

**THE MARYLAND HEALTH CARE DECISIONS ACT:  
ACHIEVING THE RIGHT BALANCE?**

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## INTRODUCTION

*David left here at 8:30 one night to go over to his fiancée's house. He was down on Northern Parkway going eastbound and a truck coming westbound hit a bump in the road, crossed the median strip, and hit him head on. We didn't get a call until 11:00 that night and they told us that he was in the Emergency Room and he was hurt pretty badly. So we went down and I couldn't believe my eyes. I couldn't believe that that was the son that I'd seen just a few hours ago. He was covered with bandages. He was obviously in a coma. Blood and broken bones . . . it was pretty awful. We were taken into a room where the doctors came in. We were told that they would tell us what his condition was and we sat down, Lin and I (Lin was David's fiancée), and my other son Michael. The doctor said your son is in a coma and we don't expect him to live. If he does live he probably will never regain consciousness. There wasn't much else to say. That was his condition. He had broken bones. . . . He had a ruptured spleen. A lot of those things they could take care of. But they couldn't fix the ultimate damage which was the brain damage . . . the persistent vegetative state. . . . If we brought him home and he got pneumonia he would die. But the medical profession could keep him living for 20 or 30 years.*

*So this was the dilemma we were faced with and I said to Dr. Richardson if you agree with the diagnosis of persistent vegetative state—take as long as you want to observe him—but if you agree I would like to have the tubes removed, have the life support systems taken away. And he agreed to that. So after a few months of observing him and we did too, everyone did, there was no change. There was not even a slight improvement. There was no improvement. And he agreed and he said "I agree with you but you are going to have to go to court to do this." I said "Court!" That was brand new to me and nobody had said anything about laws about this and I said "why?" and he said "Because you don't have the power to do anything. You don't have his power of attorney, he hasn't left any directives and you can't make this decision for him because he is over 21."*

*You know that for all that we had been through with the accident, the initial reaction to the accident, and then all the hope that something good was*

*going to happen, and the receding hope—well he's never going to be the same but maybe he'll walk, but maybe he'll talk, but maybe he's not going to do anything. All of that emotional trauma and then to finally have to make a decision David was going to die. He had to die. And then to have to deal with people who said you don't have the right to make that decision. I can't tell you the effect that it had on the family. It made us all so angry that here we had come to this place, David had come to this place. All the people who were in the know agreed and then there were these other rules and regulations that we had to meet that didn't seem to have any bearing on anything but legalese.*

Nicci Bojanowski<sup>1</sup>

On May 12, 1993, Maryland Governor William Donald Schaefer signed into law the Maryland Health Care Decisions Act.<sup>2</sup> The law, which went into effect on October 1, 1993, covers advance directives and medical decisionmaking, including termination of life support, for individuals who lack decisionmaking capacity. It significantly changes the way cases similar to that of David Bojanowski are resolved.

The relatively swift passage of the law came as a surprise to many, including those who worked on the legislation. Views on the issue of withholding and withdrawal of life-sustaining treatment (LST) run deep and are strongly held by individuals in our society. For many it is an issue of personal liberty not to be infringed by the state or health care providers. For others, it is an issue of the sacredness of human life, a sacredness that should be protected by the state, not whittled away by judgments of family or medical staff that a certain quality of life is not worth supporting.

Although many of the issues addressed in the legislation have been litigated in state courts where the views of individual parties have been pitted against one another, the passage of legislation offers an opportunity for all citizens of a state to express their views on these important questions and ultimately involves politics—the power of various constituencies to parlay their views into legislative enactments or to negotiate with each other in an effort to reach a compromise. Voices that may not be heard in individual cases decided in the courts may have significant influence in the state legislature.

At this time, all but three states (Massachusetts, Michigan and New York) have legislation on living wills and all but one state (Ala-

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1. THE HEALTH CARE DECISIONS ACT (Maryland Public Television 1993). David Bojanowski was 26 years old when he was involved in the tragic car accident. After a year in a persistent vegetative state, a judge allowed his feeding tubes to be removed, and he died in October 1991. See Mary Knudson, *A Matter of Life and Death*, BALT. SUN, Mar. 8, 1992, at 1A.

2. MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1994).

bama) on durable powers of attorney for health care or appointment of a proxy for health care decisionmaking.<sup>3</sup> In addition, most states now have legislation allowing family members to make medical treatment decisions for patients who lack decisionmaking capacity.<sup>4</sup> In some states, this legislation has sailed through the legislature with little difficulty, while in others, it has engendered considerable legislative battles, some lasting for years.<sup>5</sup> In many states, different views on the issues have resulted in accommodation of positions of various constituencies. For example, although appellate courts that have considered the issue have not placed any more stringent conditions on the withdrawal or withholding of feeding tubes than on other forms of medical treatment, advance directive statutes in several states have.<sup>6</sup> This treatment of artificial sustenance is also at odds with the leading

3. STATE JUSTICE INSTITUTE, GUIDELINES FOR STATE COURT DECISION-MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 209-21 (1993) (hereinafter GUIDELINES FOR STATE COURTS); CHOICE IN DYING, INC., REFUSAL OF TREATMENT LEGISLATION: A STATE BY STATE COMPILATION OF ENACTED AND MODEL STATUTES (1992).

4. As of January 1, 1994, 34 states had such legislation. Charles P. Sabatino, *New State Health Care Decisions Legislation: 1993 Annual Summary*, ABA Comm. on Legal Problems of the Elderly (1994) (hereinafter *New Health Care Decisions Legislation*).

5. For example, in New Jersey, the state legislature debated passage of a living will statute for 17 years prior to its ultimate enactment. Telephone Conversation with Robert S. Olick, former Executive Director of the New Jersey Comm'n on Legal & Ethical Problems in the Delivery of Health Care (Aug. 17, 1993).

