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## Navigating Professional Norms in an Inter- Professional Environment: The ‘practice’ of Healthcare Ethics Committees

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“It is the history of jurisdictional disputes  
that is the real, the determining history of  
the professions.” -Abbot, *The System of  
Professions*<sup>1</sup>

One of the hallmarks of a profession is the ability to set boundaries and exclude others from practicing in the field; however in an increasingly interprofessional world, these boundaries can be difficult to navigate. Recently, the Supreme Court case, *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, reminded us that jurisdictional debates are alive and well across a variety of disciplines.<sup>2</sup> In this case, the North Carolina State Board of Dental Examiners (the Board) sent cease and desist letters to non-dentist teeth whiteners demanding that they stop the unlicensed practice of dentistry. The Federal Trade Commission argued that this violated unfair trade practices under anti-trust law. Amici curiae briefs were filed by a variety of professional groups—from physicians and lawyers

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<sup>1</sup> ANDREW ABBOTT, *THE SYSTEM OF PROFESSIONS: AN ESSAY ON THE DIVISION OF EXPERT LABOR* 2 (University of Chicago Press 1988).

<sup>2</sup> *North Carolina Bd. of Dental Exam'rs v. F.T.C.*, 135 S.Ct. 1101 (2015).

to nurses and radiologists—illustrating the wide reaching concerns regarding the ability to define and enforce professional boundaries across many fields.

Professional turf is most strongly established for long-standing, traditional occupations such as medicine and law. For example, all fifty states have legislation that defines and regulates the practice of law and medicine and provides sanctions for those that overstep these bounds without a license. However, even these fields have many instances of newer professions or sub-disciplines practicing within traditional space. Health care ethics consultants are prime examples of individuals working at the very intersection of both law and medicine.

Health care ethics committees (HCECs) are groups within hospitals or other health care settings that are called upon to assist with difficult ethical dilemmas that arise in patient care through such consultations.<sup>3</sup> Typical topics covered by committees include end-of-life care, decisional capacity, and course of treatment decisions—ethical areas that implicate and intersect with questions of law, medicine, and other professional realms.

There is a growing movement to professionalize the field of ethics consultations in order to create standards and ensure competency. However the multi-disciplinary composition of HCECs can lead to conflict between the emerging norms of the “ethics professional” and the long-standing norms of the members’ disciplines—often medicine, nursing, law, hospital chaplaincy, social work, or other health-related fields. Any one of these grounded professions could be used to examine how the growing field of ethics consultation may encroach upon the established boundaries of the field.<sup>4</sup> This article explores law as an illustrative example and seeks to address whether participation in ethics consultations could be considered the practice of law.

The article begins with a presentation of the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* in Section I in order to frame the discussion of professional boundary disputes within current context. Section II provides a historical background of the development of HCECs, including a description of their general structure and membership composition. Section III presents the growing professionalization of HCE consultants, including the introduction of competency standards, quality review, and ethical guidance for the practice of ethics consultation. This

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<sup>3</sup> When these committees were first formed, they were often called hospital ethics committees, or HECs. However, there has been a growing movement to refer to them as health care ethics committees (HCECs) in order to acknowledge the increasing breadth of settings of house ethics committees, such as outpatient care in the community and long-term care facilities.

<sup>4</sup> Deborah Cummins, *The Professional Status of Bioethics Consultation*, 23 THEOR. MED. BIOETH. 19, 34 (2002) (“Facilitating ethical decisionmaking at the bedside of patients is a core concern for healthcare ethics consultation, but it is only peripheral to medicine and to the court system. Thus . . . the conditions exist for jurisdictional boundary disputes between ethics consultation and medicine, ethics consultation and the courts, and possibly ethics consultation and other contiguous professions.”).

movement towards professionalization is motivated by goals to ensure adequate training and competency of those conducting ethics consultations and to bring legitimacy to those performing the consults; however these new standards may be at odds with established professions. This potential to overstep the bounds of other professions is discussed at length in Section IV. This section discusses whether and how ethics consultations could be considered the practice of law through the application of five common legal tests. Under several of these tests, ethics consultants can potentially be considered as engaging in the practice of law—a determination that carries with it the threat of criminal and civil sanction or, in the case of attorney members, potential loss of licensure. This section discusses several of these implications as well as highlights ways that these complications have been approached in the context of mediation, where similar debates regarding the unauthorized practice of law have occurred. The final section of the paper, Section V, takes a step back from the practical debates of the rest of the paper to engage in a theoretical exploration of how the implications from *North Carolina State Board of Dental Examiners v. Federal Trade Commission* regarding board oversight of a profession could apply in the field of HCEC as certification boards and professional governing bodies are established.

Overall, the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* decision provides an illustrative and provocative framework to explore how the interdisciplinary nature, and increasing professionalization, of HCE consultations may affect both individuals and the field of clinical ethics consultation. As the burgeoning field of ethics consultations continues to professionalize, there is an imperative for further guidance for consultants regarding how the practice of ethics consultations may intersect with the practice of law.

## I. PROFESSIONAL BOUNDARIES

Professionalization encompasses forming standards, ensuring quality, and creating a code of ethics; however, it also establishes ‘turf.’<sup>5</sup> Instituting rules for those who are sufficiently trained naturally allows for the exclusion of those who are not sufficiently trained in the field.<sup>6</sup> Sometimes this is implicit; other times it is explicitly codified into law. For example, every state has a law that defines the practice of medicine and establishes rules ensuring that only trained physicians engage in such activities.<sup>7</sup>

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<sup>5</sup> See, e.g., Harold L. Wilensky, *The Professionalization of Everyone?*, AM. J. SOC. 137, 138 (1964) (explaining that professions establish exclusive jurisdiction); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 5* (Basic Books, Inc 1982) (noting that “the profession has been able to turn its authority into social privilege, economic power, and political influence”).

<sup>6</sup> See, e.g., Wilensky, *supra* note 5, at 148–49.

<sup>7</sup> Brief for Am. Dental Ass’n et al. as Amici Curiae Supporting Petitioner at 2, *North Carolina Bd. of Dental Exam’rs v. F.T.C.*, 135 S.Ct. 1101 (2013) (No. 13-534).

The establishment of professional territory is often justified out of concerns for individual safety and the imperative need for consistent quality among a category of service. Without ensured quality some may be harmed by incompetent individuals holding themselves as sufficiently skilled in the field. However, professionalization also economically impacts the field. Those who are actively involved in the profession, not a neutral third-party, generally define competency and required qualifications. Thus, those most likely to benefit economically from limiting competition are the ones who create the passcode to the club, so to speak. Complications arise when those setting the boundaries seek to enforce their territorial privilege to the exclusion of others. This is exemplified in the *North Carolina State Board of Dental Examiners v. Federal Trade Commission*.

Is offering teeth whitening services the “practice of dentistry”? It may appear at first blush to be a rather innocuous question, but this inquiry emerged as an entrenched legal battle that traveled all the way to the U.S. Supreme Court, resulting in a decision that has sweeping implications across a broad range of fields. In early 2015, the Court ruled on this controversy in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*. The case began when the Board issued cease and desist letters to non-dentists who were performing teeth whitening services in malls, spas, and other locations.<sup>8</sup> The letters stated that teeth whitening was the “practice of dentistry” and threatened criminal sanctions if the individuals continued to offer the services without a dentistry license.

In response to the cease and desist letters, the Federal Trade Commission (FTC) sought administrative action because they argued that, under the Federal Trade Commission Act (FTCA), excluding non-dentists from the teeth-whitening market constituted unfair methods of competition.<sup>9</sup> A majority of the Board’s members actively participated in the dentistry market and some members of the board performed teeth-whitening services for their clients.<sup>10</sup> Non-dentists generally charged lower prices for their teeth-whitening services and complaints brought to the Board regarding this practice referenced concerns about price, not potential harm to consumers.<sup>11</sup> Indeed, a “wealth of evidence” suggests that the teeth-whitening procedure is safe.<sup>12</sup> Additionally teeth-whitening products are available over-the-counter at many drug stores, but the cease and desist letters were sent only to the individuals performing the services, not to entities within the commercial market. Therefore, there was a strong argument that the cease and desist letters were sent due to market concerns rather than concerns for public safety.

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<sup>8</sup> North Carolina Bd. of Dental Exam’rs, 135 S.Ct. at 1108.

<sup>9</sup> Federal Trade Commission Act, 15 U.S.C § 45 (2010).

<sup>10</sup> North Carolina Bd. of Dental Exam’rs, 135 S.Ct. at 1107, 1116 (2015).

<sup>11</sup> *Id.* at 1109.

<sup>12</sup> *Id.*

The Board argued that, as a state-established entity, they were immune from anti-competition claims under state-action doctrines; however, the FTC reasoned that immunity was not applicable since the Board was not actively supervised by the State.<sup>13</sup> An Administrative Law Judge (ALJ) held that the Board had violated antitrust law by unreasonably restricting trade. This determination was sustained by the FTC and affirmed by the Fourth Circuit and, ultimately, the Supreme Court.<sup>14</sup>

As *North Carolina State Board of Dental Examiners v. Federal Trade Commission* highlights, state licensure laws can immensely impact individuals. The case underlines the very real complications and applications of state licensure rules to everyday people. Although the state statute regulating the practice of dentistry in North Carolina did not definitely speak to whether teeth whitening services constituted the practice of dentistry, the Board interpreted it as such.<sup>15</sup> In general, the statutes surrounding professional practices do not clearly define every boundary of allowable practice—instead they provide general guidelines and broad definitions of practice.<sup>16</sup> For example, North Carolina delineates thirteen categories of dentistry practice that provide the general framework of the practice of dentistry.<sup>17</sup> While it would sometimes be easy to clearly determine whether an activity fell into these categories—e.g. “extracts a human tooth or teeth”<sup>18</sup>—, other categories may be more difficult to identify.

Teeth whitening is not specifically listed in the statute defining dentistry, but the “removal of stains, accretions or deposits” is.<sup>19</sup> Setting aside the antitrust elements of this case, the root question is whether teeth whitening constitutes the “removal of stains” as contemplated by North Carolina statute. Whitening teeth could easily be considered the removal of stains, but several counterarguments were discussed in court filings: (1) the statute was passed in 1930, prior to chemical teeth whitening, thus did not encompass this procedure<sup>20</sup>; and (2) over-the-counter teeth whitening strips are sold in pharmacies and these were not also targeted by the board. The best interpretation of the statute is, at least for this paper, irrelevant, but it is important to note how individuals can find themselves at the crossroads of reasonable interpretations facing the threat of criminal sanctions. Reasonable differences could also occur in ethics and law, which may be

<sup>13</sup> North Carolina Bd. of Dental Exam'rs, 152 F.T.C. 640 (2011).

<sup>14</sup> *Id.*; North Carolina Bd. of Dental Exam'rs v. F.T.C., 717 F.3d 359 (4th Cir. 2013); North Carolina Bd. of Dental Exam'rs., 135 S.Ct. 1101.

<sup>15</sup> North Carolina State Bd. of Dental Exam'rs v. F.T.C., 135 S.Ct. at 1108.

<sup>16</sup> See, e.g., Jacqueline M. Nolan-Haley, *Lawyers, Non-Lawyers and Mediation: Rethinking the Professional Monopoly from a Problem-Solving Perspective*, 7 HARV. NEGOT. L. REV. 235, 262 (2002) (noting that definitions of the “practice of law” are varied, and often vague, across states).

<sup>17</sup> N.C. CODE ANN. § 90-29(b) (2011).

<sup>18</sup> *Id.* § 90-29(b)(3).

<sup>19</sup> *Id.* § 90-29(b)(2).

<sup>20</sup> Brief for Am. Antitrust Inst. as Amicus Curiae Supporting Respondent at 14–15, North Carolina Bd. of Dental Exam'rs v. F.T.C., 135 S.Ct. 1011 (2015).

more open to interpretation of practice of law definitions than dentistry due to broader definitions of the practice and the frequent interdisciplinary merging of these fields with others.

## II. HEALTH CARE ETHICS COMMITTEES

### A. History

In the last fifty years, the field of established HCECs has evolved from a few sporadic committees to an entrenched and valuable mainstay of almost every hospital in the United States. This growth can be attributed in part to advanced medical technologies that allow us to extend life for patients with critical illness<sup>21</sup> or raise novel ethical issues in their adoption.<sup>22</sup> Additionally, a growing patients' rights movement has increased the number of ethical questions raised regarding patient autonomy and decision making in clinical care.<sup>23</sup>

Beyond technology, several prominent court cases and policies propelled ethics consultations forward as a viable option to address ethical concerns in medical facilities. Although HCECs existed prior to 1976, the New Jersey Supreme Court seminal end-of-life case, *In the Matter of Karen Quinlan*, created the original impetus for the emerging HCEC field.<sup>24</sup> In 1975, Karen Quinlan became unconscious after several extended periods without breathing and from that time onward continued in a persistent vegetative state. Ms. Quinlan's father sought to be named her guardian and requested removal of life-sustaining treatment, including the respirator, given the medical judgment that she would never regain cognitive function.<sup>25</sup> The treating physician believed that removal of the respirator was against medical tradition and refused to comply with the request.<sup>26</sup> The dispute eventually entered the judicial system and was appealed to the New Jersey Supreme Court. The Supreme Court sided with Ms. Quinlan's father and ordered him to be appointed guardian of Ms. Quinlan.<sup>27</sup> The court also noted that prior to removal of life-sustaining treatment, a health care ethics

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<sup>21</sup> Martin L. Smith, *Mission, Vision, Goals: Defining the Parameters of Ethics Consultation*, in GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES 32, 33 (D. Micah Hester & Toby Schonfeld, eds., 2012).

<sup>22</sup> See, e.g., Jean E. McEwen et al., *The Ethical, Legal, and Social Implications Program of the National Human Genome Research Institute: Reflections on an Ongoing Experiment*, 15 ANN. REV. GENOMICS & HUM. GENETICS 481 (highlighting some of the ethical issues raised in the clinical implementation of genomic technologies) (2014).

<sup>23</sup> Smith, *supra* note 21, at 34; see also, Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 805 (1991).

<sup>24</sup> Stuart J. Youngner et al., *A National Survey of Hospital Ethics Committees*, 11 CRITICAL CARE MED. 902, 902 (1983).

<sup>25</sup> *In Re Quinlan*, 70 N.J. 10, 18 (N.J. 1976).

