²⁹³ Given this substantial risk of bias in end-of-life medical decisions, the law must provide better protection for incompetent patients who cannot speak for themselves.²⁹⁴

prediction that the number of those at least sixty-five is expected to rise from 12.6 percent in 1997 to 17.7 percent in 2020).

288. Cohen, *supra* note 21, § 18.06 (explaining that these groups have reached this agreement because court proceedings can be time-consuming and emotionally and financially costly for both patients and providers and citing several decisions that support this conclusion).

289. *See id.* § 18.06 (“To avoid some of the negative aspects of judicial intervention, institutional dispute resolution mechanisms have been created One mechanism for resolving disputes that deserves special attention is the institutional ethics committee.”).

290. Capron, *supra* note 29, at 422.

291. Spielman, *supra* note 33, at 180.

292. Hoffmann, *Does Legislating Hospital Ethics Committees Make Sense?*, *supra* note 30, at 108, 115 (reporting the results of a multi-state survey in which it was determined that nearly all members of ethics committees, even legal counsel, were hospital employees and the vast majority were health professionals and that 42 percent of respondents in a survey of hospital staff in five Maryland hospitals “thought that the role of the [ethics committee] was to *decide* ethical issues”); Hoffman, *Regulating Ethics Committees*, *supra* note 30, at 758–61 (outlining many of the same findings).

293. *See supra* Part II.

294. *See* Pope, *supra* note 31, at 274–84 (“For example, a treatment decision may be *biased* when the decision maker is prejudiced against the race of the patient.”).

Futility disputes should be taken out of the hands of institutional ethics committees and instead resolved by independent Futility Dispute Resolution Boards. Modeled after the Iowa Substitute Medical Decision-Making Boards,²⁹⁵ these new boards would operate at the state and local level and would be required to follow specific substantive and procedural regulations. More specifically, FDRBs would be required to comply with rules regarding composition; accessibility; procedures for application submission and information gathering; procedures for conducting the hearing, reporting, and state agency review; and a substantive decisionmaking standard. This solution upholds the patient's right to make autonomous medical decisions by limiting the considerations that can factor into a futility dispute decision. In doing so, it further protects the physician's right to resist a surrogate's request to provide treatment that would be harmful or ineffective in treating the patient's illness. Finally, it provides a clear, statutory procedure for resolving futility disputes, thus ensuring a neutral and effective forum for consideration of third-party decisions affecting the well-being of incompetent patients.

*Ashley Bassel**

295. IOWA CODE § 135.28–135.29 (2009).

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