6. Until recently, several state living will statutes required the provision of nutrition and hydration except in certain circumstances. See, e.g., Illinois Living Will Act, ILL. ANN. STAT. ch. 755, para. 35/2-2(d) (Smith-Hurd 1992); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. § 16-36-4-1 (Burns 1993); Kentucky Living Will Act, KY. REV. STAT. § 311.624(5)(b) (Baldwin Supp. 1991); Missouri Life-Support Declarations Act, MO. ANN. STAT. § 459.010(3) (Vernon 1992); New Hampshire Living Wills Act, N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1992); North Dakota Uniform Rights of Terminally Ill Act, N.D. CENT. CODE § 23-06.4-06.1 (Supp. 1993); Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, OKLA. STAT. ANN. tit. 63, § 3101.3(6) (West Supp. 1994). During the past year, a number of these states, e.g., Indiana and Kentucky, have relaxed their statutes to allow individuals to refuse artificial nutrition and hydration through their living wills. IND. CODE ANN. § 16-36-4-1 (Burns Supp. 1994); 1994 KY. REV. STAT. & R. SERV. 235 (Baldwin). In Maryland, prior to the enactment of the Health Care Decisions Act of 1993, the Life Sustaining Treatment Act required that persons be permitted to die naturally if terminally ill, "with only the administration of medication, the administration of food and water, and the performance of any medical procedure that is necessary to provide comfort care or alleviate pain." MD. CODE ANN., HEALTH-GEN. § 5-602(c) (1990). A 1988 Opinion by the Maryland Attorney General, however, stated that such a provision was probably unconstitutional and that citizens could modify the statutory form to reflect their wishes not to receive artificially administered nutrition and hydration. 73 Op. Att'y Gen. 162 (1988). A number of state durable power of attorney for health care acts have also restricted the withdrawal or withholding of artificial nutrition or hydration unless specified conditions are met. See, e.g., Missouri Durable Power of Attorney for Health Care Act, MO. ANN. STAT. § 404.820(2),(4) (Vernon Supp. 1993); Nebraska Power of Attorney for Health Care Act, NEB. REV. STAT. §§ 30-3418(2) (Supp. 1992); New York Health Care Proxy Act, N.Y. PUB. HEALTH LAW § 2982(2)(b) (McKinney Supp. 1993); South Dakota Durable Power

medical-ethical authorities in the country as well as with various professional societies,<sup>7</sup> yet reflects the views of a number of religious groups and right to life organizations.

State law also places limitations on family decisionmaking authority. In a number of states there are no statutes authorizing family members to make medical treatment decisions on behalf of an incapacitated relative. In others, family members have authority to consent to medical treatment generally but no explicit authority to refuse life-sustaining treatment.<sup>8</sup> In other states, statutes limit family decisionmaking to terminate life support to cases where the patient is terminally ill.<sup>9</sup> Again, this restriction is in contrast to much of the case law that has permitted families to consent to the withholding or withdrawal of life support when patients are in a persistent vegetative state or have some other disease not considered terminal.<sup>10</sup> As in the case of advance directive legislation, in some states family members may not make a decision to withhold or withdraw artificial nutrition and hydration.<sup>11</sup> As a result, it seems that on the whole, state legislation in the area of termination of life support has been more "conservative" than court decisions covering the same issues.

This Article uses the recent experience in Maryland with the passage of the Health Care Decisions Act of 1993 to explore the issue of accommodation in state legislation on advance directives and surrogate decisionmaking for incapacitated individuals and the policy and practical implications of the ultimate legislation passed. The Maryland "story" provides an excellent medium for this examination as it involved two competing pieces of legislation representing two seemingly different schools of thought or philosophies about (1) the role

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of Attorney Act, S.D. CODIFIED LAWS ANN. § 59-7-2.7 (1993); Wisconsin Power of Attorney for Health Care Act, WIS. STAT. ANN. § 155.20(4) (West Supp. 1993).

7. See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION, WITHHOLDING OR WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT (1989, 1986); AMERICAN ACADEMY OF NEUROLOGY, POSITION OF THE AMERICAN ACADEMY OF NEUROLOGY ON CERTAIN ASPECTS OF THE CARE AND MANAGEMENT OF THE PERSISTENT VEGETATIVE STATE PATIENT (1988); AMERICAN GERIATRICS SOCIETY, AGS POSITION STATEMENT: MEDICAL TREATMENT DECISIONS CONCERNING ELDERLY PERSONS (1987); UNITED STATES CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY (1987).

8. See, e.g., GA. CODE ANN. § 31-9-2 (1991); IDAHO CODE § 39-4303 (1985). See also *New Health Care Decisions Legislation*, *supra* note 4, at 13.

9. See, e.g., Judith Areen, *Advance Directives Under State Law and Judicial Decisions*, 19 LAW, MED. & HEALTH CARE 91, 98 (1991); FLA. STAT. ANN. § 765.305 (West Supp. 1992); IOWA CODE ANN. § 144A.7 (West Supp. 1992).

10. See, e.g., Areen, *supra* note 9, at 97; *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986); *In re Torres*, 357 N.E.2d 332 (Minn. 1984).

11. Areen, *supra* note 9, at 98-99.

of the state and the state's interests in these cases; (2) the basic purpose of the legislation; (3) the role of courts vis-a-vis other decisionmakers; and (4) the role of law generally in such issues. Both bills were subject to significant public scrutiny and debate and provide a rich history for examination and analysis.

## I. BACKGROUND

In February 1993, two comprehensive bills on health care decisionmaking were introduced into the Maryland Senate.<sup>12</sup> Senate Bill 676 (SB 676), introduced by Senator John Pica, was drafted by a committee chaired by Judge John Carroll Byrnes (Circuit Court of Baltimore City) and composed of representatives from the Office of the Attorney General, the Health Law Section of the Maryland State Bar, the Maryland Disability Law Center and the University of Maryland School of Medicine (hereinafter the "committee proposal"). The committee was established in March 1992 and functioned under the auspices of the Conference of Circuit Judges.<sup>13</sup> Senate Bill 664 (SB 664), introduced by Senators Paula Hollinger, Mary Boergers and Vernon Boozer, was modeled after the Virginia Health Care Decisions Act<sup>14</sup> and was put forward by a coalition of consumer and provider group representatives<sup>15</sup> (hereinafter the "coalition proposal").

The drafters of the coalition proposal responded to drafts of the committee proposal that they felt to be too restrictive of individual and surrogate decisionmaking. Those who worked on the committee bill argued that the coalition bill was too expansive, not providing sufficient protections for incapacitated patients. Although both bills covered virtually the same territory—advance directives and surrogate

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12. Subsequently, identical legislation was introduced into the Maryland House of Delegates. The companion bill to SB 676 was HB 1243, introduced by Delegate Sheila Hixson. Minor amendments were made to SB 664 in the Senate Judicial Proceedings Committee and it was introduced into the House as HB 1432 by Delegate Leonard Teitelbaum.

