Special Section:
Issues in Organization Ethics and Healthcare

Organizational Ethics Programs and the Law

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Max Weber, the grandfather of organizational theory, recognized the close association between health care organizations and law.[1] When he introduced the concept of a legal–rational bureaucracy, he used hospitals and clinics to illustrate it. Today, there is little doubt that healthcare organizations are "law-saturated," if not always fully compliant with the law. Like Weber's legal–rational bureaucracies, healthcare organizations have highly formalized rules and procedures. They pay a great deal of attention to legal criteria in decisionmaking, and some have entire departments devoted to legal risk management.

The legalization process has advantages and disadvantages for organizations.[2] Legalization can play a fundamental role in controlling discretion and minimizing arbitrariness in decisionmaking, in securing fairness and equal treatment, in protecting entitlements and rights, and in specifying responsibilities. Legalized approaches foster deliberation and careful weighing of evidence. They can help legitimatize power. In addition, by helping to create the frameworks used to facilitate common understandings they can support collaborative activity in a pluralistic society. Legalization can, however, be overplayed. It can become dysfunctional, for example, when formal legal procedures are maintained at the expense of the ends the legal procedures were designed to serve, or when moral reasoning is reduced to mere rule following.

This article begins with the assumption that the environments of healthcare organizations are highly and inescapably legalized, and that legalization has the potential for both positive and negative influence on healthcare organizational ethics programs (OEPs). Looking back briefly on the experience of healthcare ethics committees (HECs), it will analyze both their internal and their external legal environments. Having characterized the likely external legal environment for OEPs as more constraining than that of HECs, it illustrates by means of a case study several ways that administrators involved with OEPS may think about organizational ethics and law: legalism, efficient compliance, ethical thinking within a compliance framework, and efficient breach. Finally, it describes an approach that healthcare workers conspicuously failed to take in this case, and suggests why it would have been difficult to take in a highly regulated environment. The approaches described will shape the internal culture of OEPs, and familiarity with them should help OEP participants begin to develop more well-thought-out approaches to law.

HECS: Legalism Despite a Relaxed External Legal Environment

A look back at the history of HECs and law provides a useful perspective from which to think about OEPs and law. That history can be analyzed in terms of

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HECs' internal and external legal environments. The internal environment of HECs can be understood as the weight and interpretation given to law by those on the committee, while the external environment is the law on the books relevant to HECs and its enforcement by legal institutions—the regulatory environment. The internal environment of HECs has frequently been described as far too legalistic. Legal scholars as well as ethicists, including George Annas, Kenneth DeVille, Marshall Kapp, Robert Weir, Tom Murray, Daniel Callahan, and John Golenski, have made this complaint.[3]

The problem of legalism has seemed serious enough that a unique approach to ethical decisionmaking has been developed to counteract it. HECS have been urged by the Berkeley Bioethics Consultation Group and others to deliberate and make tentative decisions without any information about the law. Only after the "ethically best" course of action has been chosen in isolation from knowledge about law are members encouraged to seek legally relevant information.[4] The reason for controlling the flow of information in this way is to protect moral reasoning from collapsing into legalism. This "legal blinders" approach might be thought of as a kind of epistemological paternalism to which members of the committee agree to subject themselves in order to avoid contaminating their ethical judgment.[5]

The tendency toward legalism within HECs has developed despite a fairly relaxed external legal climate. Judicial deference to HECs was evident as early as the 1976 Karen Ann Quinlan decision,[6] which immunized physicians' withdrawal of ventilator support for Ms. Quinlan if her family and physicians consulted with an ethics committee and the committee agreed with the decision. Today, so high a degree of legislative deference to HECs is evident in some states' immunity and privilege statutes that one scholar has argued HECs' legal function in those jurisdictions is being transformed from that of an adjunct to the judiciary into that of the forum of last resort.[7]

HECs have dealt primarily with issues that had previously been left to physicians. When HECs were begun, they were expected to be less intrusive on physicians' authority and on physician–patient relationships and physician–family relationships than courts would be. HECs were expected to be an aid to physician decisionmaking, in part because they could substitute for legal decisionmaking. Prosecutors did not strictly enforce homicide laws against physicians who withdrew life support.[8] Judges wanted to make the lives of physicians easier by getting the law out of their lives.[9] There was plenty of room for deference to extralegal decisionmakers, such as physicians and, derivatively, HECs.