<sup>26</sup> *In Re Quinlan*, 137 N.J. 227, 259 (N.J. Super. Ct. Ch. Div. 1976).

<sup>27</sup> *Quinlan*, 70 N.J. at 55.

committee or similar entity at the hospital, should be consulted and if it agreed with the attending physician's determination that there continued to be 'no reasonable possibility' of Ms. Quinlan's recovery, then the family's wish for removal of life-sustaining treatment should be granted.<sup>28</sup> The court added that "said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others."<sup>29</sup>

With this call, the New Jersey Supreme Court heightened awareness of HCECs nationwide and highlighted their potential roles including confirming medical determinations, assisting with end-of-life decision-making, and insulating parties involved from civil or criminal liability.<sup>30</sup> In the following years, however, controversy ensued over whether these roles were appropriate for ethics committees.<sup>31</sup> In a 1983 report of end-of-life decisions, the President's Commission for the Study of Ethical Problems in Medicine (hereinafter the Commission) reviewed the potential role of HCECs.<sup>32</sup> Of the potential HCEC roles highlighted in *Quinlan*, the Commission found that confirmation of prognosis was not necessarily a proper role, but that providing a forum for ethical discussion and avoidance of the legal system were possible beneficial functions. Avoidance of the legal system, however, is not the same role as the creation of insulation from criminal and civil liability. The Commission encouraged ethical discussion that would help to solve problems prior to an entrenched legal battle, but appeared uncomfortable advocating for blanket legal immunity:

The appropriate standard of liability should be determined not simply by worries about ensuring that individuals will serve as members of ethics committees, but also by a concern that their deliberations not be unduly circumscribed by concerns about prosecution. Perhaps a 'good faith' standard and exclusion from criminal conspiracy liability would suffice.<sup>33</sup>

The number of HCECs increased most precipitously in the early 1990s. In 1992, the Joint Commission on the Accreditation of Healthcare

<sup>28</sup> The court got the idea for the HCEC from a short and somewhat obscure law review article written by a pediatrician in Texas, Dr. Karen Teel. Wolf, *supra* note 23, at 798; Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 262 (2009).

<sup>29</sup> *Quinlan*, 70 N.J. at 55.

<sup>30</sup> Youngner et al., *supra* note 24, at 902.

<sup>31</sup> See, e.g., *id.* (noting that the "New Jersey Supreme Court created confusion about the committee's role by calling it an ethics committee but assigning it a prognostic function").

<sup>32</sup> PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS (1983).

<sup>33</sup> *Id.* at 168.

Organizations (JCAHO) mandated that all hospitals have a mechanism for addressing ethical concerns in order to meet accreditation requirements.<sup>34</sup> When the President's Commission undertook analysis for their 1983 report, only about 1% of U.S. hospitals had ethics committees, despite the increased awareness of HCECs garnered by Quinlan.<sup>35</sup> By 1999, a second national study found that 93% of hospitals surveyed had established committees, most of which were established seven years prior—coinciding with the JCAHO accreditation requirement.<sup>36</sup> More recent policies, court cases, and legislation have continued to recommend or mandate HCECs. For example, Maryland has legislation that requires hospitals to have ethics committees and several other states have explicitly included HCECs in the chain of surrogacy legislation.<sup>37</sup> Additionally, some states have included ethics committee in procedural steps that occur when a patient representative is requesting medical treatments that the healthcare team views as futile.<sup>38</sup>

### B. HCEC structure

The early reports, policies, and cases that led to the proliferations of HCECs generally did not provide guidance regarding the roles or structure of the committees. Thus, HCECs have variability in their procedures, although there is broad consistency in the literature regarding overarching roles.<sup>39</sup> In the 1983 report, the Commission laid out several primary functions of HCECs, three of which have stuck to this day: policy formation, education, and consultation.<sup>40</sup> Under the policy formation role, HCECs review, update, and formulate hospital policies based on ethical and legal considerations. Under the education role, members of the HCEC disseminate information to staff at the hospital and members of the community about common ethical concerns and issues that arise in patient care. Finally, in ethics consultation services, the primary focus of this paper, members of the

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<sup>34</sup> JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO), COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS Standard RI. 1.1.6.1 (1992).

<sup>35</sup> Youngner et al., *supra* note 24, at 903 (finding, additionally, that 41% of the hospitals identified as having ethics committees were in New Jersey).

<sup>36</sup> Glenn McGee et al., *A National Study of Ethics Committees*, 1 AM. J. BIOETHICS 60, 61 (2001).

<sup>37</sup> Thaddeus Mason Pope, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns*, 15 CARDOZO J. CONFLICT RESOL. 425 (2014); *see, e.g.*, CAL. HEALTH & SAFETY CODE § 1418.8 (2015) (establishing an interdisciplinary review team to review medical interventions for patients in nursing homes without capacity to make decisions and without surrogate decision makers); *see also* IOWA CODE § 135.29 (2015) (creating a local substitute medical decision-making board for patients without surrogate decision makers available).

<sup>38</sup> *See, e.g.*, VT. HEALTH & SAFETY CODE § 166.046(b) (West 2015).

<sup>39</sup> For example, a 2007 study of HCEC procedures found that committees varied in the procedures they used in consultations, such as seeing the patient or voting on outcomes, but that there was overall consistency of the goals of the committees. Ellen Fox et al., *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J. OF BIOETHICS, 20 (2007).

<sup>40</sup> PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 32, at 160.



HCEC are called upon to facilitate discussion and resolution of ethical issues in particular patient situations.<sup>41</sup>

Although issues of practice of law may potentially arise during ethics education and policy development, this article focuses on ethics consultations. Consultations are more likely to implicate two themes that are important for practice of law issues: 1) there are specific individuals that could be considered potential ‘clients’—whether the physicians, medical team, patients, or families—; and 2) the specific nature of the consultation case is more likely to raise issues of application of facts to law.

Ethics consultations are one of the most significant functions of HCECs, with over 80% of committees performing consultation services.<sup>42</sup> They are defined as “a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value laden concerns that emerge in health care.”<sup>43</sup> Consultations may involve a number of important steps, such as: discussions between patients, family members, and the health care team; mediation; and recommendations of permissibly ethical courses of action. Common topics for ethics consultations include end-of-life choices, patient autonomy, and capacity.<sup>44</sup>

A major source of debate is the appropriate level of HCEC members’ directiveness when conducting ethics consultations. Consultations can either provide a range of ethical options for individuals or they can provide a definitive recommended course of action. A small minority of HCECs issue binding decisions for the parties involved.<sup>45</sup> Generally, however, issuing binding decisions is seen as an inappropriate role for consultation because such an ‘authoritative approach’ emphasizes “consultants as the primary moral decision makers at the expense of the appropriate moral decision makers.”<sup>46</sup> Many HCECs, therefore, adopt a more facilitative approach with goals to open dialogue between the individuals involved in the case and create space for moral and value consensus-building.<sup>47</sup> This facilitative

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<sup>41</sup> George A. Kanoti & Stuart J. Youngner, *Clinical Ethics Consultation*, in *ENCYCLOPEDIA OF BIOETHICS* 439 (Stephen G. Post ed., 2004) (“A clinical ethics consultant is defined here as a person who upon request provides expert advice to identify, analyze, and help resolve ethical questions or dilemmas that arise in the care of patients.”).

<sup>42</sup> McGee et al., *supra* note 36 (finding that 86% surveyed had consultation services); Fox et al., *supra* note 39, at 15 (finding that 81% of HCECs had consultation services and an additional 14% were developing the service).

<sup>43</sup> Smith, *supra* note 21, at 33; *but see* Giles R. Scofield, *What Is Medical Ethics Consultation?*, 36 *J.L. MED. & ETHICS* 95 (2008) (noting that the exact definition of ethics consultation is difficult to pinpoint and most remain quite vague).

<sup>44</sup> McGee et al., *supra* note 36.

<sup>45</sup> *Id.*; *but see* Pope, *supra* note 37, at 428 (noting the increasing number of states that have given HCECs decision-making authority).

<sup>46</sup> AMERICAN SOCIETY OF BIOETHICS AND HUMANITIES, *Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities* 5 (2006).

<sup>47</sup> *See, e.g.*, AMERICAN SOCIETY OF BIOETHICS AND HUMANITIES, *Core Competencies for Healthcare Ethics Consultation 2nd Edition: A Report of the American Society for Bioethics and Humanities*, 6

approach, however, can still encompass a broad range of options from a list of permissible options, a recommendation specific to these options, or one recommended course of action.<sup>48</sup> Overall, how directive a consultation is may ultimately affect practice of law questions, as discussed further below.<sup>49</sup>

### C. HCEC membership

#### 1. Multi-disciplinary committees

The common scope of duties—policy, education, and consultation—unifies HCECs across the country; however, beyond broad duties HCECs are variable, especially in size and membership. Overwhelmingly, HCECs are multidisciplinary: both in the inclusion of various types of clinical care perspectives, as well as the inclusion of non-clinical professionals. This multidisciplinary nature is seen as a benefit, if not a requirement, for the successful application of ethics in the healthcare system.<sup>50</sup> “An ethics committee allows for an array of knowledge and perspectives to be brought to bear on consultation, education, and policy issues; otherwise, the ethics ‘mechanism’ of the hospital might as well be served by one or two individuals.”<sup>51</sup>

Indeed, throughout the history of HCECs, calls for multidisciplinary membership have been a constant presence. For example, in *Quinlan*, the New Jersey Supreme Court latched onto the idea of ethics committees from a “short and obscure” law review article authored by a pediatrician that highlighted the merits of ethics committees.<sup>52</sup> In the article, the author, a practicing pediatrician, advocated for ethics committees as a tool to diffuse legal liability from a single physician to a range of individuals.<sup>53</sup> She explicitly highlighted the differing backgrounds of members of ethics committees, from physicians, theologians, attorneys, and social workers.<sup>54</sup> The *Quinlan* court cited this description, indicating that when calling for ethics committees as insulators of liability, they were envisioning a group

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(2011); Note however, that even when an HCEC provides recommendations, these recommendations may in effect be binding due to various factors, such as courts accepting decisions or patients feeling pressure. Pope, *supra* note 37, at 436.

<sup>48</sup> Smith, *supra* note 21, at 35.

<sup>49</sup> See *infra* Part IV.D.

<sup>50</sup> See, e.g., Bernard Lo, *Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 N. ENGL. J. MED. 46, 47 (1987) (noting that including both physicians and nurses on a committee can help to bring different perspectives to the discussions).

<sup>51</sup> D. Micah Hester & Toby Schonfeld, *Introduction to Healthcare Ethics Committees*, in GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES 1, 5 (D. Micah Hester & Toby Schonfeld, eds., 2012)

<sup>52</sup> Wolf, *supra* note 23, at 798; *Quinlan*, 70 N.J. at 49.

<sup>53</sup> Karen Teel, *The Physician's Dilemma—a Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975).

<sup>54</sup> *Id.* at 9.

comprised of disparate backgrounds.<sup>55</sup> Other seminal calls for the establishment of ethics committees similarly include mention of the cross-disciplinary nature of the committee. For example, the Commission advocated that, “institutions should consider seriously the advantages of a diverse membership.”<sup>56</sup> The 1992 JCAHO ethics accreditation standard does not explicitly call for a specific type of membership—it broadly requires hospitals to have a “mechanism for the consideration of ethical issues.”<sup>57</sup> However, JCAHO does tangentially advocate for some diversity of membership in an ethics committee. The nursing section of the 1992 standards states that “when the hospital has an ethics committee or other defined structures for addressing ethical issues in patient care, nursing staff members participate.”<sup>58</sup>

Although the merits of multidisciplinary committees are universally embraced, not all professions are uniformly welcomed into HCECs with open arms. Three potential members raise particular concerns: hospital administrators, risk managers, and hospital attorneys.<sup>59</sup> These individuals, it is feared, may be more likely to have direct conflicts-of-interest in case consultations because their primary job description generally includes insulating the hospital from legal liability or ensuring the financial well-being of the organization. Therefore, difficult ethical deliberations, such as those about hospital error or end-of-life treatment, may invoke a conflict between the best interest of the patient and the best interest of the hospital, making a neutral ethical evaluation of the situation difficult.<sup>60</sup> This conflict of interest, however, may be an underlying issue for all members of the HCEC when they are also employees of the hospital.<sup>61</sup> Although the conflict-of-interests are more overt for administrators, risk-managers, or hospital counsel, any physician, nurse, social worker, or other hospital employee could have an implicit bias towards protecting his or her employer.

Overall, a wide-variety of professions are seen as appropriate training or background for ethics committee membership. Common backgrounds include physician, clergy or chaplains, administrator, nurse, attorney, social worker, community or lay representative, risk managers, psychologists, and

<sup>55</sup> Quinlan, 70 N.J. at 49–50; Teel, *supra* note 53, at 9 (in an interesting aside, the court did exclude Teel’s comment about how these committees were sometimes pejoratively called a ‘God Squad’).

<sup>56</sup> PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 32, at 166.

<sup>57</sup> JCAHO, *supra* note 34, at RL.1.1.6.1.

<sup>58</sup> *Id.* at NC.3.2.1.

<sup>59</sup> HESTER & SCHONFELD, *supra* note 51, at 6.

<sup>60</sup> See, e.g., AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES, *Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants*, 3 (2014) (providing the example that the director of an intensive care unit may desire to decrease the length of stay of the patient—an outcome that may not be the best option for the patient).

<sup>61</sup> Pope, *supra* note 28, at 276 (noting that, “As a result of . . . economic dependence, the committee members may tend to act out of a sense of duty to the institution.”).

philosophers.<sup>62</sup> HCEC membership is thus generally comprised of a variety of professional perspectives, although sometimes they can be dominated by a particular profession or have a large representation of one profession, such as chaplains at a religious hospital.<sup>63</sup>

## 2. Attorney-members

Generally, physicians and other individuals with clinical training comprise the largest group of membership in HCECs; however, attorneys make up a small, but consistent presence in the field. There are generally three types of attorneys that could serve as members of HCECs: hospital counsel; an attorney otherwise employed by the hospital or university, such as a law professor or a staff member in another role who has a law degree and license; or an attorney from the community who is not employed by the hospital or university.

In 1983, 41% of committees participating in a national survey had at least one attorney.<sup>64</sup> By 2001, across the board, HCECs averaged one attorney per committee.<sup>65</sup> Despite the consistent presence of attorneys, the merits of their membership on HCECs is often debated.<sup>66</sup> These statistics and many debates about the merits of attorneys on HCECs conflate the three types of attorneys that can serve; however the influence and conflicts differ significantly between these three subgroups. The concerns raised by those arguing against attorneys on health care ethics committees tend to fall into two camps: personal dynamics and conflicts of interests. Neither of these concerns is insurmountable.