13. REPORT OF THE BILL DRAFTING COMMITTEE TO THE MARYLAND GENERAL ASSEMBLY, THE HEALTH CARE DECISION-MAKING ACT OF 1993, S.B. 676 [hereinafter REPORT OF THE BILL DRAFTING COMM.].

14. VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1993).

15. The group included representatives from the University of Maryland School of Law, the Maryland Chapter of the AARP, the United Seniors of Maryland, the Medical and Chirurgical Faculty of Maryland (the state medical association), the Maryland Hospital Association, the Alzheimer's Association (Maryland Chapter), the Maryland Legal Aid Bureau, Health Care For All, Emergency Medicine Physicians (Maryland Chapter), Medical Directors of Long Term Care Facilities (Maryland Chapter), Maryland Bar Sections on Estates and Trusts and Delivery of Legal Services, National Association of Elderlaw Attorneys (Maryland Chapter), and the Women's Law Center.

decisionmaking, physician responsibilities, and guardianship—they took considerably different approaches to the issues.

## II. SENATE BILL 676 AND ITS PRECURSORS

The intent of the drafters of the committee proposal was to produce a comprehensive piece of legislation covering (1) individual decisionmaking by a competent person; (2) decisionmaking by judges under Maryland guardianship law; (3) durable powers of attorney for health care; (4) living wills; (5) surrogate/family decisionmaking; and (6) emergency treatment and other decisions by physicians.<sup>16</sup> The committee articulated the need for a comprehensive approach in its report to the legislature, which stated:

There is virtually unanimous opinion that these areas of the law should not be legislated separately. Although separate legislation might permit shorter bills, it could result in six different sets of standards and serve no one's interest, particularly doctors, patients, and the families of patients. The public interest is better served by uniform standards that respect and balance both personal health care autonomy and life preservation. To achieve uniform standards, the General Assembly of Maryland must enact a comprehensive law.<sup>17</sup>

Consistent with this goal, the committee produced a series of comprehensive draft bills that covered each of these areas.<sup>18</sup> The proposals provided that a competent individual had a right to refuse life-sustaining medical treatment, unless the individual was the sole provider of a minor child and the life-sustaining treatment would allow her to continue to provide for the care of the child or children. In these cases, the individual was required to seek court approval before refusing life support.<sup>19</sup> With regard to advance directives, the propos-

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16. REPORT OF THE BILL DRAFTING COMM., *supra* note 13, at 6.

17. *Id.*

18. The drafting committee circulated three draft proposals for public comment. The dates of these drafts were April 30, 1992, October 5, 1992, and December 13, 1992.

19. The proposals provided that an individual could not decline or discontinue a life-sustaining procedure without court approval if

(A) The principal was: (1) The sole natural or appointed guardian of a minor child; and (2) immediately prior to the onset of the medical condition currently affecting the individual, the individual was providing for the child's support, care, nurture, welfare, and education; and (3) the provision of health care would afford the individual a reasonable expectation of recovery.

April 30, 1992 Draft, §§ 5-710, 5-719. Recovery was defined as "to a reasonable degree of medical certainty, the individual would regain the capacity that the individual had, prior to the onset of the medical condition currently affecting the individual, to provide for the child's support, care, nurture, welfare, and education." April 30, 1992, §§ 5-710, 5-719; *see*

als kept much of the existing legislation on living wills intact; however, the drafters revised the statutory living will form to allow individuals to choose whether they wanted to treat artificial nutrition and hydration differently than other forms of life-sustaining treatment.<sup>20</sup> In addition, the proposals permitted a living will to take effect not only when a patient was terminally ill,<sup>21</sup> but also when a patient was permanently unconscious.<sup>22</sup>

The proposals also established a statutory foundation for durable powers of attorney for health care<sup>23</sup> with standards regarding who could serve as an agent, the formalities of execution for these documents, and standards for decisionmaking by a health care agent.<sup>24</sup> This had been lacking in Maryland. The proposals did not include a model statutory form, but rather provided that the Attorney General, in consultation with a number of interested parties, would prepare and disseminate a model durable power of attorney for health care decisions form.<sup>25</sup> Finally, in the area of advance directives, the proposals codified a provision in an earlier Attorney General's Opinion, permitting competent individuals to make an oral advance directive by talking directly to their physician about their desires for life-sustaining treatment.<sup>26</sup>

In cases in which a patient did not appoint an agent, the proposals expressly gave family members the authority to make medical deci-

*also* October 5, 1992 Draft, §§ 20A-507, 20A-701; December 13, 1992 Draft, §§ 20A-701 to -702. The limitation did not consider the burdensome nature of the treatment proposed or make exception for individuals such as Jehovah's Witnesses with religious objections to certain types of life-sustaining treatments.

20. April 30, 1992 Draft, § 5-602(c); October 5, 1992 Draft, § 20A-402(c); December 13, 1992 Draft, § 20A-401(c).

21. The then-existing living will statute limited the application of the living will to those cases in which two physicians certified that a patient had a terminal condition. MD. CODE ANN., HEALTH-GEN. § 5-602(c) (1990).

22. April 30, 1992 Draft, § 5-602(c); October 5, 1992 Draft, § 20A-402(c); December 13, 1992 Draft, § 20A-401(c).

23. April 30, 1992 Draft, § 5-711; October 5, 1992 Draft, § 20A-501; December 13, 1992 Draft, § 20A-501.

24. April 30, 1992 Draft, §§ 5-711 to -716; October 5, 1992 Draft, §§ 20A-501 to -506; December 13, 1992 Draft, §§ 20A-501 to -509. The decisionmaking standards included substituted judgment or, if this was an insufficient basis for an agent to make a decision, the best interests of the patient, unless the patient was in a persistent vegetative state. April 30, 1992 Draft, § 5-727; October 5, 1992 Draft, § 20A-504; December 13, 1992 Draft, § 20A-505.