A second reason for legal deference toward HECs was that their bread and butter issue was one that was usually located at the private end of the public–private spectrum: forgoing life support. Following the Supreme Court's 1990 *Cruzan* decision, which was widely understood as having the effect of diminishing family authority for medical decisionmaking, many states enacted statutes designed to help restore family authority and shift such decisionmaking back to the private end of the spectrum.[10] For example, although a process for end-of-life decisionmaking for incapacitated patients without advance directives was established by the state legislature in Illinois, it was called a "private decision making process."[11] The Supreme Court of Indiana, commenting on a similar law in that state, noted that it did not view the existence of its Health Care Consent Act as having transformed life and death decisionmaking from a private to a public issue.[12]

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In contrast to the medicalized and privatized issues that HECS have dealt with, OEPs will be dealing with issues that, by definition, involve others than physicians and families—often several healthcare organizations and numerous providers that have multiple, complex relationships with each other. Issues such as admissions, discharges, transfers, referrals, and marketing and billing practices cannot be viewed either as strictly medical issues or as private issues; law, which represents public values, addresses each of them.[13] In fact, the list of organizational ethics issues developed by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) overlaps with the list of issues the Office of the Inspector General (OIG) considers significant enough public problems to audit for purposes of prosecuting fraud and abuse.[14] So, while the *Quinlan* court thought HECs would make good substitutes for legal decisionmakers, it is highly unlikely that the OIG would suggest anything of the kind. The OIG has recommended OEPs, not as a substitute for legal compliance, but as a way to shore it up or demonstrate that noncompliance is being corrected.[15]

Organizational Ethics Programs: A More Constraining External Legal Environment

As a result of the fact that the pedigree and work of OEPs are a mix of law and ethics, the issue of possible deference to the judgment of OEPs will be close only in a handful of jurisdictions: those few whose judiciaries must begin with a presumption of deference to hospital policy, and a few more that may include OEPs under immunity and privilege statues from which HECs benefit. Even there, deference may be a realistic possibility on only a very narrow range of issues.

The presumption of judicial deference to hospital policy is derivative of the presumption of deference to hospital medical staff decisions, which is thought to be good policy in some states largely because of the highly specialized and technical nature of medical decisionmaking. The limits of such judicial deference, however, are evident even in a familiar "medical ethics case": the 1986 Beverly Requena case.

> Beverly Requena was a competent, 55-year-old woman with amyotrophic lateral sclerosis (ALS). In April of 1985 she entered St. Clare's Riverside Medical Center in New Jersey. She communicated to the hospital that when she lost the ability to swallow she would refuse to accept feeding by a nasogastric tube or other device. Her family and physicians accepted her decision. The hospital, however, gave notice of its policy against withholding artificial feeding or fluids in July of 1986. The hospital wanted to transfer Mrs. Requena to another hospital seventeen miles away, which had comparable facilities for her care, and which would acquiesce in her refusal of artificial nutrition and hydration. But Mrs. Requena did not want to leave St. Clare's, which had become familiar to her. So the hospital brought an action to compel Mrs. Requena to leave the hospital.

The *Requena* court's approach to the case can help us see that even if courts begin with the assumption of deference to hospital policy, organizational decisionmaking will receive deference only if other conditions are met. The court acknowledged that subversion of hospital policy by the judiciary is a serious

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action. It noted that (in New Jersey),[16] "judges are generally expected to defer to the policy decisions of hospital managers and governing bodies."[17] But since Mrs. Requena's legal right to refuse treatment conflicted with hospital policy, the court could not simply defer to the hospital. Instead, the court attempted to balance the rights of the hospital and those of Mrs. Requena. In doing so, the court noted that the hospital had not consulted with treating physicians. This lack of appropriate medical input into a medical matter was compounded by a lack of organizational attention to procedural issues, such as involving medical staff in developing its general ethical rules. The lack of proper procedure was highlighted again as the court noted that the hospital had not given adequate notice of its policy to Mrs. Requena. For these reasons, the hospital did not prevail. Thus, even where there is a judicial presumption of deference to hospital policy, if insufficient weight has been given to legal concerns that reflect public values, such as process and patient rights, the judiciary may conclude that deference is unwarranted.