Under the first concern, individuals argue that attorneys do not have the desirable traits for effective communication in the HCEC because they are generally adversarial, or at least seen as adversarial.<sup>67</sup> Personal dynamics concerns generally are founded on gross assumptions about attorneys and

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<sup>62</sup> Youngner et al., *supra* note 24, at 904 (finding that at 40% or more of hospitals had at least one physician, clergy, administrator, attorney, and nurse); McGee et al., *supra* note 36, at 61 (finding that "although physicians and nurses are the predominant participants in HECs, pharmacists, psychologists, ethicists, patient advocates, and laypersons are also represented on nearly all committees."); Fox et al., *supra* note 39, at 17 (finding that "individuals performing ethics consultation were almost all physicians (34%), nurses (31%), social workers (11%), chaplains (10%), or administrators (9%) [and] fewer than 4% were attorneys, other healthcare providers, laypersons, or 'other' (e.g., philosophers, theologians)."); see generally Michael Burgess et al., *Feeder Disciplines*, in *THE HEALTH CARE ETHICS CONSULTANT* (Francoise E. Baylis eds., 1994) (discussing various types of disciplines that feed into work as an ethics consultant).

<sup>63</sup> For example one study found a committee with nine attorneys or risk managers on a committee of 25. McGee et al., *supra* note 36, at 61.

<sup>64</sup> Youngner et al., *supra* note 24, at 904.

<sup>65</sup> McGee et al., *supra* note 36, at 61.

<sup>66</sup> See generally Randall B. Bateman, *Attorneys on Bioethics Committees: Unwelcome Menace or Valuable Asset*, 9 J.L. & HEALTH 247 (1994); see also Amy L. McGuire et al., *The Ethics of Lawyer-Ethicists*, 33 J.L. MED. & ETHICS 603, 603-04 (2005).

<sup>67</sup> Bateman, *supra* note 66, at 271; McGuire et al., *supra* note 66, at 604.

their personalities. Personality traits, to be fair, are very important for the smooth functioning of HCECs. The American Society of Bioethics & Humanities (ASBH), an academic society of individuals interested in applied and academic bioethics, has disseminated a list of necessary skills, knowledge, and traits for HCEC members. In their report *Core Competencies for Health Care Ethics Consultation* (hereinafter “Core Competencies”), they list five broad categories of attributes that all individuals participating in an HCEC should have: tolerance, patience, and compassion; honesty, forthrightness and self-knowledge; courage; prudence and humility; and integrity.<sup>68</sup> However, the general assumption that attorneys will automatically not have these traits given their training in litigation and legal posturing is an overreach.

The concerns of adversarial personalities are likely misconstrued interpretations of a broader point about professional norms and styles. Because legal training emphasizes an adversarial environment and tactics, there is a concern that over-reliance on attorneys and legal traditions will erode the collaborative goals of HCECs.<sup>69</sup> However, many attorneys receive training during law school in other, non-adversarial, skill sets, such as negotiation and mediation that can be helpful to the committee.<sup>70</sup> Indeed, the Core Competencies report recommends that consultants have basic knowledge of health law and skills that are common to the skills taught in legal mediation, such as the ability to facilitate meetings, the ability to engage individuals in effective communication, and the ability to identify conflicts and underlying value uncertainties.<sup>71</sup> Many see the virtues of having attorneys on committees, given the expertise and knowledge they can bring to the table.<sup>72</sup>

A more notable apprehension regarding attorney participation on ethics committees is the second concern: conflict-of-interest. As discussed above, if an attorney member is also an employee of the hospital, they may be unable to balance their loyalties between the hospital and the patient—an especially powerful worry if the attorney is hospital counsel. Under rules of professional responsibility, attorneys owe a duty of loyalty to their client.<sup>73</sup> This requires them to, among other things, be zealous advocates for their client, maintain confidentiality, and to act in the best interest of the client.

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<sup>68</sup> CORE COMPETENCIES 2011, *supra* note 47, at 32. For further discussion on ASBH and core competencies, see *infra* Part III.B.1.

<sup>69</sup> Kanoti & Youngner, *supra* note 41, at 441; see also Jeffrey W. Stemple, *The Inevitability of the Eclectic: Liberating ADR from Ideology*, 2 J. DISP. RESOL. 247, 276, 282 (discussing similar assumptions that occur when lawyers participate in mediation).

<sup>70</sup> McGuire et al., *supra* note 66, at 604–05.

<sup>71</sup> CORE COMPETENCIES 2011, *supra* note 47, at 22–25.

<sup>72</sup> McGuire et al., *supra* note 66, at 604 (noting that “legal education alone is usually not lethal to the sensitivity required for the role of ethics consultant.”); see also Burgess et al., *supra* note 62.

<sup>73</sup> MODEL RULES OF PROF'L CONDUCT R. 1.7 cmt. (2014) (commenting that “loyalty and independent judgment are essential elements in the lawyer's relationship to a client.”).

The hospital is the client of hospital counsel; therefore, there may be very real and intractable conflict-of-interest issues when the ethical options for treatment of patients and resolution of consultations conflicts with the best interest of the hospital. A counter argument is that no conflict of interest actually exists as long as the hospital counsel has: the support at the institutional level to ‘wear two hats’ during the service on the HCEC; and the ability to recuse himself or herself in situations where a direct conflict-of-interest may be present, such as when the attorney would be the only hospital attorney available to assist in a potential lawsuit if the case at hand were to go to trial.<sup>74</sup> Under this view, conflicts-of-interest are only perceived, not actual because:

(1) it is generally advisable for health care institutions to promote the ethical practice of medicine; (2) hospital policies should be ethical, but they should also not conflict with the law; and (3) when the law and ethics diverge, hospital staff and patients should be educated about relevant ethical considerations, and should also be informed of their legal rights and any potential risk of liability.<sup>75</sup>

It remains unclear however, whether this rosy view of conflicts-of-interest plays out in practice.

Additionally, because hospital counsel hold prominent positions of administration in the hospital, there is also concern that, during committee discussions and votes, they will wield too much power. Ethical options may include illegal ones or, at the very least, options that are suspect in the legally conservative position of the hospital. It may create conflict for hospital counsel to balance professional duties to the client and a robust discussion of all ethical options. They may tend towards seeing the law as the only answer to ethical questions. If hospital counsel remarks that a certain course of action is against the law or not in the hospital’s best interest, it may be difficult, if not impossible, for others to discuss the issue or chose a different path—even if an ethically permissible one.

However, as evidenced by the continued presence of attorneys on HCECs, attorneys are valuable assets for committees. ASBH recommends that all individuals on the committee have basic knowledge of health law, but that at least one member of the committee can access someone with advanced knowledge of health care law.<sup>76</sup> This recommendation does not mandate that an attorney serve on the committee, rather it suggests that

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<sup>74</sup> McGuire et al., *supra* note 66, at 604, 606.

<sup>75</sup> *Id.* at 604.

<sup>76</sup> Both editions of the Core Competencies utilize this idea of basic knowledge and access to advanced knowledge. CORE COMPETENCIES 2011, *supra* note 47, at 26–27; CORE COMPETENCIES 2006, *supra* note 46, at 20–21.

“advanced knowledge of relevant health law could be available to the process, if ethics consultants know how to reach legal counsel with expertise in ethics-related health law.”<sup>77</sup> However, an attorney on the committee can help to highlight legal issues and provide background on relevant state and federal law on an immediate and regular basis and otherwise be an active and valuable member of the team.<sup>78</sup>

There are two strategies that HCECs utilize to ensure the presence of legal expertise while minimizing concerns of conflict-of-interest and discussion dominance. First, HCECs sometimes invite hospital counsel to participate in the meetings, but without full membership. Under this type of *ex officio* membership, counsel is present during discussions and potentially consults to provide information about laws and hospital policy, but does not have any decisional or voting rights at the meetings. The hope is that the HCEC will gain the benefits of the counsel’s expertise without having them control discussion. However, there still may be concerns of influence, as members of the committee may remain loath to go against the counsel, even if counsel isn’t officially voting or providing formal recommendations.

Second, in order to ensure sufficient expertise in health law on the committee, HCECs will include an attorney member whose job is not hospital counsel, such as a health law professor or other affiliated attorney. Since these individuals do not represent the hospital as clients, it is hoped that this will lessen conflict-of-interest concerns. However, the professional norms of these seemingly more neutral come from the same body of policy as those governing hospital counsel. Thus, attorney members must also grapple with considerations such as whether they have an attorney-client relationship with anybody in a consultation and, if so, whom; to whom do they owe confidence and loyalty. While not as overt, these considerations may create subtle conflict-of-interest situations and may lead to the practice of law.

### III. PROFESSIONALIZATION

Within the bioethics community there is a growing movement towards, and ensuing angst about, professionalization. As the number of HCECs has burgeoned, so too have the discussions of the bounds of clinical ethics and who is competent to serve as an ethics consultant. “Who should be considered health care ethics consultants? Whom should they advise? What should be their responsibilities and what kind of training should they have? Should there be some kind of accreditation or certification program to ensure

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<sup>77</sup> CORE COMPETENCIES 2011, *supra* note 47, at 21.

<sup>78</sup> McGuire et al., *supra* note 66, at 604–05.

that those who call themselves ethics consultants are in fact qualified to advise, consult, research, and write in health care ethics?<sup>79</sup>

These questions, posed in the preface of a 1994 book, *The Health Care Ethics Consultant*, remain as highly debated over two decades later.<sup>80</sup> However, unlike two decades ago, the field is now robust and, in many ways, has ‘come of age’.<sup>81</sup> The overarching questions over the roles of HCEC members and the measures of competency for conducting consultations have sparked calls for formal professionalization of the field. Professionalization in ethics consultations, like organizational efforts across many fields, could take many different forms, from credentialing to licensing to formal educational requirements.<sup>82</sup> No official standardization has yet occurred for a number of reasons: the field was in its infancy<sup>83</sup>; the diversity of the field makes standardization of norms difficult<sup>84</sup>; and there remains questions over what the ultimate goals and styles of ethics consults should be.<sup>85</sup> However, fears about inconsistent quality of ethics consultations have reinvestigated the calls for standards and have swayed some of the initial skeptics.<sup>86</sup>

#### A. *Professionalization: goals and motivations*

In many sectors, professionalization is a coveted rite of passage—it is a dynamic process by which occupations adopt crucial structural changes in the direction of a profession.<sup>87</sup> Professionalization stems, in part, from core beliefs that “certain work is so specialized as to be inaccessible to those lacking the required training and experience.”<sup>88</sup> Its goals are to: establish

<sup>79</sup> THE HEALTH CARE ETHICS CONSULTANT, V (FRANCOISE E. BAYLIS eds., 1994).

<sup>80</sup> See, e.g., Giles R. Scofield, *What Is Medical Ethics Consultation?*, 36 J.L. MED. & ETHICS 95, 95–96 (2008); Tapper, *supra* note 21.

<sup>81</sup> Scofield, *supra* note 80, at 95 (“Bioethicists are plying their trade mainly as ethics consultants in hospital settings and as researchers and educators with university affiliations . . . . With increasing frequency, bioethicists are also functioning in a variety of peripheral contexts, such as media interviews, media panels, and public education forums. We find bioethicists on commissions and committees, in the courtroom, in the boardroom, and in the corridors of power—virtually everywhere that expert opinion is sought on the ethical issue of the day.” In short, they are ‘players,’ members of a field of practice that has come of age.” (citations omitted)).

<sup>82</sup> CORE COMPETENCIES 2011, *supra* note 47; THE HEALTH CARE ETHICS CONSULTANT, *supra* note 79.

<sup>83</sup> Scofield, *supra* note 80, at 99 (noting that the field can no longer be called nascent, but is now in an ‘adolescent’ phase).

<sup>84</sup> Kanoti & Youngner, *supra* note 41, at 442; Anita J. Tarzian, *Credentials for Clinical Ethics Consultation—Are We There Yet?*, 21 HEC FORUM 241, 242 (2009).

<sup>85</sup> Diane Hoffmann et al., *Are Ethics Committee Members Competent to Consult?*, 28 J.L. MED. & ETHICS 30, 30 (2000) (noting that whether one follows a consultative or facilitative approach to consults alters the requisite skills needed to competently complete a consult); Kanoti & Youngner, *supra* note 41 at 440 (noting a debate about whether the expertise of consultants should stem from practical clinical experience or moral theory and ethical principles.).

<sup>86</sup> Eric Kodish et al., *Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities*, 43 HASTINGS CENT. REP. 26, 26 (2013).

<sup>87</sup> HOWARD M. VOLLMER & DONALD L. MILLS, PROFESSIONALIZATION vii-viii, 9 (Howard M. Vollmer & Donald L. Mills, eds., Prentice-Hall 1966).

<sup>88</sup> ELIOT FREIDSON, PROFESSIONALISM, THE THIRD LOGIC: ON THE PRACTICE OF KNOWLEDGE 17 (University of Chicago Press eds., 2001).



standards of excellence; form rules of conduct; imbue responsibility to members; create norms for training and recruitment; protect individuals within the field; raise the field to a heightened societal standing; and to secure control—often economic—of an area.<sup>89</sup> Hallmark requirements for the establishment of a profession, include, among other things, a knowledge base, standard norms of practice, professional associations, a code of ethics, and specific training criteria to ensure quality control.<sup>90</sup>

These requirements ultimately serve to establish the profession as an authoritative body.<sup>91</sup> Members of a profession “claim authority, not as individuals, but as members of a community that has objectively validated their competence.”<sup>92</sup> Ensuring competency is, and has always been, one of the primary interests of professional movements.<sup>93</sup> This is no less true for the current HCE consultant professionalization movement. The professionalization movement seeks to establish and maintain “standards of competency for practitioners.”<sup>94</sup> An ethics consult that is performed inadequately or by someone who is incompetent is problematic because consults can be requested in the context of life and death situations and at the very least, involve individuals at an extremely vulnerable moment.<sup>95</sup> However, professionalization goals can raise ire from those without specific training in bioethics, who nonetheless, feel that they are sufficiently prepared to competently address ethical issues in clinical care.<sup>96</sup>

The professionalization of bioethics, as it relates to ethics consultations, is complicated by the fact that bioethics is a field that draws upon many disciplines. One might view themselves as a professional in any number of other fields, such as medical, nursing, and legal, but also a professional in bioethics. Others may view themselves as tied to only one profession, with a focus in bioethics, such as a philosopher who focuses on bioethics.

