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How Hospital Leaders and Risk Managers Can Nurture Ethics-Driven Lawyering

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Abstract

How hospital lawyers assess legal risk in clinically and ethically complex cases can shape risk management operations, influence clinicians' morale, and affect the care patients receive. This article suggests that many disagreements, particularly those involving key ethical and legal questions arising from a patient's care, should launch a process that might include family meetings, early palliative care integration, and ethics consultation or committee review of clinical teams' and surrogates' reasons and perspectives. This article also explains why exploration of these perspectives can motivate fuller understanding of the sources of clinical and ethical disagreements and inform the approach to legal advice that hospital executives and risk managers should foster.

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Legal Support for Ethics Processes

Suppose a patient on mechanical ventilation in an intensive care unit (ICU) is dying of widely metastatic cancer. The treating team believes that the patient's best interest would be served by compassionate extubation and comfort care. But suppose a surrogate is requesting, or perhaps demanding, that "everything be done" and that mechanical ventilation be continued.

This disagreement should be the beginning of a process, not the end of it. Through family meetings, early palliative care involvement, ethics consultation, and ethics committee review, a treating team's and surrogate's rationales can be fully understood and assessed against pertinent ethical norms and clinical realities. At some point in this process, however, a physician worried about the family's threat to get a lawyer if its demands are not met might call the hospital's legal counsel. What happens when clinical and ethical questions about a patient's best interests become focused instead on legal questions about risk mitigation?

This article addresses the impact of hospital-based legal counseling practices and how these practices shape risk management operations, influence clinician morale, and help resolve disputes about patient care. Legal counsel either can support ethics-driven approaches to conflict resolution or, if its view of risk assessment is too narrow, will likely frustrate an organization's ethics processes and procedures by taking ethically laden clinical decisions out of the purview of clinicians and the ethics committee. In this article, we call for lawyers giving advice in these conflict situations to be mindful of the hospital client's commitment to ethically sound clinical decision making and for senior executives, who speak for the client, to ensure that risk-related advice supports this commitment.

Critical Care Ethics

Every experienced clinician in emergency or critical care medicine is likely to have encountered troubling situations involving seriously ill patients unable to decide important issues directly. These situations include uncertainty about goals of care, given a lack of guidance from the patient; ambiguous provisions in an advance directive if such exists; disagreements among surrogate decision makers, including contention over who is entitled to speak for the patient; and disputes between surrogate decision makers and clinicians over the value of a life-extending intervention for a patient. These cases play out within both a legal and an ethical framework. Every state has some type of law that addresses **decision making for incapacitated patients**, although there is considerable heterogeneity.¹ Decision making for incapacitated patients invokes ethical principles, such as respect for autonomy and beneficence, as well as reflection on what counts as virtuous action under the circumstances.² Ever since the litigation over Karen Ann Quinlan's ventilator more than 40 years ago, the law and ethics of end-of-life care have been intertwined.³

These situations will likely be complex and emotional, often involving surrogate requests for the initiation or continuation of interventions when the clinicians believe that the patient is beyond rescue. Discordant perceptions have many causes.⁴ The surrogate might recount past situations in which other clinicians had said the patient was dying but then the patient recovered, so they no longer trust predictions of imminent death. Similarly, a surrogate may mistakenly believe that the patient's condition is virtually identical to that of another family member who recovered. Or the surrogate might believe the patient will recover based on signs of improvement that family members see when they interact with the patient but that the treating team never sees. Or perhaps a surrogate, such as a spouse in a decades-long marriage, is just so anxious at the thought of losing a life partner that emotion blocks the ability to process the information. Not infrequently, surrogates invoke the possibility of a miracle. Sometimes, out of fear of and frustration at the medical team's broaching of the idea of shifting to comfort measures only, a family member threatens to take everyone to court.