25. SB 676, § 13-713.

26. 73 Op. Att'y Gen. at 185. The oral directive was valid as long as the patient's expressed wishes were entered into the patient's medical record by his physician. April 30, 1992 Draft, § 5-705; October 5, 1992 Draft, §§ 20A-203(1), 20A-303; December 13, 1992 Draft, § 20A-301.



sions for incapacitated patients, including the authority to withhold life-sustaining treatment from patients under certain circumstances.<sup>27</sup> Prior to the new legislation, an Attorney General's Opinion provided that family members could consent to the withholding or withdrawal of life-sustaining treatment from an incapacitated patient, but *only* if the patient was terminally ill.<sup>28</sup> This was the state of the law when Nicci Bojanowski attempted to have her son, David, taken off of life support. The proposed legislation codified the authority of certain family members to make this decision and expanded the family's authority to act to include cases in which the patient was permanently unconscious. The committee proposal established an order of priority of surrogate decisionmakers<sup>29</sup> consistent with the hierarchy set forth in the then existing substituted consent law,<sup>30</sup> "with the addition of persons who [were] not blood relatives but who, by virtue of their relationship and concern for the patient, [would be] reliable surrogates."<sup>31</sup> The proposals also provided that surrogates and agents were to make a decision on behalf of an incapacitated patient using a substituted judgment standard or, if unable to arrive at a decision using that standard, with a best interest test.<sup>32</sup> However, as with an agent, a

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27. April 30, 1992 Draft, § 5-726; October 5, 1992 Draft, § 20A-601; December 13, 1992 Draft, § 20A-601.

28. 73 Op. Att'y Gen. at 196-99. The Opinion stated that a close family member may decide to withdraw or withhold artificial nutrition or hydration without court proceedings if:

- (i) The person is disabled and terminally ill;
- (ii) The attending physicians agree that foregoing treatment is medically proper;
- (iii) The family member determines that foregoing treatment is what the disabled person would want done or, if that is unknown, is in the person's best interest;
- (iv) No other family member disagrees with the decision; and
- (v) When applicable, the hospital's patient care advisory committee has not advised against foregoing treatment.

*Id.* at 199.

29. April 30, 1992 Draft, § 5-726(A); October 5, 1992 Draft, § 20A-601(C); December 13, 1992 Draft, § 20A-601(C).

30. MD. CODE ANN., HEALTH-GEN. § 20-107(d) (1990 & Supp. 1992) ("In the absence of a durable power of attorney that relates to medical care . . . any of the following individuals may give a substituted consent to medical care, . . . : (i) A spouse . . . ; (ii) An adult child . . . ; (iii) A parent . . . ; (iv) An adult sibling . . . ; (v) A grandparent . . . ; (vi) An adult grandchild . . . ; (vii) An adult aunt or uncle . . . ; (viii) An adult niece or nephew . . . ; (ix) An adult cousin.").

31. REPORT OF THE BILL DRAFTING COMM., *supra* note 13, at 20.

32. April 30, 1992 Draft, § 5-727(A)(4); October 5, 1992 Draft, § 20A-604(B); December 13, 1992 Draft, § 20A-602.

surrogate could *not* use a best interest test to withhold or withdraw life support from a patient in a persistent vegetative state.<sup>33</sup>

The proposals also provided standards for judges in guardianship cases or cases involving the termination or withholding of life support. For competent patients with minor children, the judge was to consider the needs of the child for the continued care of the parent.<sup>34</sup> If the life-sustaining treatment could restore the parent to a condition where he or she could care for the child, the judge could decide not to grant the competent person's request not to receive life-sustaining treatment.<sup>35</sup> Judges could only grant a request to withhold or withdraw life support if there was clear and convincing evidence of the patient's wishes or clear and convincing evidence that such action would be in the patient's best interest.<sup>36</sup> As was the case for an agent and surrogate, a judge could *not* grant a request to withhold life support from a patient in a persistent vegetative state on the basis of a best interest test.<sup>37</sup>

Finally, the proposals provided that a physician need not offer a patient medical treatment that the physician considered "medically futile,"<sup>38</sup> nor obtain consent for failure to provide such treatment.<sup>39</sup>

33. April 30, 1992 Draft, § 5-727; October 5, 1992 Draft, § 20A-604(C); December 13, 1992 Draft, § 20A-602(C)(2).

34. April 30, 1992 Draft, § 13-715; October 5, 1992 Draft, § 13-715; December 13, 1992 Draft, § 13-715.

35. *Id.*

36. April 30, 1992 Draft, §§ 13-712 to -713; October 5, 1992 Draft, §§ 13-712 to -713; December 13, 1992 Draft, §§ 13-712 to -713.

37. April 30, 1992 Draft, § 13-713; October 5, 1992 Draft, § 13-713; December 13, 1992 Draft, § 13-713.

38. A definition of medically futile was provided in the drafts. The April 30, 1992 Draft, § 5-703(M) defined medically futile to mean: "(1) To a reasonable degree of medical certainty, not expected to achieve a clinically significant beneficial effect on a medical condition; or (2) prolonging a dying process in its final stage under circumstances that would make treatment inconsistent with generally accepted medical standards and standards of ethical practice." The definition was altered in the October 5, 1992 Draft as follows:

"Medically futile" means that, to a reasonable degree of medical probability, a medical treatment or procedure will not: (1) Prevent or postpone for more than an insignificant length of time the death of the individual; (2) Improve or maintain the health of an individual; or (3) Prevent or reduce the deterioration of the health of an individual.

October 5, 1992 Draft, § 20A-101(R).

The definition remained the same in the December 13, 1992 Draft, though the term "medically futile" was changed to "medically ineffective." December 13, 1992 Draft, § 20A-101(R).

39. April 30, 1992 Draft, § 5-704; October 5, 1992 Draft, § 20A-205; December 13, 1992 Draft, § 20A-204.

Although the committee proposal underwent a significant evolution from its initial conception to its final form, as introduced, the bill remained significantly more restrictive than its rival, SB 664. The primary criticisms of the committee proposals were their (1) extensive reference to "state interests," including the state's interest in the preservation of life, the prevention of suicide, the protection of innocent third parties and the preservation of the ethical integrity of the medical profession; (2) distinct treatment of artificial nutrition and hydration from other types of life-sustaining treatment; (3) numerous restrictions on agent and family decisionmaking; (4) restrictive approach to termination of life support for patients in a persistent vegetative state; and (5) length, detail, and complexity.

#### A. *State Interests*

The committee proposals placed significant emphasis on the concept of state interests. The earliest draft (April 30, 1992) included the following section, entitled "Legislative Findings":

The General Assembly finds and declares that:

(a) The state on behalf of all of its citizens has an interest in the preservation of the life of each of its citizens.

(b) The state on behalf of all of its citizens has an interest in preventing individuals from committing suicide and in preventing others from assisting an individual to commit suicide.

(c) The state on behalf of all of its citizens has an interest in ensuring, to the extent possible, that the welfare of minor children not be seriously impaired as a result of a decision to withhold or withdraw life-sustaining procedures.