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<sup>89</sup> VOLLMER & MILLS, *supra* note 87, at xi.

<sup>90</sup> See, e.g., Wilensky, *supra* note 5 at 138 (noting that a profession requires a technical basis and needs to be able to “convince the public that its services are uniquely trustworthy.”); see also VOLLMER, *supra* note 87, at 9 (“professionals seem to possess: (1) systematic theory, (2) authority, (3) community sanction, (4) ethical codes, and (5) a culture.”).

<sup>91</sup> STARR, *supra* note 5, at 9.

<sup>92</sup> *Id.* at 12.

<sup>93</sup> VOLLMER & MILLS, *supra* note 87, at 5–6 (citing A. M. CARR-SAUNDERS & P. A. WILSON, *THE PROFESSIONS* (Oxford: Clarendon Press 1933)).

<sup>94</sup> Susan Sherwin, *Certification of Health Care Ethics Consultants*, in *THE HEALTH CARE ETHICS CONSULTANT 13* (Francoise E. Baylis eds., 1994) (noting that the objective of creating standards for competency “is surely the principal rationale behind proposals to institute the various procedures and criteria that are customarily associated with certification.”); see also Laura Williamson, *The Quality of Bioethics Debate: Implications for Clinical Ethics Committees*, 34 *J. MED. ETHICS* 357, 357 (2008) (highlighting the concerns about the quality of ethical assessment in clinical ethics).

<sup>95</sup> Tarzian, *supra* note 84, at 241 (noting that ethics consults are generally called when patients are “at their most vulnerable, emotionally, physically, spiritually.”); see also Kodish et al., *supra* note 86, at 26.

<sup>96</sup> Hoffmann et al., *supra* note 85, at 36 (determining that many ethics committees in Maryland hospitals “function based on the belief that no special expertise is necessary to perform an ethics consult.”).

Professionalization is seen as beneficial because it helps to define what an ethics ‘expertise’ means.<sup>97</sup> This is especially relevant given the placement of HCECs in hospital settings where markers of expertise and professionalism are highly valued. Consults are usually called to bring in highly trained and skilled experts in a field, such as a neurology or surgical consult. Thus, the conception of an ethics ‘consult’ within a hospital creates expectations about how to set hiring criteria and evaluate candidates and employees.<sup>98</sup> A more formal training or certification system would provide transparency as to the roles of clinical ethicists and the scope of practice—thus more clearly guiding hiring norms for hospitals.<sup>99</sup> Of course, this returns us to the normative debate and uncertainty about what the goals and roles *should* be. This revolving argument is one likely reason that formal, required guidance has not been established, and why debates continue to return to concerns of quality.

### B. Professionalization and HCE Consultants

Although a formal credentialing, accreditation, licensing, or certification system has not been established, the leading society in the bioethics field, the ASBH, has taken concrete steps towards professionalization with the goal of increased standardization. Three primary changes have been to: promulgate the list of desired ‘core competencies’; develop a ‘quality attestation’ process; and create a code of ethics. These changes begin to set up ways that HCEC members can claim professional status. It is notable that by focusing upon competencies and attestation, ASBH has located the individual consultant as the source of professional legitimacy and the one that needs to establish and prove professional legitimacy; however, given the multidisciplinary nature of HCECs, ASBH could have instead focused upon qualifications of the committee as a whole.

#### 1. Core competencies

The ASBH promulgated a list of the core skills, knowledge, and attributes that ethics consultants should have through the Core Competencies report—first in 2006 and with an update in 2011. The report does not require every individual consultant to have mastery of every skill and knowledge

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<sup>97</sup> Lisa M. Rasmussen, *An Ethics Expertise for Clinical Ethics Consultation*, 39 J.L. MED. & ETHICS 649, 650 (2011) (“The interest in certification, credentialing, licensing, accrediting, or in other ways formalizing clinical ethics consultation is partly motivated by the desire to establish what moral expertise in the field amounts to.”).

<sup>98</sup> Kanoti & Youngner, *supra* note 41, at 441 (“Unlike traditional medical consultants, clinical ethics consultants are not subject to widely accepted standards and procedures for training, credentialing, maintaining accountability, charging fees, obtaining informed consent, or providing liability coverage.”).

<sup>99</sup> Rasmussen, *supra* note 97, at 658.

areas. Instead, the report recommends that every member of the team have a basic level of most skills and knowledge areas, and that the committee overall have access to someone with advanced skills or knowledge in each area, either through a team member or through optional contact with a person outside the committee.<sup>100</sup> The report also covers emerging process standards of HCECs and evaluation methods and recommendations for HCECs.<sup>101</sup>

The primary goal of the Core Competencies maps the often-highlighted desire of professionalization overall—improve the quality of ethics consultation.<sup>102</sup> “Patients, families, surrogates, and healthcare professionals should be able to trust that when they seek help regarding the ethical dimensions of health care, ethics consultants are competent to offer that assistance.”<sup>103</sup> The interpretation of the Core Competencies as a definitive standard for the burgeoning field has developed over time. The Task Force that created the first version of the competencies made explicitly clear that they were not creating mandatory requirements:

The Task Force: does not wish certifying or accrediting bodies to mandate any portion of its report; believes that certification of individuals or groups to do ethics consultation is, at best, premature; and, does not intend for its report used to establish a legal national standard for competence to do ethics consultation.<sup>104</sup>

The initial Task Force rejected calls for certification and accreditation for a variety of reasons including: the possibility that consultants would be viewed as the ‘primary moral decision makers’ thus pushing patients and providers outside of the discussion and assessment; the potential loss of disciplinary diversity; the potential institutionalization of one particular view of morality; the difficulty in evaluating what ‘good’ ethics is; and the cost of implementation.<sup>105</sup> These motivations for retaining the voluntary nature of their recommendations mirrored many of the discussions and concerns highlighted in the literature around that time.<sup>106</sup> Just thirteen years after the initial Core Competencies report, however, the ASBH Task Force changed its message. The second, and most current, edition of the competencies notes, “[t]o the extent that the ultimate commitment of the

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<sup>100</sup> CORE COMPETENCIES 2011, *supra* note 46, at 25.

<sup>101</sup> *Id.* at 10–18; 34–46.

<sup>102</sup> *Id.* at 19.

<sup>103</sup> *Id.*

<sup>104</sup> CORE COMPETENCIES 2006, *supra* note 46, at 31.

<sup>105</sup> *Id.* at 31–32; Kodish et al., *supra* note 86, at 28.

<sup>106</sup> See, e.g., Tarzian, *supra* note 84, at 245, 245–46 (“One concern with the program accreditation approach is that it will squelch innovation and diversity in CEC approaches due to the need to endorse common standards.” Additionally, only those activities that can be ‘objectively measured’ will be able to be evaluated for competency.)

Task Force is to improve and maintain the quality of [consultations] performed, the Task Force endorses holding individuals performing [consultations] accountable to the standards outlined in this report.”<sup>107</sup> Thus, a certification or credentialing process or an accrediting program could use the report to guide standards for the profession. Despite this shift, the report still remains shy of fully advocating or creating professional requirements or norms. For example, it suggests the development of a mechanism for individuals to ‘voluntarily demonstrate’ their qualifications.<sup>108</sup> Thus, the report does not outwardly call for accreditation, credentialing, or other more formal measures of qualifications, but does take a further step towards that direction.

## 2. *Quality attestation*

In 2013, shortly after the second edition of the Core Competencies, the ASBH created an assessment tool to measure the quality of ethics consultants.<sup>109</sup> This two-part “quality attestation” process ostensibly determines whether an individual is competent and able to carry out a clinical ethics consultation.<sup>110</sup> When developing this process, the task force tried to balance ensuring competency with the recognition that consultants come from diverse backgrounds.<sup>111</sup> The first step of quality attestation is a portfolio review of the candidate’s educational background, ethics consultation training, consultation philosophy, and examples of consultations completed by the candidate.<sup>112</sup> The second step is an oral examination where an ASBH committee and the candidate discuss both cases from the portfolio and model vignettes.<sup>113</sup> In 2015, a group reported on a “proof of concept” study for case complexity assessment, but quality attestation overall has not yet been fully implemented.<sup>114</sup>

It is unclear the extent to which quality attestation will take hold as a legitimate way for individuals currently engaged in ethics consultations to show proof of their competency. The task force acknowledged the many remaining pieces to develop, such as the procedure for those that do not ‘pass’ the initial test and how to transition the oversight of the test from internal in the ASBH to an independent body.<sup>115</sup> Others have argued that the

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<sup>107</sup> CORE COMPETENCIES 2011, *supra* note 46, at 51.

<sup>108</sup> *Id.*

<sup>109</sup> THE HASTINGS CTR., *Improving the Quality of Clinical Ethics Consultants* (Center Press Release 2013), <http://www.thehastingscenter.org/News/Detail.aspx?id=6559> (last visited Nov. 11, 2015).

<sup>110</sup> Kodish et al., *supra* note 86, at 27.

<sup>111</sup> *Id.* at 29–30.

<sup>112</sup> *Id.* at 30.

<sup>113</sup> *Id.* at 33. (Although the task force leaves open the possibility for a more extensive oral examination in the future).

<sup>114</sup> B. Spielman et al., *Case Complexity and Quality Attestation for Clinical Ethics Consultants*, 26 J CLIN. ETHICS 231 (2015).

<sup>115</sup> *Id.* at 34–35.

attestation process is being proposed prematurely and that more work needs to be accomplished before it is implemented.<sup>116</sup> Nevertheless, the development of the quality attestation illustrates a major step by the ASBH towards professionalizing the field. It is easy to imagine how this test could quickly become a necessary standard for those wishing to hold ethics consultation positions in major hospitals.

### 3. Code of ethics

The third major, recent step that the ASBH has taken towards professionalization is the development of a code of ethics.<sup>117</sup> A formal code of ethics is one common sign of the professionalization of a discipline or field.<sup>118</sup> In January 2014, the ASBH Board of Directors approved the first code of ethics. The code includes seven broad ethical standards that members of HCECs should strive to meet: be competent; preserve integrity; manage conflicts of interest and obligation; respect privacy and maintain confidentiality; contribute to the field; communicate responsibly; and promote just health care within HCECs.<sup>119</sup>

Even after the Code of Ethics was approved by the ASBH Board of Directors it engendered continued debates about the necessity and practicality of the document.<sup>120</sup> Similarly to the quality attestation debate, the Code of Ethics faces difficulties trying to pinpoint common ground in a diverse field. Currently the code is only aspirational—individuals should try to conform, but there are no clear penalties if one does not comply.<sup>121</sup> However, unless and until there is something to take away from an individual, such as a license or certification, there will not be an internal way of policing the ethics.<sup>122</sup> Questions remain whether violation of such a code could be brought to bear in any type of malpractice case against a medical team or hospital.

<sup>116</sup> Autumn Fiester, *Clinical Ethics Credentialing and the Perilous Cart-Before-the-Horse Problem*, 14 AM. J. OF BIOETHICS 25 (2014).

<sup>117</sup> ASBH CODE OF ETHICS, *supra* note 60.

<sup>118</sup> See, e.g., Tarzian, *supra* note 84, at 241.

<sup>119</sup> ASBH CODE OF ETHICS, *supra* note 60; The Code was developed by the Advisory Committee on Ethics Standards—a subcommittee of the ASBH.

<sup>120</sup> See, e.g., Bert Molewijk et al., *Fostering the Ethics of Ethics Consultants in Health Care: An Ongoing Participatory Approach*, 15 AM. J. OF BIOETHICS 60 (2015) (noting that the concepts within the code are so broad and abstract as to be impractical); Stephen R. Latham, *Professionalization of Clinical Ethics Consultation: Defining (Down) the Code*, 15 AM. J. OF BIOETHICS 54, 55 (2015) (highlighting that it is difficult to know how to apply some of the code's principles since it is not clear in whose agency an ethics consultant acts, unlike in the case of medicine or law where the professional has clear patients or clients).

<sup>121</sup> See Adam Peña, *A Critique of the (Aspirational) Code of Ethics*, 15 AM. J. OF BIOETHICS 62 (2015) (the author argues that the code should not merely be aspirational; even if difficult or impossible to enforce currently, it should be advertised as an authoritative statement).

<sup>122</sup> Anita J. Tarzian et al., *A Code of Ethics for Health Care Ethics Consultants: Journey to the Present and Implications for the Field*, 15 AM. J. OF BIOETHICS 38, 48 (2015).

#### 4. Next steps

Although there have not been specific next steps of professionalization introduced by the ASBH, it appears likely that movement towards certification, accreditation, or recognition of other professional standards will continue unabated. Through a steady shift towards standardization, the field has transitioned from questions of *whether* to professionalize towards questions of *how*.<sup>123</sup> The next step may come through formal adoption of the quality attestation,<sup>124</sup> an accreditation system for training programs,<sup>125</sup> or perhaps through a written competency exam.<sup>126</sup> Despite the uncertainty of form, it is clear that professionalization is likely to continue its steady forward motion.

#### IV. THE PRACTICE OF LAW AND THE PRACTICE OF ETHICS CONSULTATIONS

HCECs exist at the intersection of ethics, medicine, law, and many other health and social science fields. Medicine and law, of course, are two of the oldest and most deep-rooted professions in society.<sup>127</sup> The more established and mature a profession, the more likely it is to have strong territorial interests and the more likely these interests are to be protected through state legislation. For example, many states have legislation that defines rules for the practice of dentistry, medicine, nursing, and law.<sup>128</sup> The desire for professional boundaries is especially conspicuous in those very professions that are interdisciplinary in nature, like mediation, ethics consultations, or administration. When multiple groups with unique trainings and backgrounds participate in the same occupational space, there is a natural

<sup>123</sup> Ellen Fox, *Developing a Certifying Examination for Health Care Ethics Consultants: Bioethicists Need Help*, 14 AM. J. OF BIOETHICS 1, 1 (2014).

<sup>124</sup> See *supra* Part III.B.2.

<sup>125</sup> Jeffrey P. Spike, *The Birth of Clinical Ethics Consultation as a Profession*, 14 AM. J. OF BIOETHICS 20, 21 (2014).