Legal Risk Advice

Addressing these situations effectively requires empathetic physicians who can listen to the surrogate's story, can **identify the ethical values at stake**, and are courageous enough to keep working through these complex dynamics with the family. This kind of process will only occur if the hospital's leadership has made it the ethical default for everyone in the hospital, including hospital counsel. Consider the introductory case of the dying ICU patient. The initial disagreement over the goals of care should be channeled into an ethics-oriented dispute resolution process that respects both the family's standing and the physicians' medical judgment. One robust template for this

process is discussed below. A danger, however, is that advice about legal risk might come so early and be so emphatic as to block the unfolding of this process.

It has long been recognized that a lawyer's participation in such emotionally fraught cases, particularly if they go to a hospital's ethics committee, risks directing the committee's attention to legal issues instead of ethical ones.⁵ A situation like the surrogate's disagreement with the ICU physicians involves several aspects of law: state laws that address decision making for incapacitated patients, which usually rank-order potential surrogates and standards for decision making, especially for decisions about life-sustaining treatments⁴; substantive and procedural law on hospital and clinician tort liability; and the licensing and regulatory regimes entailing standards, inspections, and grounds for professional discipline. Clinicians usually do not have an accurate and detailed understanding of the law.⁶ Hence, they must rely on the hospital lawyer's advice.

If the lawyer's advice to the attending physician or to the hospital ethics committee is blunt and unreflective—for instance, if it's that the surrogate has statutory authority to decide on treatment issues and that acquiescing to the surrogate's request would avoid the risk of a lawsuit—it is predictable that the treating team will retreat from advocating for the patient's best interest. Apart from the fear of liability, physicians dread the loss of time and other burdens they would face if they became enmeshed in legal proceedings.^{7,8} It is difficult to maintain an in-depth discussion of whether a treatment might be ethically inappropriate if clinicians focus instead on ominous legal advice. The experience of one bioethicist-lawyer is pertinent: "Once my audience thought I knew something about the law, the ethics discussion became completely short-circuited—everyone just wanted to know what the law required."⁹

If legal advice effectively forecloses discussion of the ethics of critical care, especially if such supplanting of ethics is seen as endorsed by the institution itself, clinicians' experience of moral distress is a likely outcome.¹⁰ Moral distress results when clinicians recognize the ethical dimensions of a situation and yet are prevented from acting on all the interests and values at stake.¹¹ Hospitals have a strong interest in reducing clinicians' moral distress, given its impact on quality practice, patient safety, and retention of skilled professionals.^{12,13}

A lawyer-driven outcome inconsistent with ethically sound medicine deserves its own term of reproach: *nomicogenic harm* (from *nomikos* (lawyer) and *genic* (arising from)). Excellence in hospital lawyering avoids nomicogenic harm. Hospital lawyers and risk managers can play a crucial role in maintaining ethics-based practice. Indeed, following an ethically sound process itself reduces risk of litigation, because it manifests the hospital's commitment to procedural fairness and avoidance of ad hoc decision making.

In the case of the cancer patient dying in the ICU, for example, the lawyer might advise that discontinuing mechanical ventilation in a patient with widely metastatic cancer in order to maximize comfort is well within standard of care; that the surrogate's authority is not unfettered and must be exercised within the legal standards of surrogate decision making, which parallel ethical criteria; and that, consequently, the overall litigation or regulatory risk of discontinuing mechanical ventilation is low. Legal advice of this kind reflects ethically attentive lawyering and preserves ethical discourse.

The 5-Society Statement Model

A **conflict resolution process** in which all ethically relevant considerations can be discussed and an ethically optimal decision reached is required for Joint Commission accreditation for hospitals.¹⁴ However, the Joint Commission requirement is quite general and does not elaborate on the details of the process. One ethically sound conflict-resolution process is a multisociety policy statement formally adopted in 2015 by 5 professional societies (the American Thoracic Society, the American Association for Critical Care Nurses, the American College of Chest Physicians, the European Society for Intensive Care Medicine, and the Society of Critical Care Medicine).¹⁵ The 5-society statement recommends specific steps that should be followed when clinicians are asked for treatments that they believe should not be administered. These are “treatments that have at least some chance of accomplishing the effect sought”—and hence are not physiologically futile—“but clinicians believe that competing ethical considerations justify not providing them.”¹⁵ Although the policy statement is broad enough to encompass situations in which the patient would have an extended life expectancy if the treatment were administered (eg, initiating dialysis in a patient in a persistent vegetative state), most cases will involve critical care patients in the last stage of life (eg, continuing mechanical ventilation in a patient with widely metastatic cancer).