(d)(1) The state on behalf of all of its citizens has an interest in preserving the ethical and professional integrity of the health care professions.

(2) A health care provider should always act in accordance with the provider's ethical precepts and may not be required to act in violation of those precepts.<sup>40</sup>

A subsequent draft, dated October 5, 1992, included almost identical language<sup>41</sup> and added the following preamble:

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40. April 30, 1992 Draft, § 5-701.

41. The Legislative Findings Section of the October 5th draft stated:

The General Assembly finds that:

(a) The state, on behalf of all of its people, has an interest in the preservation of life.

(b) The state, on behalf of all of its people, has an interest in the prevention of suicide and assisted suicide.

WHEREAS, the constitutional law of this nation recognizes an individual's right to both personal health care decisionmaking, complementing the common law doctrine of informed consent, and the *preservation of life*, and

WHEREAS, the people of Maryland have a constitutional liberty interest in making personal health care decisions; and

*WHEREAS, the State of Maryland on behalf of all of its people, has an interest in assuring that legislation to safeguard personal health care decisionmaking also reflects our societal concern for life preservation, for the needs of minor dependents who may be affected by a health care decision, and for the professional and ethical integrity of the health care community; and*

WHEREAS, the State is constitutionally permitted to enact reasonable safeguards to protect the integrity of individual health care decisions, to protect the vulnerable and the dependent, including some people with disabilities and some elderly people, and to assure that health care decisions made by a surrogate on behalf of an incapacitated patient are in keeping with the wishes of the patient or are in the best interest of the patient; and

WHEREAS, the balance struck by this law furthers the *preeminent societal value that the life of every individual has worth in and of itself and is not to be devalued by reason of an individual's incapacity or perceived diminished "quality of life,"* whether because of emotional, mental, or physical disability or because of advanced age or economic disadvantage; and

WHEREAS, this law is intended to provide standards for decisionmaking about life-sustaining procedures but not to suggest what the decision of any individual should be; and

WHEREAS, it is the intent of the General Assembly that this law advance the interests and wishes of the individuals whose life and health may be affected by its provisions, not the interests and wishes of others, including those who are granted authority under this law to act on behalf of an individual;<sup>42</sup>

A subsequent draft, on December 13, 1992, preserved the Preamble virtually intact, but revised the Legislative Findings section and called

(c) The state, on behalf of all of its people, has an interest in ensuring, to the extent possible, that . . . a decision to withhold or withdraw a life-sustaining procedure not seriously impair the welfare of minor children.

(d) The state, on behalf of all of its people, has an interest in the ethical and professional integrity of the health care professions.

October 5, 1992 Draft, § 20A-102.

42. October 5, 1992 Draft at 4-5 (emphasis added).

it a "Statement of Legislative Policy."<sup>43</sup> While the draft preserved the listing of the "four state interests," in an effort to gain public acceptance, the drafters added an initial statement recognizing the rights of individuals to make health care decisions and the appropriateness of family decisionmaking for incapacitated patients.<sup>44</sup> The final committee proposal eliminated the Legislative Policy section but maintained the Preamble. In a final report to the General Assembly the drafters of the committee proposal included the following explanation for this ultimate compromise:

Some persons believe, particularly when the health care decision concerns life itself, that the "state interests" should have the strongest influence, while others believe the "state interests" should be weak or have no influence. Our compromise proposes that these four oft-cited common law "state interests" be stated on behalf of the people and rather than use [sic] them as governing standards, implement them in specific ways within the text of the bill itself.<sup>45</sup>

Thus, the recognition of these state interests was used to support specific provisions in the proposed legislation, in particular the provision placing obstacles in the way of a competent person's refusal of life-sustaining treatment if the individual had minor children.<sup>46</sup> The focus on state interests also bolstered the proposals' numerous restrictions on the use of a living will to effectuate termination of life support as well as decisionmaking by both agents and surrogates.

As ultimately introduced by Senator Pica, the committee proposals did *not* include the restriction on competent adults with minor children and included a somewhat modified version of the Preamble. Deleted from earlier drafts of the proposal was the reference to a com-

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43. December 13, 1992 Draft, § 20A-102.

44. *Id.* ("The general intent of this title is to further the constitutional and common law rights of individuals to self-determination about health care decisions and to foster family-based decisionmaking when an individual is not capable of exercising those rights independently."). This was followed by reference to the four state interests:

(B) The intent of certain provisions of this title is the specific application of the interest of the state, on behalf of all of its people, in:

(1) The preservation of life;

(2) The prevention of suicide and assisted suicide;

(3) The safeguarding, to the extent reasonably possible, of minor children against the serious impairment of their welfare that might result from a decision to withhold or withdraw a life-sustaining procedure; and

(4) The ethical and professional integrity of the health care professions.

*Id.*

45. REPORT OF THE BILL DRAFTING COMM., *supra* note 13, at 7.

46. *See supra* note 19.

mon law doctrine of "preservation of life" as well as the following provision:

WHEREAS, the State of Maryland on behalf of all of its people, has an interest in assuring that legislation to safeguard personal health care decisionmaking also reflects our societal concern for life preservation, for the needs of minor dependents who may be affected by a health care decision, and for the professional and ethical integrity of the health care community. . . .<sup>47</sup>

### B. *Artificial Nutrition and Hydration*

While SB 676, as ultimately introduced, did not distinguish between artificial nutrition and hydration and other forms of life-sustaining treatment, all of the committee proposals made this distinction. Early drafts required agents and surrogates to provide explicit evidence of an individual's wishes to refuse artificial nutrition and hydration as distinct from life support more generally.<sup>48</sup> A subse-

47. October 5, 1992 Draft at 4-5.

48. The specific language in the proposals is set forth below:

(a) A health care provider may carry out the instruction of a health care agent to withhold or withdraw a conduit, such as a tube or intravenous line, that supplies food or water to the principal only if:

(1) The power of attorney for health care decisions expressly authorizes the health care agent to make decisions concerning the withholding or withdrawal of a conduit that supplies food or water to the principal;

(2) The instruction of the health care agent carries out a specific intention of the principal with respect to a conduit that supplies food and water, as expressed in:

(i) The power of attorney for health care decisions or other advance directive; or

(ii) Any writing by the principal reviewed by the health care provider.

April 30, 1992 Draft, § 5-718; *see also* October 5, 1992 Draft, § 20A-605.