<sup>126</sup> See, e.g., Bruce D. White et al., *Structuring a Written Examination to Assess ASBH Health Care Ethics Consultation Core Knowledge Competencies*, 14 AM. J. OF BIOETHICS 5 (2014); see also Fiester, *supra* note 116 Adam Peña et al., *Same Goal, Different Path*, 14 AM. J. OF BIOETHICS 23 (2014); Toby Schonfeld et al., *Connecting Certification and Education*, 14 AM. J. OF BIOETHICS 18 (2014); Bethany Spielman, *Problems in Testing Clinical Ethicists' Competence in Health Law*, 14 AM. J. OF BIOETHICS 27 (2014); Spike, *supra* note 125.

<sup>127</sup> See, e.g., Stemple, *supra* note 69, at 276 ("Although many nonlawyer mediators come from fields frequently described as professions (psychology, sociology, engineering, and architecture), they do not have the same established infrastructure and prestige that attends society's traditional professions such as law and medicine.").

<sup>128</sup> Brief for Am. Dental Ass'n et al. as Amici Curiae Supporting Petitioner, at 5, North Carolina Bd. of Dental Exam'rs v. F.T.C., 135 S.Ct. 1101 (2013) (No. 13-534); STARR, *supra* note 5, at 4 (noting that, "in America, no one group has held so dominant a position in this new world of rationality and power as has the medical profession." Although the territory is well established in that the importance of excluding unqualified individuals from practicing medicine or law is universally recognized, the explicit boundaries of the turf is not necessarily clear.

jostling for status as a legitimate participant in the field.<sup>129</sup> Professionalization thus secures “occupational gains” over other similar groups.<sup>130</sup> As such, any effort to definitely establish professional ‘turf’ for members of HCECs has the potential to conflict with or overstep the bounds of law and medicine in particular.<sup>131</sup> Thus, as calls for professionalization of HCE consultants continue, it is important to reexamine whether the ‘practice’ of ethics consultations may implicate the practice of law or medicine.<sup>132</sup>

#### A. *Parallels to mediation*

The field of mediation shares many similarities with ethics consultations regarding the professionalization and practice boundaries issues.<sup>133</sup> The two

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<sup>129</sup> Wilensky, *supra* note 6.

<sup>130</sup> For example, in the context of alternative dispute resolution and mediation, non-lawyer mediators attempt to create “occupational gain” over lawyer mediators by establishing professional norms of ‘facilitative’ mediation because this method of mediation differentiates from ‘evaluative’ mediation—a method more closely tied to legal training. *See, e.g.*, Stemple, *supra* note 69, at 278 (“A significant percentage of the facilitative mediation community is composed of nonlawyers who stand to gain a good deal professionally to the extent that mediation is defined as disparately from adjudication and negotiation as possible.”).

<sup>131</sup> Although there could also be similar discussions about whether HCE consultations are the practice of medicine, this line of questioning arises less often than whether consultants may engage in the practice of law. There are several likely reasons. First, HCECs are historically predominantly comprised of physicians and other clinicians. When a clinician opines about the medical aspect of a consultation, it is less likely to raise concerns as when a clinician opines about a legal aspect of a consultation. Second, consultations are generally requested by physicians or members of the healthcare team. This team presumably is already clear about the medical treatment options, although they may be unsure of which option is ethically recommended or permissible. Thus, it is more likely that HCE consultants would step in to provide opinions about law than to overstep the healthcare teams’ pre-existing opinions about medical care. Because practice of law issues are more likely to arise, this paper focuses on that particular aspect; however, practice of medicine issues could still arise if a non-physician makes medical recommendations or otherwise crosses the boundaries of medicine.

<sup>132</sup> In the past, others have considered whether ethics consultations could be considered the practice of law. *See, e.g.*, McGuire et al., *supra* note 66; Bethany Spielman, *Has Faith Health Care Ethics Consultants Gone Too Far—Risks of an Unregulated Practice and a Model Act to Contain Them*, 85 MARQ. L. REV. 161 (2001). Despite conclusions that in some instances consultations could implicate practice of law rules, there has not appeared to be any widespread changes of practice in the HCEC field. Therefore, it is important to continue to examine this issue, especially in light of the recent Supreme Court case.

<sup>133</sup> In addition to the similarities of the two fields, there is also ongoing discussion about whether mediation should be used as a tool to resolve ethical dilemmas in healthcare. Ethics consultations involve not only ethical dilemmas and value consensus, but also must oftentimes address the interpersonal dynamics and conflicts between family members, the patient, and the healthcare team. *See, e.g.*, NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, *BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS* xi (Vanderbilt University Press 2011); Lisa Soleymani Lehmann, *Family Dynamics and Surrogate Decision-making*, in *GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES* 63, 68 (D. Micah Hester & Toby Schonfeld, eds., 2012). For this reason, professional standards of ethics consultations include not only skills and knowledge of ethics, but also skills revolving around interpersonal dynamics. *See supra* Part III.B.1. Proponents for mediation in ethics consultations highlight the benefits of the consultant role as a neutral third party that allows patients, families, and the healthcare team to come to a consensus, without imposition of a course of action by an ethics consultant. *See, e.g.*, Autumn Fiester, *The Failure of the Consult Model: Why “Mediation” Should Replace “Consultation,”* 7 AM. J. OF BIOETHICS 31 (2007) (critiquing the number of ethics consultations that end in a single best course of

fields have many analogous features: consultants, like mediators, are generally seen as being neutral third parties; consultations, like mediations, strive to bring parties to a consensus outside of the adversarial realm of litigation; and both consultations and mediations raise legal issues. Mediation attracts individuals from a variety of different backgrounds and, although it shares many educational underpinnings with law, it is comprised of attorneys and non-attorneys alike. Mediation also underwent similar angst and steps towards issues of professionalization that are occurring in the HCEC field.<sup>134</sup> Although the practice of mediation is not uniformly professionalized throughout the country, there are certification programs, professional bodies, and a code of ethics.<sup>135</sup>

The two fields are also alike in their goals of resolving conflicts between parties without resorting to the judicial system. The fields are seen as beneficial given their non-adversarial nature and the use of both mediation and ethics consultations have been advocated for by judges and the legal community given the potential to amicably resolve issues before resorting to the stretched-thin legal system. However, given the close ties to the legal field, both ethics consultations and mediation have the potential to overreach, or appear to overreach, professional boundaries and meld into the practice of law. Due to these similarities, the following discussion of practice of law standards will often draw upon examples and solutions from mediation.

### B. *Unauthorized practice of law*

Just as in the case of teeth-whitening and the practice of dentistry, the definition of practice of law is not a clear and bright rule.<sup>136</sup> Historically, unauthorized practice of law (UPOL) rules first emerged in the late 19<sup>th</sup>

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action recommendations by consultants, thus taking decision-making power away from the patients and families). Mediation is seen as appropriate for HCE consultations because it shifts decision-making power to the patients and family members—those most affected by the situations under discussion. JAY E. GREINIG, ALTERNATIVE DISPUTE RESOLUTION § 20:22 1 (Thomson/West 2005). Indeed, the growing movement towards utilizing conflict resolution techniques in the hospital setting has led to the formation of “bioethics mediation.” Bioethics mediation “combines the clinical substance and perspective of bioethics consultation with the tools of the mediation process, using the techniques of mediation and dispute resolution.” DUBLER & LIEBMAN, *supra* note 133, at 35.

<sup>134</sup> See, e.g., Nolan-Haley, *supra* note 16, at 243 (discussing the increased professionalization of mediation, “[t]he growth of mediation activity in so many sectors has resulted in the notion of mediation as an emerging profession, with its indicia of formal expertise, regulatory power and a desire by members to be accepted as professionals.”).

<sup>135</sup> See, e.g., Dana Shaw, *Mediation Certification: An Analysis of the Aspects of Mediator Certification and an Outlook on the Trend of Formulating Qualifications for Mediators*, 29 U. TOL. L. REV. 327 (1997); AM ARBITRATION ASS’N, MODEL STANDARDS OF CONDUCT FOR MEDIATORS (2005).

<sup>136</sup> See, e.g., Quintin Johnstone, *Unauthorized Practice of Law and the Power of State Courts: Difficult Problems and Their Resolution*, 39 WILLAMETTE L. REV. 795, 806 (2003); Deborah L. Rhode & Lucy Buford Ricca, *Protecting the Profession or the Public? Rethinking Unauthorized-Practice Enforcement*, 82 FORDHAM L. REV. 2587, 2588 (2014); see also Derek A. Denckla, *Nonlawyers and the Unauthorized Practice of Law: An Overview of the Legal and Ethical Parameters*, 67 FORDHAM L. REV. 2581 (1998).



century with prohibitions on non-lawyers appearance in court.<sup>137</sup> In the early 20<sup>th</sup> century, these rules expanded to prohibit non-lawyers from engaging in a much broader range of activities outside of the courtroom.<sup>138</sup> As states have expanded the definition of the practice of law to activities outside the courtroom, they have experienced difficulty in creating clear and bright-line rules. Many state statutes define the practice of law by referring to specific categories of tasks or activities, such as appearing in court, creating legal documents, holding oneself out as an attorney, and providing legal advice.<sup>139</sup> Other states and courts have developed broad tests to try to delineate the proper bounds of law.<sup>140</sup> All 50 states now have legislation that regulates the UPOL.<sup>141</sup> Despite the variability and lack of concrete definitions, the UPOL has great implications for members of HCECs, attorney and non-attorney alike: Violations can incur strict penalties, both civil and criminal.<sup>142</sup> Some states even create a private right of action for individual harmed by the UPOL.<sup>143</sup>

In 2003, the ABA Task Force on the Model Definition of the Practice of Law drafted a recommended definition of UPOL. Their strategy was to combine a list of tasks that are usually considered the practice of law with the application of a broader test; the “application of legal principles and judgment to the circumstances or objectives of another person or entity.”<sup>144</sup> Additionally, the Task Force recommended that states outline the minimum qualifications and competencies for attorneys licensed to practice.<sup>145</sup> The overarching rationale for UPOL legislation, including the ABA model rules, is to protect individuals from harms of receiving incompetent legal services.<sup>146</sup> However, there is also a strong economic motivation for creating a legal monopoly through exclusion of non-lawyers from the field.<sup>147</sup> The ABA Model Definition of the Practice of Law was critiqued as being overly

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<sup>137</sup> Denckla, *supra* note 136, at 2583.

<sup>138</sup> *Id.* at 2587–88.

<sup>139</sup> AMERICAN BAR ASSOCIATION, *Model Definition of the Practice of Law Report*, 4 (2003).

<sup>140</sup> *See, e.g.*, RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 4(b) (2000) (noting that the courts played a large role in defining practice of law).

<sup>141</sup> An unlicensed individual can either be a non-lawyer who does not have a license to practice or a lawyer who has a license to practice in one state, but is engaging in the practice of law in a different state, without obtaining sufficient permission or falling into a statutory exception.

<sup>142</sup> Johnstone, *supra* note 136, at 806–07; Denckla, *supra* note 136, at 2587 (noting that two-thirds of states have made it a criminal misdemeanor to engage in the unauthorized practice of law); *see e.g.*, N.C. GEN. STAT. ANN. § 84-8 (2011) (creating a Class 1 misdemeanor for any person violating UPOL rules in the state of North Carolina).

<sup>143</sup> *See, e.g.*, N.C. GEN. STAT. ANN. § 84-10.1 (2011) (creating a private cause of action in North Carolina for “any person who is damaged by the unlawful acts”).

<sup>144</sup> ABA *Model Definition of the Practice of Law* (2003).

<sup>145</sup> *Id.*

<sup>146</sup> Denckla, *supra* note 136.

<sup>147</sup> *Id.* at 2594.

broad and creating too much economic protection for attorneys, to the detriment of the public.<sup>148</sup>

More broadly, others have critiqued the continued enforcement of state UPOL rules because there little evidence of harm to the public from unauthorized practice and because there is a high level of unmet legal needs across the country.<sup>149</sup> Like the dentistry case, actions taken not for public protection, but predominantly for business protection, are evaluated more closely than others. While there is broad acknowledgement in the sociology literature that one purpose of a profession is to protect members, in part economically, this goal is generally seen to be secondary to the primary goal of service.<sup>150</sup> For example, in 1975, in *Goldfarb v. Virginia State Bar*, the U.S. Supreme Court held that state bars are subject to antitrust laws.<sup>151</sup> The court recognized the motivations of the state bar to benefit its members through anticompetitive measures and removed state immunity from the organization when acting within these goals.<sup>152</sup> The case effectively curtailed many of the UPOL enforcement efforts by state bars across the country.<sup>153</sup> However, there has been a subsequent revitalization of UPOL enforcement, with focus in the fields of internet legal form providers, immigration services, multi-jurisdictional firms, and real estate.<sup>154</sup>

### C. North Carolina UPOL

North Carolina's practice of law statutes and regulations, like many state rules, exemplifies the lack of bright line guidance. North Carolina laws provide a circular definition whereby the "practice of law" is generally defined as "performing any legal services."<sup>155</sup> The statute delineates several examples of services that fall under this category, such as preparing documents, filing court petitions, and advising or giving legal opinions.<sup>156</sup>

<sup>148</sup> See, e.g., MODEL DEFINITION, *supra* note 139, at 4; RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 4(b).

<sup>149</sup> See, e.g., Denckla, *supra* note 136, at 2594 (noting that there is no guarantee that lawyers across the board will be any more or less competent than non-lawyers at assisting clients); Rhode & Ricca, *supra* note 136, at 2605 (noting the lack of evidence of public harm from UPOL and the fact that most complaints filed with enforcement agencies came from attorneys, not individual consumers).

<sup>150</sup> See, e.g., VOLLMER, *supra* note 87, at 51 ("a profession, 'says the ethical code of the American Medical Association,' has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration.").

<sup>151</sup> *Goldfarb v. VA. State Bar*, 421 U.S. 773 (1975).

<sup>152</sup> *Id.*

<sup>153</sup> Denckla, *supra* note 136.

<sup>154</sup> *Id.*; Rhode & Ricca, *supra* note 136.

<sup>155</sup> N.C. GEN. STAT. ANN. § 84-2.1.