Further, in those jurisdictions where HECS benefit from immunity and privilege statutes, OEPs ought not assume that deference will be extended to them. In Maryland the language of one such statute gives immunity only to committees that advise about medical options for patients with life-threatening conditions. In Montana immunity is given only to "medical ethics reviews."[18] Only in Hawaii is it reasonable to believe that the immunity already granted HECs by statute might extend to OEPs. There, immunity is given to "ethics committees," which are defined broadly enough to include those involved in some selected OEP activities.[19] Thus, in the majority of cases, OEPs will carry on their work in a far more constraining external legal environment than HECs have done; they will experience the regulatory intensity of the healthcare environment more directly.

Administrative Approaches to Law

Given the low likelihood that healthcare OEPs can escape a constraining external legal environment, participants should think carefully about the relationship of their work to law. They should understand a variety of approaches that administrators and healthcare workers may take toward the law: legalism (sometimes informed by an efficient compliance view of the law), ethical thinking within a compliance framework, and efficient breach. They should not expect to encounter frequently the epistemic paternalism that some healthcare ethics committees have adopted. I will illustrate these approaches using a case study: Ravenswood Hospital and the death of Christopher Sercye.

> Christopher Sercye, a fifteen-year-old Chicago boy, suffered gunshot wounds in May 1998 while playing basketball with his friends in an alley behind Ravenswood Hospital. His friends tried to get him into the hospital but they were unable to transport him the last 35 feet. They sought help from the police, who were, coincidentally, at the hospital. The officers radioed for an ambulance, which would have taken the boy to a trauma center. When the ambulance didn't arrive in six minutes, emergency room personnel called 911. They also prepared for the boy's admission, though the emergency room was filled to capacity at the time and the hospital was not a trauma center. Emergency room personnel did not bring the boy inside or assist him while

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> he was on the street. After a few more minutes had elapsed, police officers grabbed a wheelchair and transported Sercye into the emergency room. Shortly thereafter, Sercye went into cardiac arrest and died. When asked why they did not help the boy earlier, emergency room personnel cited hospital policy, which forbade them to leave the building.[20]

This case involved three kinds of law, broadly understood. The first was the federal Emergency Medical Treatment and Active Labor Act (EMTALA), developed to protect patients in need of emergency care. EMTALA requires a hospital to screen any individual who comes to an emergency department seeking medical care and determine whether the person has an emergency medical condition. If the individual has an emergency medical condition, the hospital must either stabilize the medical condition or transfer the person to another medical facility in accordance with the law's transfer requirements.[21] The second "law" was Ravenswood Hospital's no-leaving-the-premises policy. Though developed by the hospital, it reflects tort law, which encourages minimizing the risk of injury to employees and to patients already in the emergency room.[22] The third law was Illinois' Emergency Medical Services (EMS) Systems Act, intended to coordinate and integrate emergency medical services within the state.[23] This act prohibits transferring patients from an emergency room to a trauma unit. Instead of such transfers, protocol requires emergency room staff to call 911 and request transport to a trauma center. The following section will focus on administrative approaches to the first law, EMTALA, as evidenced by the development of Ravenswood's no-leaving-the-premises policy.

Legalism and Efficient Compliance

Under EMTALA, a hospital must screen any individual who comes to the emergency department seeking medical care and determine whether the person has an emergency medical condition.[24] The language of the act does not specify when a person has "come to" an emergency department, and there is no clear consensus among circuit courts about what it means to do so. On one hand, the Seventh Circuit Court of Appeals had determined in another Chicago case that an infant in full cardiac arrest had *not* "come to" an emergency department even though paramedics had contacted the telemetry system operator located at the hospital and the infant was in fact only five blocks from the hospital.[25] On the other hand, a rarely cited federal regulation states that being on hospital property *is* equivalent to "coming to" an emergency department.[26]

Ravenswood Hospital's policy prohibiting emergency personnel from leaving the premises was consistent with a narrow interpretation of the Emergency Medical Treatment and Active Labor Act (EMTALA), but not with a more expansive interpretation. Legalism, the view that ethics can be reduced to rule-following or "technical compliance," may therefore have been at work among those who developed the no-leaving-the-premises policy.