With respect to surrogate decisionmaking, the proposals stated:

A health care provider may carry out the instruction of a surrogate decisionmaker to withhold or withdraw a conduit, such as a tube or intravenous line, that supplies food or water to the principal only if:

(a) The instruction of the surrogate decisionmaker carries out a specific intention of the individual with respect to a conduit that supplies food and water, as expressed in:

(i) Any writing reviewed by the health care provider; or

(ii) Any form of communication to the individual's attending physician recorded in the individual's medical records. . . .

April 30, 1992 Draft, § 5-730.

Legislation in a small number of other states includes a similar requirement. For example, Maine, Minnesota, and New York allow an agent to withdraw artificial nutrition and hydration only if such authority has been expressly delegated by the patient. *See* ME. REV.

quent draft modified this stringent standard somewhat by requiring that a health care agent or surrogate determine prior to instructing the withholding or withdrawal of a feeding tube that the instruction:

- (1) Reflects the specific intent of the principal regarding feeding tubes as expressed in an advance medical directive;<sup>49</sup>
- (2) Reflects a medically informed substituted judgment regarding feeding tubes; or
- (3) [Is] in the best interest of the principal.<sup>50</sup>

This draft also required that the health care provider certify in writing the basis of the agent's or surrogate's decision.<sup>51</sup>

*C. Restrictions on Effectiveness of Living Wills and on Powers of Agents and Surrogate Decisionmakers*

The committee proposals included numerous restrictions on the effectiveness of various mechanisms through which decisions regarding life-sustaining treatment could be made for an incapacitated patient.<sup>52</sup> For example, the proposals maintained many of the restrictive elements of the then existing living will law. These included a single

STAT. ANN. tit. 18A, §§ 5-501 to -506 (West Supp. 1992); MINN. STAT. §§ 145C.01-.15 (Supp. 1993); N.Y. PUB. HEALTH LAW §§ 2980-94 (McKinney Supp. 1993).

49. This provision applied only to agents. *Compare* December 13, 1992 Draft, § 20A-508(A) *with* December 13, 1992 Draft, § 20A-604(A).

50. *See* December 13, 1992 Draft, § 20A-508(A). If a patient was in a persistent vegetative state, a physician could not certify that withholding or withdrawal of the artificial nutrition and hydration was in the patient's best interest. *See* December 13, 1992 Draft, §§ 20A-508(B), -604(B).

51. *See* December 13, 1992 Draft, §§ 20A-508(C), -604(C). This provision was deleted upon introduction of the bill in the Senate.

52. In his testimony to the Senate Judiciary Committee on the proposed legislation relating to health care decisions (the committee proposal), dated December 18, 1992, Ron Landsman, an elder law attorney in private practice, speaking on behalf of the active Maryland members of the National Academy of Elder Law Attorneys, described the committee proposal as follows:

The proposal of the committee chaired by Judge Byrnes would deny the right to make advance medical decisions to most citizens of Maryland at some time in their life—people who lose capacity by reason of stroke, heart attack, senile dementia, or any of its many causes.

The committee proposal would provide a State-mandated straight-jacket "health care declaration" limiting in State-prescribed words the decisions we as citizens would be permitted to make for our future health care.

The advisory committee proposal would effectively destroy the widespread use of health care powers of attorney by limiting in the most crucial and sensitive areas the powers that could be granted to agents.

The advisory committee proposal would deny family members the right to make many important medical decisions—no matter how careful, thoughtful, conscientious, and loving they might be—for an ill or dying loved one.

mandatory form for health care instructions,<sup>53</sup> a provision requiring that a health care practitioner provide medication for relief of pain or discomfort despite the wishes of the patient (prior to incompetence),<sup>54</sup> her agent, or surrogate,<sup>55</sup> and a limitation on the use of the document to cases in which the patient had a terminal condition or a condition of permanent unconsciousness.<sup>56</sup>

The final draft included some minor burdens on the health care agent. For example, a health care agent was required to tell the patient's health care provider whether his or her decision was based on: (1) the explicit instructions of the patient; (2) a substituted judgment; or (3) the patient's best interest. The health care provider was then required to certify the basis of the agent's decision in writing.<sup>57</sup>

In the area of surrogate decisionmaking, the proposal limited a surrogate's ability to consent to the withholding or withdrawal of life-

Such restrictive legislation is not necessary. Many other states have developed comprehensive, appropriate legislation for good medical decision-making. Testimony of Ron Landsman, National Academy of Elder Law Attorneys, before Senate Judicial Proceeding Comm. 1 (Dec. 18, 1992).

53. The statutory language stated that "[a] Living Will shall be substantially in the following form: . . ." SB 676, § 20A-406(A).

54. Some patients may not want pain medication as it may render them groggy and unable to understand what is going on around them. In other cases it may shorten or prolong a dying process.

55. SB 676, § 20A-205.

56. *Id.* § 20A-405. Virtually all living will statutes include similar restrictive provisions. See NORMAN L. CANTOR, *ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY* 34 (Ind. Univ. Press 1993). Until recently, most living will statutes actually confined removal of life-sustaining treatment to cases where a patient is in a "terminal condition." *Id.* at 35. Several still do. Although the definition of terminal condition varies among jurisdictions, one formulation provides that a terminal condition is an irreversible condition that will lead to death in a relatively short time despite the application of life-sustaining treatment. In a few states, the definition is more restrictive, requiring that death be imminent despite the application of life-sustaining treatment. Such definitions clearly do not include those in a persistent vegetative state (hereinafter "PVS") or with a chronic debilitating illness. Cantor writes that historical reasons for such legislative limitations included concerns about exploitation of helpless individuals in the medical setting, thinking that government interests in promoting sanctity of life might override a broader category of patient rights and perhaps, most importantly, political pressure from religious groups and right-to-life organizations. *Id.* at 37. More recently, many states have broadened the application of living wills to include cases of patients in a persistent vegetative state. See, e.g., 1993 UTAH LAWS 129; VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1993).