<sup>156</sup> *Id.* § 84-2.1. The full practice of law definition is:

Performing any legal service for any other person, firm or corporation, with or without compensation, specifically including the preparation or aiding in the preparation of deeds, mortgages, wills, trust instruments, inventories, accounts or reports of guardians, trustees, administrators or executors, or preparing or aiding in the preparation of any petitions or orders in any probate or court proceeding; abstracting

The rules, however, do not constitute definitive, bright line rules. “It was not the purpose and intent of the statute to make unlawful all activities of lay persons which come within the general definition of practicing law.”<sup>157</sup> Individuals who are not members of the North Carolina State Bar, or who do not fall under limited exceptions, are prohibited from practicing law in the state.<sup>158</sup> Violations of this ban are subject to criminal sanctions and private causes of action.<sup>159</sup> The Authorized Practice Committee, a standing committee of the North Carolina State Bar has the authority to: investigate allegations of UPOL; issue cease and desist letters; refer matters to the district attorney for criminal proceedings; and issue advisory opinions on potential practice of law issues.<sup>160</sup> Recent injunctions won by this committee illustrate the range of allegations brought before the committee, from holding oneself out as providing legal services, preparing legal documents, and providing legal advice as the primary unauthorized activity.<sup>161</sup>

Several recent investigations of the North Carolina Unauthorized Practice Committee foreshadow the ripple effects of the *NC Board of Dentistry* decision that are likely to resonate beyond dentistry. For example, the protracted saga between LegalZoom, Inc. and the North Carolina State Bar highlighted similar tensions as those between the Board of Dentistry and teeth whiteners. LegalZoom is an online company that helps individuals create their own legal documents, such as wills, business contracts, and divorce agreements.<sup>162</sup> There has been ongoing controversy regarding whether LegalZoom and other similar companies are practicing law when facilitating document creation for individuals. For example, in 2003, the NC State Bar made a determination that LegalZoom was not engaged in the unauthorized practice of law; however, in 2008, the regulatory agency sent

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or passing upon titles, the preparation and filing of petitions for use in any court, including administrative tribunals and other judicial or quasi-judicial bodies, or assisting by advice, counsel, or otherwise in any legal work; and to advise or give opinion upon the legal rights of any person, firm or corporation. *Id.*

<sup>157</sup> *State v. Pledger*, 257 N.C. 634, 637 (1962) (explaining that even though the preparation of legal documents is the practice of law, there are situations, where preparation of a legal document by a non-lawyer would not constitute the unauthorized practice of law because the drafter has a “primary interest in the transaction”).

<sup>158</sup> N.C. GEN. STAT. ANN. § 84-4.

<sup>159</sup> *Id.* § 84-8 (stating that a violation of practice of law rules constitutes a Class 1 misdemeanor); *Id.* § 84-10.1 (providing individuals affected by unauthorized practice of law to bring a private cause of action for the recovery of damages and attorneys’ fees).

<sup>160</sup> *Id.* § 84-37; 27 N.C. Admin. Code 1D.0201; 27 N.C. Admin. Code 1D.0206(1), (4), (6), (7).

<sup>161</sup> See, e.g., N.C. STATE BAR, *Preventing Unlicensed Legal Practice of Law*, <http://www.ncbar.com/programs/upl.asp> (last visited Dec. 5, 2015); *The N.C. St. B. v. Lighthouse Title Agency, Inc.*, et al. 05 CVS 10637 (granting an injunction for, in part, the preparation of deeds is the practice of law); *The N.C. State Bar v. Kolodner, et al.* 05 CVS 09856 (finding that negotiating with creditors regarding debts that are subject to litigation constitutes the practice of law because it involves providing legal advice and drafting documents); *The N.C. State Bar v. Leapfrog Enter., et al.*, 03 CVS 9813 (holding that providing “document preparation services” constituted the practice of law).

<sup>162</sup> *Brief of LegalZoom.com, Inc., North Carolina Bd. of Dental Exam'rs v. F.T.C.*, 135 S.Ct. 1101 (U.S. 2015).

the company a cease and desist letter warning them of violation.<sup>163</sup> The debate about the allowable scope of services offered by LegalZoom continued until the two parties reached a settlement in October 2015.<sup>164</sup>

In 2013, the North Carolina State Senate introduced legislation that would broadly redefine the practice of law in the state.<sup>165</sup> Although the State Bar strongly felt that this version of amendment was too broad they acknowledged the improbability that LegalZoom would be enjoined from doing business in the state. Therefore, they worked to propose an alternative version acceptable to the bar that regulated, rather than banned, internet form providers like LegalZoom.<sup>166</sup> LegalZoom and the State Bar ultimately agreed upon draft language, but the 2013-2014 North Carolina General Assembly came to a close without introduction of the bill.<sup>167</sup>

Both LegalZoom and the North Carolina State Bar filed amicus briefs in *NC Board of Dentistry*. As the NC State Bar notes, they are similar to the Board of Dental Examiners in that they are established by the state to protect the public and are comprised of primarily of practicing professionals.<sup>168</sup> They argued that removing state sovereign immunity protections would undermine regulatory functioning by: diverting financial resources away from practice of law investigations to litigation regarding state oversight; increasing antitrust actions and defenses for state bars; dissuading lawyers from serving on state boards; and chilling enforcement action due to board members fears of personal liability.<sup>169</sup> In contrast, LegalZoom's brief argues that the public is being harmed by lack of access to affordable legal services due to the over-regulation of the market by biased private actors with an economic stake in the game.<sup>170</sup>

The *NC Board of Dentistry* decision reinvigorated efforts to amend North Carolina's unauthorized practice of law statute. In 2015, the North Carolina General Assembly again considered altering the definition—the bill is currently pending.<sup>171</sup> The proposed bill clarifies rules on providing preform legal documents to individuals.<sup>172</sup> Additionally, in response to the Supreme Court case, one version under consideration proposed state

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<sup>163</sup> *Id.* at 19–20.

<sup>164</sup> *See, e.g.*, LegalZoom.com, Inc. v. N.C. State Bar, 2014 WL 1213242 (N.C. Sup. Ct. 2014); *see also* LegalZoom.com, Inc. v. N.C. State Bar, 2012 WL 3678650 (N.C. Sup. Ct. 2012); *see also* LegalZoom.com, Inc. v. N.C. State Bar, 2015 WL 6441853 (N.C. Sup. Ct. 2015).

<sup>165</sup> Ronald G. Baker, *The Fun Comes to a Halt*, 19 N.C. STATE B.J. 5 (2014).

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> Brief of the N.C. State Bar, as Amici Curiae in Support of Petitioner at 2, N.C. State Bd. of Dental Exam'r v. F.T.C., 135 S.Ct. 1101 (2015) (noting that the State Bar Council has 61 lawyers, 4 lawyers as officers, and 3 public members. It is unclear from the brief whether the members of the public are non-practicing attorneys or non-attorneys); *see also* N.C. Gen. Stat. § 84-15 (noting that the state bar was established as "an agency of the State of North Carolina").

<sup>169</sup> Brief of the N.C. State Bar, *supra* note 168 at 3–4.

<sup>170</sup> Brief of LegalZoom.com, 135 S.Ct. at 6.

<sup>171</sup> Ronald L. Gibson, *An Update on Legislation and Litigation*, 20 N.C. STATE B.J. 5, 8 (2015).

<sup>172</sup> H.B. 436, §84-2.1(b)(2). Gen. Assemb. (N.C. 2015).

oversight when the State Bar issues cease and desist letters. Under this process, the State Bar would submit potential cease and desist demands to the Attorney General prior to sending them.<sup>173</sup> “The purpose of the review by the Attorney General is to ensure that the proposed demand to cease and desist or action is State action that is consistent with the authority of the Council and that would be entitled to State action immunity under the federal antitrust laws.”<sup>174</sup>

#### D. HCE Consultation and the Practice of Law

Stepping from practice rules to application: do the consultants who participate in HCE consultations ever ‘practice law’? Given the interdisciplinary and inter-professional nature of HCECs, questions of law naturally arise throughout the process, thereby potentially implicating practice of law issues for both attorney and non-attorney members of the committee alike. Law and medicine is inexorably intertwined, and often, these two intersect in the very instances when ethical dilemmas arise and an HCE consultation may be called. For example, legal issues of decisional capacity and proxy determination will naturally be an integral part of the discussion in an ethics consult concerned with the capacity of a critically ill patient without an advanced healthcare directive to consent to a procedure. Our society has often turned to the legal system to address difficult ethical problems in medicine, such as end-of-life decision-making and sufficient informed consent. This is why HCE consults are valuable, to remove such ethical decisions from the litigious realm;<sup>175</sup> however, this also means that some of the important precedence and guidance in this area is framed in law.

Issues of law in the hospital setting can range from the fairly straightforward—such as where a parent falls within the statutory list of proxy decision makers—to more nuanced areas—such as whether a physician can refuse a patient’s request for a treatment judged to be medically ineffective, a scenario often couched in “futility” language. Legal issues can also be brought into healthcare discussion by a variety of actors, from a physician, to a force outside an ethics consultation or a member of the ethics committee itself. Overall, there are a myriad of ways that one can envision law arising in a clinical setting,<sup>176</sup> but the mere mention of the law in and of itself does not automatically transition a person to the practice of law realm. This brings

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<sup>173</sup> H.B. 436, §84-37(a1). Gen. Assemb. (N.C. 2015).

<sup>174</sup> *Id.*

<sup>175</sup> See *supra* Part II.A.

<sup>176</sup> See, generally, Bethany Spielman, *Invoking the Law in Ethics Consultation*, 2 C.A.M.B. QUARTERLY OF HEALTHCARE ETHICS 457 (1993) (noting eight ways that the law arises in a consultation setting: to enrich ethical reasoning; to delineate duties; to debunk legal myths; to anticipate litigation behavior; to demonstrate the correctness of a proposed solution; to show which options may be easily implemented; to advocate for the patient; and to offer legal advice).

us back to when and how the fuzzy definitions of practice of law statutes should be applied in the healthcare setting.

Many legal activities included in practice of law definitions do not directly relate to the work of HCE consultants. Health care ethics consultants are unlikely to appear in court or draft legal documents.<sup>177</sup> They may, however, be in situations where they provide legal advice or fall into a catch-all definition of practice of law, such as the provision of ‘legal services’.<sup>178</sup>

Courts or state legislation use five common tests to assist in interpretations of the practice of law determinations: 1) the “affecting legal rights test”; 2) the “commonly understood” test—what tasks are commonly understood in the community to be the domain of attorneys; 3) the “relating law to specific facts” test—whether the task involves application of legal principles and statutes to fact specific situation; 4) the “client reliance” test—whether an individual believes they are receiving legal services; and 5) the “attorney-client relationship” test—whether the relationship formed during the task is similar to an attorney-client relationship.<sup>179</sup> The following subsections of this Article will explore how these tests, ranging from the broadest to the narrowest, may apply to HCE consultants. Although all members of HCECs may face potential claims of the practice of law, the implications will be different for attorney and non-attorney members of the team. Additionally, as noted below, some practice of law tests may apply differently for attorneys and non-attorneys.

### 1. *Affecting legal rights*

The affecting legal rights test is the most expansive test of the five commonly used.<sup>180</sup> Many ethics consultations will naturally affect legal rights, especially given that one of the initial motivations of HCECs was to avoid litigation of complicated medical-ethical issues. Indeed, consultation

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<sup>177</sup> These activities are generally not required as part of the ethics committee responsibilities. There may, of course, be members of the HCEC that do undertake these activities, such as a hospital counsel who appears in court or drafts contracts for the hospital. However, in these situations, the counsel would not be acting within the scope of the ethics committee. These activities are outside the general roles and responsibilities of HCE consultants to educate, assist with hospital policy, and participate in consultations. As part of consultations, consultants are often asked to place a note about the outcomes of the meetings in the patient’s medical records. This documentation helps to ensure that all members of the treating team understand that an ethics consultation was called and what the relevant points of discussion were that arose from the meetings. Although there are particular methods for this documentation, these are unlikely to rise to the level of the drafting of legal documents that are envisioned by state statutes because they do not legally bind patients the way that a contract, divorce decree, or business license application do.

<sup>178</sup> Spielman, *supra* note 176, at 465 (noting that giving legal advice is the most likely activity of a clinical ethics consultation that could overstep the bounds of the authorized practice of law).

<sup>179</sup> Roger C. Wolf, *The Gray Zone: Mediation and the Unauthorized Practice of Law*, 36 MD. B. J. 40, 41–42 (2003); David A. Hoffman & Natasha Affolder, *Mediation and Unauthorized Practice of Law: Do Mediators have a Well-Founded Fear of Prosecution?*, 6 DISP. RESOL. MAG. 20 (Winter, 2000).

<sup>180</sup> Hoffman, *supra* note 179, at 20.

could become “the forum of last resort” for decisions that go to the very heart of individual’s constitutional and statutory rights.<sup>181</sup> Thus, many activities of an HCE consultant are implicated under this extremely broad definition of the practice of law.

## 2. *Commonly understood*

Under the commonly understood test, it is the practice of law to engage in activities either: that are the customary practice of lawyers; or that the community commonly understands to be the purview of attorneys.<sup>182</sup> This tautological definition can be interpreted in two different ways. Hoffman and Affolder, writing in the ABA Dispute Resolution Magazine, construe this test in the context of mediation as, “the question of whether mediation is commonly understood to be a part of the practice of law in the community. Factors that would inform this determination might include, for example, the extent to which lawyers in a given community, as opposed to non-lawyers, routinely provide mediation services.”<sup>183</sup> Under this conception, ethics consultations would not be the practice of law, since physicians, chaplains, nurses, bioethicists, and other non-attorneys routinely provide the services in the field.<sup>184</sup>

However, this explanation is criticized as a misinterpretation of how courts originally envisioned the test.<sup>185</sup> Instead of looking at *who* commonly practices the field in question, the courts and commentators view the “commonly understood” test to explore whether it is the customary practice of attorneys to perform the *tasks* within the field.<sup>186</sup> In this case HCE consultants are open to allegations of the unauthorized practice of law. For example, in *State Bar Ass’n of Connecticut v. Connecticut Bank & Trust Co.*, the court examined whether defendants had engaged in the UPOL when they prepared tax returns and appeared before federal and state tax authorities regarding clients’ estates.<sup>187</sup> The court held that the defendants did not engage in the practice of law with these acts, but that if there had been evidence that the matters at issue “dealt with involved tax law problems of a type such that their solution would be ‘commonly understood to be the practice of law’” then the defendants would have been engaged in UPOL.<sup>188</sup>

<sup>181</sup> Wolf, *supra* note 179; Pope, *supra* note 37, at 430.