Ravenswood's approach to EMTALA might be attributed to mere oversight, were it not for the fact that the problem of "doorstep patients," such as Sercye, was foreseeable. Within the last few years, national attention had been drawn to similar deaths in the vicinity of hospitals in New York City and Florida[27] after which emergency room staff cited the same kind of policy as their reason for refusing to give medical help. Ravenswood had no policy provision to

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address situations that might demand more than a minimalist interpretation of EMTALA's requirement to care for those who "came to" their emergency room. Its approach was consistent with the view, defended by some, that the moral obligations of organizations are restricted to those already clearly contained in the law.[28]

Law-and-economics jurisprudence might characterize Ravenswood's approach to EMTALA as "efficient compliance." On such a view, a hospital should invest only as much in EMTALA compliance efforts as it calculates is efficient, i.e., perhaps enough not to be viewed as clearly noncompliant. After all, only if a hospital's violation of EMTALA is "gross and flagrant" may HCFA exclude it from participation in Medicare. And federal enforcement of EMTALA has been lax (although it has been stepped up in recent years).

Other hospitals' policies have gone further to address the problem of "doorstep patients" than Ravenswood's did. For example, the University of Wisconsin Hospital's policy was to dispatch a "blue cart" emergency team to deal with any seriously injured person outside hospital doors while simultaneously summoning emergency transport.[29] Ravenswood administration might have made the judgment that the resources necessary to ensure that such patients were cared for (extra supplies, greater liability insurance costs) could more efficiently be used elsewhere in the organization, given the low risk of penalties for violating EMTALA.

Ethical Thinking within a Compliance Framework

In the face of Ravenswood's minimal compliance with EMTALA, the Health Care Financing Administration (HCFA) threatened to exclude Ravenswood Hospital from participation in Medicare based on a failure to promptly screen and the failure to treat a patient, unless (as reported in the *Chicago Tribune*, 20 June 1998) Ravenswood provided "credible evidence that its policy had been restructured." The approach that Ravenswood then developed might be called "ethical thinking within a compliance framework." The organization had to engage in ethical deliberation to resolve a number of issues while developing the new policy. The new policy was summarized by the president and CEO of Ravenswood as follows: "If someone on or near the hospital campus is believed to need immediate medical assistance, our employees must call a special internal telephone number to report it. The call provides immediate access to an ER nurse and physician, who determine how best to treat the person. If personnel leave the ER, medical professionals from other parts of the hospital fill in."[30]

That policy was, of course, another set of rules, which conceivably could be applied in as wooden a way as the no-leaving-the premises policy. But as March and Olsen have noted,

> To say that behavior is governed by rules is not to say that it is either trivial or unreasoned. Rule-bound behavior is, or can be, carefully considered. Rules can reflect subtle lessons of cumulative experience, and the process by which appropriate rules are determined and applied is a process involving high levels of human intelligence, discourse, and deliberation . . . the number and variety of alternative rules assure that one of the primary factors affecting behavior is the process by which some of those rules, rather than others, are evoked in particular situation.[31]

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In consultation with HCFA and the Illinois Department of Public Health, Ravenswood had to determine the geographic extent of its duty to aid those outside the hospital. (Lest one underestimate the moral importance of drawing fine lines in the geography of healthcare organizations, consider the role this activity plays in mergers between Roman Catholic and secular healthcare organizations when the location for reproductive services must be determined.[32]) Administrators also had to find the best way to fulfill this "new" duty without shirking other responsibilities, such as ensuring staff safety, and without adding unreasonably to the costs of equipment and supplies, personnel, and insurance. It also had to allocate personnel and other resources so as not to jeopardize the welfare of patients already in the emergency department.

Efficient Breach

The approaches described thus far assume at least some level of compliance with EMTALA. The remaining approaches—efficient breach and epistemic paternalism—do not. Unlike Ravenswood, numerous other hospitals have virtually ignored EMTALA's requirements, perhaps practicing what the law-and-economics school calls "efficient breach." As one scholar explains, "Under this penalty-driven approach to law, what is of paramount importance about law are the penalties, either because the penalties form the basis for determining whether to obey the law or not (efficient breach), or because they form the basis for determining the law's importance and how much money a corporation would spend on compliance efforts (efficient compliance)."[33]

More than 90% of hospitals with confirmed EMTALA violations escape punishment completely; they pay no fines and are not excluded from participation in Medicare.[34] Having noticed that federal enforcement of EMTALA was episodic and variable,[35] many hospitals decided that investing in any level of EMTALA compliance would be an inefficient use of resources.