The policy statement recognizes that many disputes in critical care medicine involve contested value judgments about what is appropriate treatment. The policy statement urges hospitals to implement proactive strategies to prevent discordant views from hardening into intractable conflicts, which might occur if a surrogate decision maker requests a treatment that is potentially inappropriate.¹⁵ Proactive communication consists of well-conducted family meetings focusing on the alignment of treatment options with the patient’s goals. The policy statement lays out an ethically sound, 7-step process for resolving seemingly intractable disagreements that can arise toward the end of a patient’s life.

The policy statement emphasizes early involvement of expert consultants (often palliative care, ethics, or both) who are particularly skilled in conflict resolution before conflicting positions become entrenched (Step 1).¹⁵ The policy statement envisions an advocacy role for physicians when a surrogate insists on treatments that the physicians believe would not benefit the patient. At family meetings, physicians should share their perspective and respectfully advocate for a better alternative. The physicians should attempt to explain to—and perhaps to convince—a surrogate that the patient is dying, that all that could have been done to change that inevitable outcome has been done, and that it is time to shift from attempting life-extending interventions to comfort measures only.

Should the disagreement over the appropriateness of a treatment persist after redoubled efforts to achieve a negotiated agreement, the policy statement lays out a sequence of conflict resolution steps: giving notice to the surrogate of the process to be initiated (Step 2); getting a second medical opinion (Step 3); having an interdisciplinary hospital committee review the case, with an opportunity for clinician and surrogate to explain their positions (Step 4); offering the surrogate assistance in arranging a transfer to another institution if the committee agrees that the requested treatment is inappropriate (Step 5); informing the surrogate of the option to seek review in court (Step 6); and, finally, assuming neither transfer nor a court order, withholding or withdrawing the inappropriate treatment (Step 7).¹⁵

This consensus-based policy statement reflects a commendable effort to outline a fair process for dispute resolution in critical care. Although we are unaware of data on the number of hospitals that have adopted these recommendations in policy or practice, we hope that an increasing number will do so. The recommended process cannot succeed, however, unless it functions within a supportive context.

Ethically Attentive Lawyering

Hospital leadership and hospital lawyers are rightly concerned about legal risk; the average cost of a closed claim originating in the intensive care unit, for example, is \$350 039.¹⁶ Ethically attentive legal advice, however, does not ignore risk but instead realistically appraises it. If, in the lawyer's reasoned judgment, an ethically permissible course entails a significant liability risk, the lawyer needs to explain the nature of the risk. Conversely, if under the circumstances the risk of litigation is low (albeit not zero) and the risk of liability even lower, the legal advisor should say that.

To be avoided is legal advice given with tunnel vision: identifying only one pathway deemed by the lawyer to minimize risk, without leaving room for alternatives or considering the impact of the advice on physicians' willingness to advocate for what they see as the best interest of their patients. The 5-society statement sets out a dispute-resolution process in which the ethical concerns of both surrogates and physicians can be heard. That process will not be invoked, however, if preemptive legal advice amounts to an imperative simply to yield to surrogate demands. Instead, legal advice needs to underscore the hospital's commitment both to supporting physicians who practice excellent patient-centered medicine and to a robust process, like the 5-society statement, for addressing ethical concerns.

In summary, the hospital's legal counsel should execute its functions with ethical perceptiveness. Lawyers should consciously give legal advice that leaves as much room for the work of ethics as possible. This is not a departure from good lawyering but an embodiment of it. Legal counseling should attend to the client's interests in a broad sense, including "moral" factors.¹⁷ Furthermore, hospital leadership should make clear that, given an institutional commitment to ethically sound medicine, this is the kind of lawyering it expects.

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