<sup>182</sup> *State Bar Ass’n of Conn. v. Conn. Bank & Trust Co.*, 140 A.2d 863 (1958); Paula M. Young, *A Connecticut Mediator in a Kangaroo Court: Successfully Communicating the Authorized Practice of Mediation Paradigm to Unauthorized Practice of Law Disciplinary Bodies*, 49 S. TEX. L. REV., 1073–74 (2007).

<sup>183</sup> Hoffman, *supra* note 179, at 20.

<sup>184</sup> See *supra* Part II.C.1.

<sup>185</sup> Young, *supra* note 182, at 1074–75.

<sup>186</sup> *Conn. Bank*, 140 A.2d 863; Young, *supra* note 182.

<sup>187</sup> *Conn. Bank*, 140 A.2d at 871.

<sup>188</sup> *Id.*

Although the court does not further elucidate what tax problems may rise to this level, the case illustrates an examination of the nature of the tasks rather than the type of person usually performing similar tasks. Thus, under the task specific interpretation of this test, consultants may be practicing law if they deal with complex issues that are commonly associated with law. Because ethics consultations can at times raise complex legal issues, consultants could, under the ‘commonly understood’ test cross the line into the practice of law if they engage in problem-solving surrounding these issues without referring problems to attorneys or recommending that the parties involved seek legal counsel.<sup>189</sup>

### 3. *Applying law to specific facts*

The application of law to specific facts test seeks to delineate the boundaries of legal advice. Simply providing legal information does not rise to the level of providing legal advice, but at some point along a continuum, it jumps into the realm of opinion and advice.<sup>190</sup> Providing information is acceptable for a layperson; providing legal advice is not. Commonly, the application of law to a specific set of facts or situations distinguishes legal information from legal advice. For example, predicting an outcome of potential litigation is often seen as legal advice because an individual is going beyond just having legal knowledge, but is opining and analyzing how a third party judge or jury will interpret the law.

The dichotomy commonly arises in the mediation context. In 2002, the ABA Section of Dispute Resolution issued guidance advocating that mediation is not the practice of law.<sup>191</sup> However, prior to this guidance, there was entrenched debate about whether non-attorney mediators were engaging in the UPOL. Additionally, North Carolina and Virginia guidance is at odds with the ABA guidance and these states view some mediation as potentially overstepping the bounds of practice of law.<sup>192</sup> For example, North Carolina guidelines specifically permit non-lawyer mediators to provide legal information, but not advice.<sup>193</sup> Virginia has similar rules for mediators, but provides further guidance regarding this distinction, using the application of law test to differentiate between the two. Under Virginia law, legal advice

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<sup>189</sup> *See id.*, where the court noted that the defendants provided legal information, but encouraged clients to seek legal advice from an attorney if the tax issues became too complex.

<sup>190</sup> *See, e.g.*, Spielman, *supra* note 132 at 212–13.

<sup>191</sup> ABA SECTION OF DISPUTE RESOLUTION, *Resolution on Mediation and the Unauthorized Practice of Law* (2002), [http://www.americanbar.org/content/dam/aba/migrated/2011\\_build/dispute\\_resolution/resolution2002.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/migrated/2011_build/dispute_resolution/resolution2002.authcheckdam.pdf).

<sup>192</sup> *Id.*

<sup>193</sup> Nolan-Haley, *supra* note 16 at 273; *see also* NORTH CAROLINA BAR ASSOCIATION DISPUTE RESOLUTION SECTION, *Guidelines for the Ethical Practice of Mediation and to Prevent the Unauthorized Practice of Law* (1999); NORTH CAROLINA SUPREME COURT FOR THE DISPUTE RESOLUTION COMMISSION, *Professional Conduct Standards for Mediators Standard 6* (1998) (establishing the rules of conduct for mediators in court ordered mediations).



involves the application of legal principles to facts “in a matter that (1) in effect predicts a specific resolution of a legal issues or (2) directs, counsels, urges, or recommends a course of action by a disputant or disputants as means of resolving a legal issue.”<sup>194</sup>

Providing legal information versus providing legal advice is often analogized to two strategies and styles used by mediators: facilitative mediation and evaluative mediation. In facilitative mediation, the mediator assists the parties in identifying issues and coming to resolutions, but does not give advice or opinions about the positions or arguments of the parties.<sup>195</sup> In evaluative mediation, on the other hand, mediators actively provide opinions about the situation and give advice and recommendations for the parties.<sup>196</sup> Thus, prior to the ABA guidance, several commentators argued that while facilitative mediation did not rise to the practice of law, due to the predictions and opinions made by evaluative mediators, evaluative mediation did.<sup>197</sup>

The bioethics field has also housed a debate regarding whether consultants should take a facilitative approach or an evaluative approach. These roles are defined similarly to the mediation context.<sup>198</sup> Currently, the ASBH advocates for a facilitative approach.<sup>199</sup> Although this does not preclude the consultant from making general recommendations, the ASBH cautions against making a single recommendation in order to avoid being seen as the moral authority.<sup>200</sup>

While distinctions between legal advice versus legal information and evaluative versus facilitative mediation are often presented as dichotomous distinctions, there is fluidity between the two. Mediators generally do not silo themselves into using one strategy or another, but instead switch between styles as needed for the dispute at hand. Similarly, it is nearly impossible to establish a clear definition of the distinction between legal advice and legal information. There are three main arguments that challenge

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<sup>194</sup> Nolan-Haley, *supra* note 16, at 272 (citing the Virginia guidelines on the unauthorized practice of law).

<sup>195</sup> Joshua R. Schwartz, *Laymen Cannot Lawyer, but Is Mediation the Practice of Law*, 20 CARDOZO L. REV. 1715, 1731 (1998).

<sup>196</sup> *Id.* at 1733–34.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.* at 1733 (defining evaluative mediation with reference to mediators giving advice, assessing arguments, and expressing personal opinions); *but see* DEPARTMENT OF DISPUTE RESOLUTION SERVICES OF THE SUPREME COURT OF VIRGINIA, *Virginia Guidelines on Mediation and the Unauthorized Practice of Law* (1999) (noting that it is difficult to precisely define evaluative mediation); *see also* CORE COMPETENCIES 2011, *supra* note 46, at 6–7, 9 (defining an “authoritarian approach” where the consultant is viewed as the “primary moral decision maker” who provides recommendations versus a “facilitation approach” where the consultant “helps the relevant decision makers fashion a plan that respects the needs and values of those involved and that is within the bounds of ethical and legal standards.” The relevant decision makers are generally the patient, family members, friends, or other surrogates, the healthcare team, and the institution.).

<sup>199</sup> CORE COMPETENCIES 2011, *supra* note 46, at 8.

<sup>200</sup> *Id.* at 8–9.

this distinction. First, applying law to facts cannot be enough alone to create the practice of law because this often occurs in a variety of fields.<sup>201</sup> Real estate agents, police, accountants, and government regulators must necessarily interpret and apply the law in order to complete their day-to-day work. How, after all, could a police officer decide to arrest an individual without some level of legal interpretation that the individual had violated a law? Recognizing this, some state UPOL statutes specifically exempt police and government workers.<sup>202</sup> There are many other professions not included in exceptions that consistently interact with legal interpretations, rules, and applications: accountants, real estate brokers, immigration services, and insurance agents.<sup>203</sup>

Second, in many ways, determining what legal information to provide is applying legal knowledge to specific facts. Therefore, providing relevant legal information may be impossible without falling into the application of law to facts. For example, merely identifying which laws or sections of a contract might be relevant to an inquiry has held to constitute legal advice.<sup>204</sup>

Third, the distinction between providing legal advice or information can rest on how a particular sentence is phrased. Hoffman and Affolder offer an example of five statements that a mediator could make ranging from evaluative to facilitative. The underlying substance remains the same throughout illustrating that the advice/information distinction could potentially make mediators overly focused on the phrasing of their dialogue without actually affecting the substance of their interactions with parties to the dispute.<sup>205</sup> In its guidance, the ABA acknowledges that this is one primary reason for clarifying that mediation is not the practice of law. “This Resolution seeks to avoid the problem of a mediator determining, in the midst of a discussion of relevant legal issues, which particular phrasings would constitute legal advice and which would not.”<sup>206</sup>

These difficulties of parsing out what is legal information and what is legal advice remain in the consultation context as well. As in the case of the ABA’s interpretation of mediation, HCE consultation should not be seen as the practice of law to avoid over emphasis on how consultants phrase their discussions. However, non-attorney consultants should also be wary of overstepping the bounds of legal advice through detailed analysis of how case law may apply to a specific consult or what the outcome of potential litigation may be.

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<sup>201</sup> John W. Cooley, *Shifting Paradigms: The Unauthorized Practice of Law or the Authorized Practice of ADR*, 55 DISP. RESOL. J. 72 (2000).

<sup>202</sup> Denckla, *supra* note 136, at 2587.

<sup>203</sup> Rhode & Ricca, *supra* note 136, at 2589.

<sup>204</sup> NC State Bar v. Lighthouse Title Agency, Inc., 05 CVS 10637 (holding that “by identifying certain sections of documents as responsive to a borrower’s questions” the individual was engaged in providing legal advice).

<sup>205</sup> See, e.g., Hoffman, *supra* note 179, at 3; see also Cooley, *supra* note 201, at 74.

<sup>206</sup> RESOLUTION ON MEDIATION, *supra* note 191.

#### 4. *Client reliance*

The client reliance test examines whether an individual believes that he or she is receiving legal services. The most likely individuals who could believe that they are receiving legal services would be the physician or other members of the healthcare team and the patient or family members of the patient.<sup>207</sup> Ethics consultations are most often called by physicians or other members of the healthcare team serving a patient; in some hospitals, patients and family members may not even be allowed to initiate an ethics consultation independently, but most go through the treating team for the request if they have concerns. In this way, the role of HCE consultants may be viewed as providing legal services for the healthcare team. Indeed, a survey of physicians in Maryland found that two thirds of those questioned felt that providing legal advice was an appropriate task for HCE consultants.<sup>208</sup> Although the survey did not examine whether physicians believed that they were being represented by ethics consultants, it suggests that physicians may expect a certain amount of legal analysis and opinion from ethics consultations. Thus, it is foreseeable that a court could find physician or other member of a healthcare team reliance on an ethics consultant as a provider of legal services. Similarly, a patient or family member could foreseeably rely on members of a consult team for legal advice. It is more likely that an individual may believe that they are receiving legal services if there is an attorney HCEC member participating in the consultation, although this does not necessarily have to be the case.

#### 5. *Creation of an attorney client relationship*

The attorney-client test holds that if the activity of an individual creates a relationship that looks like an attorney-client relationship, then that activity is the practice of law. Attorney client relationships can be formed either expressly or implicitly:

A relationship of client and lawyer arises when: (1) a person manifests to a lawyer that person's intent that the lawyer provide legal services for the person; and either a) the lawyer manifests to the person consent to do so; or (2) the lawyer fails

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<sup>207</sup> It may also be possible that the hospital administration would imagine that they are receiving legal services, although this is less likely because the hospital is represented by the hospital counsel and would therefore likely not expect other lawyers on the committee to also be representing them. Additionally, since the hospital would be seen as a sophisticated entity, courts may be less likely to find reliance. If the hospital counsel is on the ethics committee, then there could be complications of whether the individual is representing the hospital during their work on the ethics committee. *See supra* Part II.C.2.

<sup>208</sup> Diane E. Hoffman, *Does Legislating Hospital Ethics Committees Make a Difference-A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia*, 19 L. MED. & HEALTH CARE 105, 115 (1991).

to manifest lack of consent to do so, and the lawyer knows or reasonably should know that the person reasonably relies on the lawyer to provide the services.<sup>209</sup>

For example, an attorney-client relationship may be implicitly formed if an individual seeks legal advice from an attorney in an area where the attorney has professional competence and if the attorney agrees to or actually does provide such advice.<sup>210</sup>

Although explicit attorney-client relationships would not arise in ethics consultations, it is possible that the circumstances of a consultation would create an implicit attorney-client relationship. This implicit formation would follow similar results as the client reliance test because it similarly rests on the expectations of the individual and the actions of the attorney. As with the client reliance test, in the HCEC setting it is much more likely for this test to be met for attorney members of the consult team; although if an individual asks for legal advice and a non-attorney member provides such advice, a court may hold that activity looks sufficiently akin to an implicit attorney-client relationship that it would meet the POL threshold.

The most appropriate determination, however, is that HCE consultants have no clients at all and are more akin to third party neutrals—as in the case of mediators and other dispute resolution individuals. In mediation, the ABA recognizes the ability of certain attorneys—and also non-attorneys—to participate in a quasi-legal process without having a specific client.<sup>211</sup> Similarly, HCE consultants do not specifically represent any individual or group within the ethics situation at hand, but rather examine the issue from a neutral position.

#### 6. *POL implications for HCE consultants*

HCE consultants may be held as engaging in the practice of law under several of the five common legal tests, including affecting legal rights, relating law to specific facts, and client reliance. Some of these tests will be more likely to be met if the consultant is an attorney, but non-attorneys on the committee can also be found to be engaged in the practice of law. Consultants can work to avoid the unauthorized practice of law by limiting in-depth analysis and application of the facts of the consultation to case law and potential litigation outcomes. Additionally, consultants, especially attorneys, can make explicitly clear when interacting with individuals as part

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<sup>209</sup> RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 (2000).

<sup>210</sup> *Kurtenbach v. TeKippe*, 260 N.W.2d 53 (Iowa 1977).

<sup>211</sup> RESOLUTION ON MEDIATION, *supra* note 191, at 2 (noting that “essential to most of the common definitions of the practice of law is the existence of an attorney-client relationship. Because mediators do not establish an attorney-client relationship, they are not engaged in the practice of law when they provide mediation services.”).

of the consult that they are not providing legal services and that the parties may want to seek outside legal advice. Despite these precautions, given the breadth and ambiguity of many state UPOL rules, members of HCECs may find themselves at odds with state bars.

The potential implications of holding certain consultation activities as the practice of law are vast, although different for attorney and non-attorney members of the committee. If non-attorney members of the committee are engaging in the practice of law they may face civil and criminal penalties if they are investigated by the state bar. As an interim measure, state bars may issue cease and desist letters, just as the Board did in *North Carolina State Board of Dental Examiners v. FTC*. Although responding to cease and desist letters with changes in practice could avoid lengthy investigations and potential prosecutions, it may implicate the smooth functioning of the HCEC in the process.