Epistemic Paternalism

Ravenswood was clearly a legalized organization. One can only speculate what might have happened if the suggestion were made that administrators "not talk" about what the Health Care Financing Administration would require after the incident was publicized, what EMTALA regulations and jurisprudence required, what the state Emergency Medical Services Act required, or what the implications for hospital liability would be if emergency personnel were in the future expected to leave the hospital building in order to help individuals in the vicinity. At best, such an approach might have been viewed as not very good ethics (ethics being "an attempt to answer the question: what, *all things considered,* ought to be done in a given situation?" [emphasis added][36]) At worst, this approach might have been viewed as hopelessly decontextualized.

The Approach to Law That Health Care Workers Failed to Take

Administrators and those who participate in hospital policymaking are not the only ones whose approach to law matters. When Christopher Sercye was shot, it was healthcare workers who had the last chance to intervene. If OEPs are to

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be effective, therefore, those involved in developing and implementing them need to have realistic assumptions about what healthcare workers' responses to law will be.

Perhaps Ravenswood's emergency room staff believed that hospital policy and EMS law would be enforced, while EMTALA would not be. That explanation would account for much of their behavior. But healthcare workers rarely have a clear understanding of the sources of constraints on their work.[37] As Sandra Johnson has observed, "individual health care professionals often do not distinguish among government regulations, private accreditation standards, risk management policies, payment/reimbursement decisions, or internal corporate rules and policies when they speak of 'regulation' that restricts their practice."[38] Whether the no-leaving-the-premises policy emanated from hospital administration or the federal government was probably not an important factor in the emergency room staff's decisions about whether to bring Sercye inside. What factors may have been more relevant?

An industry publication noted, "If it had been an episode of ER, you can be sure George Clooney would have raced into the street to save the life of the injured teenage boy."[39] In the aftermath of Christopher Sercye's death, healthcare providers in some other communities—perhaps with perfect 20–20 hindsight—said that is precisely what they, too, would have done. The medical director of an emergency and trauma center in Ohio, for example, stated "Healthcare professionals should not watch people within their own sight die. You break some rules to save a life and worry about the consequences later. In this particular case [the Ravenswood staff] may not have used common sense."[40]

On this view, Ravenswood's emergency room staff were really just "bad Samaritans"—those who fail to do for a stranger something that they could have done at little or no risk, cost, or inconvenience to themselves, the omission of which results in harm.[41] Seemingly, an emergency room worker could have pulled the boy into the emergency room with minimal risk or inconvenience. Further, emergency room workers shouldn't even have thought of this as a stranger to stranger relationship; they were, after all, not just professional helpers but professional rescuers. Or perhaps the emergency room workers were "social loafers"—shirkers who put forth less effort in a group situation than in a situation of individual accountability. Indeed, psychological research suggests that at each step in the process of intervening in a crisis—noticing the emergency, interpreting the situation as an emergency, deciding to intervene, and accepting responsibility for acting—an individual's response can be inhibited by the presence of others.[42]

But what accounts for the fact that the emergency room workers did prepare a bed for Sercye and did call 911 while they would not bring him into the emergency room? What accounts for the similarity in behavior and excuses of emergency room personnel at other hospitals? Perhaps what the Ravenswood staff said should be taken more seriously: they did not offer more help to Christopher Sercye earlier because hospital policy prohibited them from leaving the Ravenswood emergency room. Research suggests that when individuals believe there is no legal duty to aid, they are less likely to define a failure to intervene as immoral.[43] When they believe there is a legal duty to aid, they are more likely to define a failure to intervene as immoral. Ravenswood emergency room workers believed there was a legal duty to stay in the emergency room, a duty reflected in hospital policy.

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They could have disobeyed the policy in order to do more for Sercye earlier. Refusing to comply with hospital policy would imply that requirements of policy and law are binding only insofar as they do not conflict with other, more important values. An individual fully committed to such an approach would have been motivated by moral views about the wrongfulness of following the no-leaving-the-premises policy and the rightness of bringing Sercye inside. He or she would have been aware of the policy (perhaps unlike the epistemic paternalist) and would have openly violated it, fully expecting to be sanctioned by the hospital. Such an approach (unlike an efficient breach approach), could have as its ultimate goal the modification of hospital policy to more fully meet moral norms of lifesaving that were only imperfectly specified in EMTALA.[44] But a highly legalistic environment changes the way people view relationships, responsibilities, and risks. In a law-saturated environment, the constraints on the exercise of individual discretion are quite dense. A decision to use unauthorized discretion and openly disobey policy is not easily made in such an environment. The process may have seemed to Ravenswood ER workers, during the minutes Christopher Sercye lay outside, less like making a clear-cut choice between right and wrong than like finding one's way out of the bramble bush of law, to use Karl Llewellyn's metaphor.[45]

Max Weber was ambivalent about the extent to which bureaucratic structures support voluntaristic behavior. A Weber scholar particularly attuned to the regulatory intensity of healthcare environments describes the problem: "Order is received, not enacted; the actor is passive, not critical."[46] That may explain much of what is important to understand about the behavior of emergency room staff in the Sercye case.