57. SB 676, § 20A-417(D). Earlier drafts of the bill, however, were considerably more restrictive. They provided that an agent could not withhold or withdraw life-sustaining treatment from a patient unless that patient was terminally ill or permanently unconscious, unless the document expressly authorized the agent to make decisions regarding the withholding or withdrawal of a life-sustaining treatment for conditions other than terminal illness or permanent unconsciousness, or unless the proposed action was consistent with other instructions of the agent as specified in another medical directive or other *writing* of the principal. See, e.g., October 5, 1992 Draft, § 20A-505(B).



sustaining treatment to cases in which the patient was terminally ill or permanently unconscious.<sup>58</sup> Early drafts required that if the patient was in a terminal condition, the surrogate was required to certify in writing that the decision to withhold or withdraw life support was based on the known wishes of the patient, or if unable to determine the patient's wishes, on the patient's best interests.<sup>59</sup> If a patient was in a condition of permanent unconsciousness, the surrogate had to certify in writing that withholding or withdrawal of life support was based on the known wishes of the patient.<sup>60</sup> This provision was later changed to require the health care provider (rather than the surrogate) to certify in writing the basis of the surrogate's decision.<sup>61</sup>

In addition to these restrictions, a health care provider could not withhold or withdraw life support if anyone in the statutory list of surrogates, including nieces, nephews and cousins, informed the health care provider in writing that they disagreed with the instruction of a higher ranked surrogate.<sup>62</sup>

Finally, there was a provision that prohibited a health care provider from complying with the instruction of a surrogate *or* agent if the provider believed that the instruction was not "reasonable and prudent."<sup>63</sup> In these cases, the provider was required either to petition the institution's patient care advisory (ethics) committee for advice, bring the matter to the attention of a state or local government agency having authority to protect the welfare of the incapacitated individual, or file a petition in a court of competent jurisdiction seeking injunctive relief.<sup>64</sup>

Restrictions or burdens on surrogate or agent decisionmaking were continued in the guidelines for judges provided in SB 676.<sup>65</sup> Life support could not be terminated unless the surrogate or agent showed there was clear and convincing evidence that the incapacitated patient would not have wanted to be sustained by life-sustaining

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58. SB 676, § 20A-502(E). Earlier drafts required that even in those cases, two physicians certify that withholding or withdrawal of life sustaining treatment would be consistent with generally accepted standards of medical practice. See October 5, 1992 Draft, § 20A-604(2); December 13, 1992 Draft, § 20A-603(B).

59. See, e.g., October 5, 1992 Draft, § 20A-604(B).

60. See, e.g., *id.* § 20A-604(C).

61. December 13, 1992 Draft, § 20A-602(D)(2); SB 676, 20A-417(D).

62. SB 676, § 20A-503(B)(1).

63. *Id.* § 20A-503(B)(2)(III).

64. *Id.* § 20A-207. Previous drafts mandated this action on the part of a physician if the physician believed that an agent or surrogate was not acting in the *best interest* of the patient. October 5, 1992 Draft, § 20A-505(C); December 13, 1992 Draft, §§ 20A-507(B), -603(A)(2)(iii).

65. SB 676, §§ 13-601 to -713.

treatment in his or her present condition<sup>66</sup> or that there was clear and convincing evidence that this was in the patient's best interest.<sup>67</sup>

*D. Termination of Life Support for Patients in a  
Persistent Vegetative State (PVS)*

Drafters of the committee bill were extremely cautious about termination of life support for someone in a persistent vegetative state.<sup>68</sup> This was reflected in the criteria that SB 676 required for determining that someone was, in fact, in such a state. The bill provided that life support could not be withdrawn from someone in a persistent vegetative state unless two physicians, one of whom was the patient's attending physician, certified that "for a period of at least 9 months, the [patient] has not exhibited any clinical sign of capacity for thought, purposeful action, [or] awareness of self and environment."<sup>69</sup> Alternatively, two physicians, the patient's attending physician and another who has special expertise in the evaluation of cognitive functioning, could certify that:

The condition of the individual has persisted for a length of time sufficient to permit the conclusion, to a reasonable degree of medical probability, that additional time to confirm the diagnosis [was] unnecessary considering: (1) the extraordinary severity of the trauma or other injury to the brain or illness affecting the brain that the individual has suffered;

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66. *Id.* § 13-712.

67. *Id.* § 13-713.

68. This cautious attitude may have been due in part to the circumstances surrounding *In re Cole*, No. 8611053/CE49265 (Balto. City Cir. Ct., May 9, 1986). Jacqueline Cole suffered a massive and sudden stroke on the morning of March 29, 1986. Ms. Cole's last words to her daughter before losing consciousness were: "Christina, I don't want to live like this." Harry A. Cole, *Deciding On A Time To Die*, 7 SECOND OPINION 1, 2 (1987). The consensus of Ms. Cole's attending physicians was that Ms. Cole would soon die as a result of the stroke. She was in a deep coma and was kept alive through the use of life sustaining treatment. While the doctors felt it would only be a matter of days before this occurred, Ms. Cole did not die. Though she began suffering secondary illnesses, she hung on to life. *Id.* at 5-6. Forty days after Ms. Cole's stroke, her husband petitioned the Circuit Court for Baltimore City for permission to disconnect her life sustaining treatment. At the hearing, presided over by Judge John Carroll Byrnes, Ms. Cole's doctors testified that it was not likely that she would ever regain consciousness, and if she did, she would be a "vegetable." The likelihood of her ever regaining neurologic recovery was somewhere between one in one hundred thousand to one in a million. *Id.* at 7. Judge Byrnes denied the request of Ms. Cole's husband because he felt more time was needed to study the law on the issue and that not enough time had passed in which Ms. Cole had been in a coma. Six days later, Ms. Cole did regain consciousness and today, after much rehabilitative therapy, she has fully recovered from the stroke. *Id.* at 9.

69. SB 676, § 20A-106(A).

and (2) the absence of any potential for rehabilitation of the individual.<sup>70</sup>

The nine-month waiting period is without basis in the medical literature and would be considered excessive by some.<sup>71</sup>

A second example of the cautiousness of the committee proposal regarding withholding or withdrawal of life support from someone in a persistent vegetative state was the prohibition on an agent, surrogate or judge from basing that decision on a best interest test.

This proposed statutory prohibition on the application of the best interest test to someone in this condition would have been truly unique. Courts have been somewhat divided on the best interest test. A few courts have relied exclusively on a substituted judgment test for patients in a persistent vegetative state, and ignored the application of a best interest test.<sup>72</sup> Other courts have applied the test to PVS patients.<sup>73</sup>

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70. *Id.* § 20A-106(B).