POL issues have different implications for attorney members of the committee, with differing impacts depending upon whether the attorney is barred in the state in which he or she is serving on the HCEC. Attorney members barred in a different state than they are working in could still be found to be engaged in the UPOL and could face similar civil and criminal penalties as non-lawyers. Additionally, the UPOL could result in sanctions or the loss of licensure from the state in which they are barred.

Attorney members barred in the state in which they are performing HCE consults would not be found to be engaging in the *unauthorized* POL; however, engaging in the practice of law during ethics consultations, even if ‘authorized’ raises great potential concerns for attorney members. If ethics consultations are the practice of law, attorneys must determine who is their client and how to apply rules of professional responsibility, such as attorney-client privilege, confidentiality, and zealous representation—professional rules that may be at odds with the expectations and professional rules of the ethics committee itself. The recently adopted ASBH Code of Ethics acknowledges that individuals on an HCEC could hold duties from multiple professions; however, under their standards, the HCEC duties should hold paramount during consults. “In addition to their role as HCE consultants, some individuals are members of other professions and may be accountable to different codes of ethics. While engaging in ethics consultation, individuals should adhere to the “Code of Ethics and Professional Responsibilities for Health Care Ethics Consultants.”<sup>212</sup> The Code does not discuss in any further length the difficulties that might arise from cross-professionalism, as the rules from other professions often do not envision being trumped.<sup>213</sup>

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<sup>212</sup> AMERICAN SOCIETY FOR BIOETHICS AND HUMANITIES, CODE OF ETHICS, *supra* note 60.

<sup>213</sup> For example, the AMA Code of Medical Ethics has several opinions specific to health care ethics committees. Some mirror the guidance of ASBH, such as Opinion 9.11(1), which states that HCECs

Navigating competing professional norms may be quite difficult in practice. For example, the ASBH rules acknowledge that there may be times when a consultant can or should disclose confidential information, such as a potential obligation to share information with “healthcare leaders and staff members”,<sup>214</sup> the ABA Model Rules of Professional Responsibility state that attorneys must make “reasonable efforts” to prevent disclosure of client information.<sup>215</sup> These two standards do not create an automatic conflict, but one could foresee situations where a lawyer on an HCEC may simultaneously be called to disclose information to hospital staff under HCEC rules, but feel the need to prevent disclosure under ABA rules.<sup>216</sup>

Divergence between ethical norms could also arise when the attorney on the HCEC is the hospital counsel. For example, under the ABA Model Rules, it is an attorney’s professional duty to disclose information to a higher authority in the hospital if the counsel knows that an employee is violating the law in a way that “reasonably might be imputed to” the hospital.<sup>217</sup> Thus, if information gathered during an ethics consult reveals a potentially illegal course of action by an employee, the professional rules for attorneys may require disclosure, while the HCEC rules advocate against disclosure.<sup>218</sup>

Although conflicts between the codes are imaginable, on their face, the two ethical codes do not automatically invite conflict. This is, in large part, due to the very broad nature of the ASBH Code. The aspirational and expansive goals of the ASBH code, such as “be competent” and “contribute to the field” are hardly open to extensive disagreement.<sup>219</sup> However, if the ASBH code rises to the level of required standards, it will likely require adaptation for clarity, since it is currently unclear how one would follow the

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should be educational and advisory. Opinion 9.115(3) also mirrors the goals of ASBH’s Code to “be competent,” but goes into further detail. “Members should include either individuals with extensive formal training and experience in clinical ethics or individuals who have made a substantial commitment over several years to gain sufficient knowledge, skills, and understanding of the complexity of clinical ethics.” However, others may lead to conflict. For example, Opinion 9.11(3) states “the functions of the ethics committee should be confined exclusively to ethical matters. The Code of Medical Ethics of the AMA is recommended for the guidance of ethics committees in making their own recommendations.” Thus, both the AMA Code of Medical Ethics and the ASBH Code of Ethics explicitly hold that they are the primary guidance for ethics committees, thus leaving physicians on committees with no clear course of action if and when these rules conflict.

<sup>214</sup> ASBH CODE OF ETHICS, *supra* note 60, at § 4.

<sup>215</sup> MODEL RULES OF PROF’L CONDUCT, R.1.6(c) (2014).

<sup>216</sup> This, of course, depends upon whether the attorney views the patient or another party in an ethics consultation as a ‘client’ or how they consider the confidentiality rules to apply in situations where they view themselves as a third-party neutral.

<sup>217</sup> MODEL RULES OF PROF’L CONDUCT, R.1.13 (b) (2014).

<sup>218</sup> *Id.* Section 1.13 (b) holds that the lawyer does not need to inform an authority figure of the hospital of the potential breach if it is “not necessary in the best interest of the organization.” Because maintaining a functioning HCEC is likely in the best interest of a hospital, one may be able to reasonably argue that following the confidentiality norms of HCECs is a legitimate course of action. *See, e.g.,* McGuire et al., *supra* note 66. This would likely depend on the potential legal liability for the hospital given the situation.

<sup>219</sup> Molewijk et al., *supra* note 120, at 60 (“Yet this generous support may be due to the fact that the elements of the code are so general that it is almost impossible to disagree.”).

guidance in certain situations.<sup>220</sup> “Portions of a code that don’t actually prescribe concrete behaviors will need to be amended, or authoritatively interpreted, so that they do—or they’ll simply fall to disuse.”<sup>221</sup>

Similar questions of cross-professional duties arise in the context of lawyer-mediators.<sup>222</sup> Originally, the legal bar did not provide clear, specific guidance on how individuals in this dual role should balance the ethical duties of the legal and mediation professions.<sup>223</sup> This led to confusion and concern about ethically permissible ways to balance the potentially conflicting professional norms.<sup>224</sup> In 2005, three professional groups from across disciplines came together to establish cross-professional standards in the field of mediation. The latest version of the “Model Standards of Conduct for Mediators” (hereinafter Standards), was approved in 2005 by the American Arbitration Association, the ABA, and the Association for Conflict Resolution.<sup>225</sup> These Standards provide broad principles regarding competency, confidentiality, and other professional norms.

Despite being compiled by cross-professional organizations, the Standards say little about the intersection of professional norms. This conflict comes up in two ways. First, the standards acknowledge that other laws, professional rules, and agreements between mediating parties may trump the Standards.<sup>226</sup> Second, the Standards discuss the mixing of professional norms in this way: “The role of a mediator differs substantially from other professional roles. Mixing the role of a mediator and the role of another profession is problematic and thus, a mediator should distinguish between the roles.”<sup>227</sup> While this does not address in depth the myriad of conflicts between professional norms that could arise in the context of mediation it does suggest that, as long as a lawyer-mediator makes clear to participants that he or she is not providing legal counsel, he or she is in the

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<sup>220</sup> *Id.* (noting the abstract nature of the code); *see also* Tarzian et al., *supra* note 122, (noting that this version of the code is only a first draft and that the code will likely need to change in the future); Latham, *supra* note 120, at 55 (noting that “. . . ethics codes are always being amended and interpreted, and they are commonly amended and interpreted downward, from the aspirational heights to the practical, applicable depths.”).

<sup>221</sup> *Id.*

<sup>222</sup> *See generally*, Michael Moffitt, *Loyalty, Confidentiality and Attorney-Mediators: Professional Responsibility in Cross-Profession Practice*, 1 HARV. NEGOT. L. REV. 203 (1996); RESOLUTION ON MEDIATION, *supra* note 191, at 2 (“An important, but still partly unresolved question concerning the ethical rules applicable to lawyers is whether, and to what extent, the rules governing the conduct of lawyers apply to lawyers when they are serving as mediators and not engaged in the practice of law.” Further, “[i]f such rules were applied, in whole or in part, they would raise a host of imponderable issues for lawyer-mediators, including who is the client and how to discharge many of the traditional duties lawyers owe to clients.”).

<sup>223</sup> Moffitt, *supra* note 222, at 210.

<sup>224</sup> Maureen E. Laflin, *Preserving the Integrity of Mediation Through the Adoption of Ethical Rules for Lawyer-Mediators*, 14 NOTRE DAME J.L. ETHICS & PUB. POL’Y 479 (2000); Moffitt, *supra* note 222; Nolan-Haley, *supra* note 16.

<sup>225</sup> AM. ARBITRATION ASS’N, MODEL STANDARDS OF CONDUCT FOR MEDIATORS, *supra* note 135.

<sup>226</sup> *Id.* at Note on Construction.

<sup>227</sup> *Id.* at Standard VI. A. 5.

realm of mediation practice. The increasing cross dialogue about intersecting professional ethics rules for mediators and lawyers helps to provide guidance for those serving dual roles. For example, the ABA now runs a searchable database of ethics opinions regarding mediation that are linked to the Standards.<sup>228</sup>

The HCEC field has not yet reached this level of cross-professional guidance. The ASBH Code of Ethics says that its rules should trump any other professional code in the context of consults, but this places individuals in a difficult dilemma when the two codes come into conflict. It is difficult for an HCE consultant who is also an attorney to determine which code to adhere to since the legal codes do not generally clearly address non-adversarial settings, but the HCEC setting codes are non-binding.<sup>229</sup> It is unclear what the consequences of breaking the ASBH Code of Ethics—the code does not discuss the topic—but potentially a significant misstep could result in removal from the committee. However, an attorney who fails to comply with state rules of professional responsibility may be faced with a suspension or revocation of their license to practice law. Faced with such disparate potential penalties, an attorney may feel pressure to follow the norms of the legal profession over those of the HCEC, despite the explicit call from the ASBH for the opposite to occur.

Overall, practice of law issues raise important concerns for both attorney and non-attorney members of an HCEC alike. Non-attorney members face potential civil and criminal sanctions and attorney members face complicated professional responsibility questions—questions that could result in professional sanction if not properly adhered to. Guidance is clearly needed from professional organizations such as the ABA and ASBH, similar to the guidance provided in the mediation setting. Until that time, HCECs should consider what practices potentially implicate POL issues and create strategies for avoiding the UPOL. For example, if requesters of ethics consults seem primarily interested in legal analysis, the HCEC can set policies for referrals to other resources within the hospital system.<sup>230</sup>

#### V. OVERSEEING PROFESSIONS: ENSURING PUBLIC SAFETY OR ENSURING A MONOPOLY?

Although the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* case invites musings over the specter of

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<sup>228</sup> National Clearinghouse for Mediator Ethics Opinion [http://www.americanbar.org/directories/mediator\\_ethics\\_opinion.html](http://www.americanbar.org/directories/mediator_ethics_opinion.html).

<sup>229</sup> Moffitt, *supra* note 222, at 211 (noting that this was also the case in mediation).

<sup>230</sup> HESTER & SCHONFELD, *supra* note 21, at 35–36 (noting that “when requesters of ethics consultations are primarily interested in legal opinions and legal answers to their questions including whether they will be sued if they pursue a specific course of action, they should be referred to clinical risk managers or legal officers for advice.”).



unauthorized practice of law investigations in HCE consultations, the holding of the case has greater repercussions for the oversight of professions. The Supreme Court held that, in order to have state immunity from antitrust claims, trade regulators, such as professional boards must be actively supervised by the state or not be comprised of active market participants.

The ruling may chill investigations into unauthorized practice of professions; at least for the time being. Professional fields across many, if not all, states currently utilize active market participants as regulators. For example, all fifty states have boards of dentistry, medicine, veterinarians, and lawyers,<sup>231</sup> and some regulate practice in areas only recently characterized as professions, such as cosmetology and interior design, that are not as clearly linked to public safety.<sup>232</sup> A myriad of groups, including those from nursing, law, veterinary science, and psychiatry, filed amici curiae briefs in the case, showing the broad reaching scope of this case. In effect, the case imposes significant challenges for regulatory boards, not actively supervised by the state, to police the unauthorized practice of the profession without threat of an antitrust claim. Each profession and regulatory body may respond to the ruling variably. Some may shy away from any actions that would appear to be anticompetitive. Others may choose to rearrange the decision-making to be actively supervised by the state in order to maintain immunity—just as North Carolina’s strategy in proposed legislation.<sup>233</sup>

The legal profession, regulated through state bars, is one of the primary fields that will have to struggle with the consequences of the case. State bars are well known for their investigations into UPOL violations and have often been criticized for undertaking these investigations for economic gain rather than to protect public well-being—the same situation as the NC Board of Dental Examiners faced.<sup>234</sup> Given the vested interest that many state bars had in the case, it is likely that they are now reevaluating their UPOL investigations and state oversight in order to avoid antitrust investigations.

For HCEC members, this means that it is less likely that a state bar will launch an investigation into their practices. One could argue that these types of investigations were unlikely before as well given that ethics consultants are hardly taking an economic market away from other practicing attorneys in the state, although investigations could still be brought under concerns for the public. After all, the closer the activity of concern moves towards threatening the health or well-being of the public, the less likely it may be to raise alarm bells of market control.

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<sup>231</sup> Brief for Am. Dental Ass'n et al. as Amici Curiae Supporting Petitioner, at 5, *North Carolina Bd. of Dental Exam'rs v. F.T.C.*, 135 S.Ct. 1101 (2013) (No. 13-534).

<sup>232</sup> Brief of LegalZoom.com, Inc., *North Carolina Bd. of Dental Exam'rs v. F.T.C.*, 135 S.Ct. 1101 (U.S. 2015).

<sup>233</sup> *See supra* Part IV.C.

<sup>234</sup> *See supra* Part I.

The decreased likelihood of an UPOL investigation, however, does not diminish the importance of this issue for HCECs and their members. Although state bar initiated investigations may be tinged with economic motivations, the underlying rationale for UPOL statutes remains: Individuals who are providing legal services should be competent to do so or the public may be harmed. Given that the very first principle in the ASBH Code of Ethics is to be competent, HCEC members should seriously consider bounds of the practice of law and reflect on the implications for competency—even without the active threat of investigation by the state bar.

## VI. CONCLUSION

A finding that health care ethics consultations can implicate practice of law issues may be a startling conclusion for members of HCECs and hospitals that rely on the ethics support of the committees alike. However, this article does not raise this issue in order to paralyze the system. Overall ethics consultations provide important and essential services to hospitals across the country. However, given the increasing professionalization of the field and the interdisciplinary nature of HCECs, it is clear that further guidance is needed for consultants regarding professional boundaries. This juncture presents an opportunity for professional societies in both fields to provide guidance, just as was done in the field of mediation. Such guidance will allow ethics consultants to competently perform services without the potential threat of sanction.