Conclusions

Given the highly legalized environments of healthcare organizations and the constraining external legal environment OEPs will probably face, participants in effective OEPs will need to move beyond an unreflective legalism or rejection of legalism, or automatic translation of epistemic paternalism from the HEC context to OEPS. As they begin to negotiate the gray areas between their work and the law they may well find themselves moving beyond the "compliance versus ethics" or "spirit versus letter" dichotomies often invoked in discussions of organizational ethics. The analysis above is not intended to suggest that organizational ethics can be reduced to law. There is indeed a place "where the law ends."[47] But this analysis should provide a rough taxonomy of approaches to law that OEPS will, inevitably, encounter and should be prepared to critically evaluate.

Notes

1. Weber M. *The Theory of Social and Economic Organization.* New York: The Free Press, 1947.
2. See generally Sitkin SB, Bies RJ. *The Legalistic Organization.* Thousand Oaks, CA: Sage Publications, 1994.
3. Annas GJ. The dominance of American law (and market values) over American bioethics. In: Grodin MA, ed. *Meta Medical Ethics, The Philosophical Foundations of Bioethics.* Dordrecht: Kluwer 1995:83–96; Annas GJ. Ethics committees: from ethical comfort to ethical cover. *Hastings Center Report* 1991;21(3):18–21; Weir RF. Pediatric ethics committees: ethical advisers or legal watchdogs? *Law, Medicine & Health Care* 1987;15(3): 99–109; Kapp MB. *Our Hands are Tied: Legal*

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Tensions and Medical Ethics. Westport, Conn.: Auburn House, 1998; Murray T. Where are the ethics in ethics committees? *Hastings Center Report* 1988;18(2):12–3; Callahan D. Escaping from legalism: is it possible? *Hastings Center Report* 1996;26(6):34–5; Golenski J. *Forming a Moral Community: A Resource for Healthcare Ethics Committees.* Berkeley, Calif.: Bioethics Consultation Group, 1992.

4. See note 3, Golenski 1992; DeVille K., What does the law say? Law, ethics and medical decision making. *Western Journal of Medicine* 1994;160 (5):478–80.
5. See Goldman AI. Epistemic paternalism: communication control in law and society. *Journal of Philosophy* 1991;88:113.
6. In re Quinlan, 355 A.2d 647, 688 cert denied, 429 U.S. 922 (1976), medical ethics committees were viewed as a mechanism "to review the individual circumstances of ethical dilemma[s] and provide assistance and safeguards for patients and their medical caretakers."
7. Wilson RF. Hospital ethics committees as the forum of last resort: an idea whose time has not come. *North Carolina Law Review* 1998;76:353
8. Dworkin RB. *Limits: The Role of the Law in Bioethical Decision Making.* Bloomington, Ind.: University of Indiana Press, 1996.
9. Annas G. Facilitating choice: judging the physicians' role in abortion and suicide. *Quinnipiac Health Law Journal* 1996;1:93
10. Johnson S. The changing nature of the bioethics movement. University of Maryland Law Review 1994;53:1051,1058–9.
11. 755 ILCS 40/20 (1996).
12. "Indiana Code § 16-8-12-4 merely recognizes the traditional and very private role which American families play in health care decisions. The existence of the statute does not convert family decisions into state action within the meaning of the fourteenth amendment to the U.S. Constitution." In the Matter of Sue Ann Lawrence, 579 N.E. 2d 32 (l991), the bioethics literature supported a privatized view. Fleetwood and Unger, for example, stated that "immunity provisions for health care professionals who follow advice from ethics committees support the public's interest in keeping personal, private decisions out of courts." Fleetwood J, Unger SS. Institutional ethics committee and the shield of liability. *Annals of Internal Medicine* 1994;120: 321. Some scholars advocate an even greater role for family and a lesser role for the individual and for the state in healthcare decisionmaking. See Boozang KM. An intimate passing: restoring the role of the family and religion in dying. *University of Pittsburgh Law Review* 1997;58:549–616; Hardwig J. What about the family? *Hastings Center Report* 1990; 20(2):5–10, 5, 6. See also Weintraub J, Kumar K, eds. *Public and Private in Thought and Practice: Perspectives on a Grand Dichotomy.* Chicago: University of Chicago Press, 1997.
13. These are some of the issues suggested as organizational ethics issues by JCAHO. See Schyve PM. Patient rights and organization ethics: the joint commission perspective. *Bioethics Forum* 1996;12(2):13–20.
14. Bartrum TE, Bryant LE, Jr. The brave new world of health care compliance programs., *Annals of Health Law* 1997;6:51–75, at 71; Radinsky G. Making sense of the federal sentencing guidelines: how health care corporations can manage risk by adopting corporate compliance programs. *Journal of Health and Hospital Law* 1997;30:113–124; Snyder AG. The false claims act applied to health care institutions: gearing up for corporate compliance. *DePaul Journal of Health Care Law* 1996;1:1; *Health Care Fraud & Abuse Compliance Manual.* Aspen, Colo.: Aspen Health Law Center, 1998.
15. See note 14, Bartrum, Bryant 1997:54. The American Hospital Association has described the relation between organizational ethics and compliance as follows: "Compliance, which is an integral component of everyone's operating culture, is most successful when built upon a strong foundation of ethics." In other words, an organization with an active awareness of its operational values (ethics) is more likely to be successful in its compliance efforts. Compliance, in the legal sense, outlines the minimal standard, an ethics and compliance program assumes the minimums are achieved and aspires to a higher standard. American Hospital Association. *Case Statement: AHA Organizational Ethics Initiative*, p. 1 (on file with author).
16. New Jersey, Ohio, and Vermont courts begin with the assumption of judicial deference to hospitals in medical staff decisions.
17. 213 N.J. Super 475 at 486, 517 A.2d 886 at 892.
18. Mont. Code Ann. 37-2-210 (1995); Md. Code Ann. Health-Gen. II 19-374 (1996).
19. "Ethics committee means a committee that may be an interdisciplinary committee appointed by the administrative staff of a licensed hospital, whose function is to consult, educate, review,

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and make decisions regarding ethical questions, including decisions on life-sustaining therapy," Haw. Rev. Stat. 663-1.7.

20. This summary of the case is based on numerous accounts of the incident in LEXIS NEWS file. During the weeks that followed the Sercye tragedy, the JCAHO, in cooperation with HCFA, conducted an investigation of the incident. The American Hospital Association advised its members to review their policies to make sure doctors and nurses have enough flexibility to respond to similar emergencies. The hospital association was inundated with calls from members inquiring about how they should change their policies. The American Medical Association was asked to develop a policy on caring for emergency patients outside hospital doors. To settle the federal government's complaint, Ravenswood Hospital agreed to pay $40,000 and to buy two quarter-page ads in the *Chicago Sun-Times* declaring that Ravenswood examines patients "without delay and regardless of their ability to pay." ($50,000 is the maximum fine for EMTALA violations).
21. 42 U.S.C. § 1395dd (1992).
22. A.L.R. 2d 396, Hospital's Liability as to Diagnosis and Care of Patients Brought to Emergency Ward (1997).
23. 210 ILCS 50/1 (1993).
24. 42 U.S.C. § 1395 (1992).
25. Johnson v. University of Chicago Hospitals, 982 F.2d 230 (7th Cir. 1992).
26. 42C.F.R. § 489.24(b) (1995).
27. Kleinfield NR. Everyone followed the rules, but a man died. *New York Times* 1994; Oct. 23:A37; Reid B. Relatives ask "why" in homeless man's death. *Baltimore Sun* 1994;Oct. 24:B12; Hospital defends refusal to give aid to dying woman. *Stuart News / Port St. Lucie News* 1996;Oct. 19: C12.
28. Fieser J. Do businesses have moral obligation beyond what the law requires? *Journal of Business Ethics* 1996;15:457–68.
29. Franklin M. Local hospitals would have helped boy. *Dayton Daily News* 1998;May 25:1B.
30. Blair B. Working toward a full recovery: hospital CEO gets crash course in crisis management after boy's death. *Modern Healthcare* 1998;July 13:36.
31. March JG, Olsen JP. *Rediscovering Institutions: The Organizational Basis of Politics*. New York: The Free Press, 1989:22, 24.
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