71. Some physicians have testified that a four to six month comatose period is used to determine whether there will be any improvement or recovery of a person in a PVS. *In re Jobs*, 529 A.2d 434, 441 (N.J. 1987); *see also* MULTI-SOCIETY TASK FORCE ON PVS, MEDICAL ASPECTS OF THE PERSISTENT VEGETATIVE STATE: STATEMENT OF A MULTI-SOCIETY TASK FORCE 28-29 (Draft #10, Feb. 1, 1993) (reporting that over half of the PVS patients who made good recoveries from traumatic injuries improved within 3 months, almost all within 6 months of injury, and the rate of recovery from 6 to 12 months was 0.5%; no good recoveries reported after 12 months. For patients with nontraumatic injuries, recovery after one month from injury is unlikely); Council Report, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 JAMA 426, 427-28 (1990) ("Once qualified clinicians have determined that a person is awake but unaware, the prognosis to the permanence of [PVS] depends on the age of the patient, the nature of the brain injury, and how long the period of unawareness has already lasted. . . . [F]ew if any patients who remain vegetative following cardiac arrest or similar asphyxial injuries recover after one month and essentially none will regain cognition after 3 vegetative months. . . . The prognosis for cognitive return in patients younger than 40 years with head injury or subarachnoid hemorrhage is somewhat better than above, but still relatively poor.").

72. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Cruzan*, By *Cruzan v. Cruzan*, 760 S.W.2d 408 (Mo. 1988) (en banc); *see also In re O'Connor*, 531 N.E.2d 607 (N.Y. 1988) (holding that hospital was authorized to insert feeding tube into PVS patient in that there was no clear and convincing proof that patient had made commitment to decline assistance under instant circumstances).

73. *See, e.g., In re L.W.*, 482 N.W.2d 60, 67-69 (Wis. 1992) (disagreeing with *Cruzan* and allowing for an objective best interest analysis); *see also Rasmussen v. Fleming*, 741 P.2d 674, 688-91 (Ariz. 1987) (holding that the best interest standard governs surrogate decision-making); *In re Drabick*, 245 Cal. Rptr. 840, 858 (Dist. Ct. App. 1988) (holding that a conservator of an incompetent person in PVS is authorized to decide to withdraw life support by conceding conservatee's best interests); *In re Conroy*, 486 A.2d 1209, 1231-33 (N.J. 1985) (holding that an objective best interest test can be used narrowly when no evidence or wishes of the PVS patient exists); *In re Guardianship of Grant*, 747 P.2d 445, 456-57 (Wash. 1987) (reasoning that, when there are no objections from family or physicians, no prior court authorization is needed before a guardian can decide that withdrawing support is in the best interests of the patient).

The debate is in part based on how the test is formulated. Although virtually all courts that have applied the test have characterized it as a balancing of the benefits and burdens associated with the proposed treatment and its alternatives, courts have differed in the weight they give various burdens and benefits and from whose perspective to weigh them. Under a benefits and burdens analysis, a number of courts have limited the relevant burdens of a patient to pain and suffering.<sup>74</sup> This formulation is problematic in the context of PVS patients who can feel no pain. Few courts have considered the broader issue of the dignity of the patient.<sup>75</sup> Furthermore, courts have determined the benefits and burdens to the patient from the perspective of her present condition, ignoring her history and making no effort to extrapolate from her prior lifestyle and values what type of decision she would make in her current situation.<sup>76</sup> In effect, the test is a purely objective one asking what would the reasonable person in this situation want, *not* attempting to incorporate any relevant values of the patient.<sup>77</sup>

A few courts have added a consideration of a patient's values to the list of issues to be considered in the best interest determination, modifying the purely objective criteria to a "limited-objective" test, but then have significantly restricted the weight to be given those values.<sup>78</sup> There are limitations to even this formulation of the best interest test, especially for a patient who was never competent or whose history is unknown.<sup>79</sup> Courts in such instances have used a more broadly based reasonable person standard, asking how would the reasonable (com-

74. See, e.g., *Conroy*, 486 A.2d at 1232-33 (insisting on a determination of suffering to apply best interest test); *Mack v. Mack*, 329 Md. 188, 218, 618 A.2d 744, 759 (1993) (rejecting use of best interest test for patient not in pain because it requires the court to make a quality-of-life judgment).

75. See, e.g., *In re L.W.*, 482 N.W.2d at 72-73 & n.17 (discussing dignity as a factor).

76. *Id.* at 70 (explaining how the best interest test does not involve analysis of patients' values).

77. Stewart G. Pollack, *Life and Death Decisions: Who Makes Them and by What Standards?*, 41 RUTGERS L. REV. 505, 520-25 (1989); Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 396-403 (1988). The legal literature on the reasonable person standard is generally unhelpful in implementing the best interest test for someone in a persistent vegetative state. Focusing on negligence and fault, the literature does not address the standard to which a permanently unconscious individual is to be held. In general, the law provides that "[a]s to his physical characteristics, the reasonable person may be said to be identical with the actor." See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 175 (5th ed. 1984). As far as mental characteristics are concerned, however, the prevailing standard is an objective one, e.g., to hold the actor to the intelligence and reasoning of the standard man. *Id.* at 176.

78. See, e.g., *Conroy*, 486 A.2d at 1231-32.

79. See, e.g., *In re L.W.*, 482 N.W.2d 60, 67-69 (1992); *In re Moorhouse*, 593 A.2d 1256, 1262 (N.J. Super. Ct. App. Div. 1991); *In re Lawrence*, 579 N.E.2d 32, 37-43 (Ind. 1991); *In*

petent) person weigh the benefits and burdens of continued treatment if in a persistent vegetative state.<sup>80</sup> Classic reports in the bioethics literature have briefly addressed this issue,<sup>81</sup> and scholars also have struggled with it.<sup>82</sup>

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*re Hamlin*, 689 P.2d 1372, 1374-78 (Wash. 1984); *In re Storar*, 420 N.E.2d 64, 72-74 (N.Y.), *cert. denied*, 454 U.S. 858 (1981).

80. See *In re L.W.*, 482 N.W.2d 60 (Wis. 1992). L.W. was a 79-year-old man with a long history of chronic undifferentiated schizophrenia who had been institutionalized since 1951. He had no close friends or relatives and had never indicated his wishes concerning life-sustaining treatment. On May 31, 1989, L.W. suffered a heart attack, which caused him to enter a persistent vegetative state. The guardian of L.W. petitioned the court for a declaratory judgment to determine whether the guardian or the court had authority to consent to the withdrawal of life-sustaining treatment. *Id.* at 63-64. The court ruled that where substituted judgment cannot be used, the proper standard is a best interest test that focuses "solely on what is currently in the patient's best interest." *Id.* at 70. Where the surrogate does not have reliable evidence of the patient's wishes, he must refer to "more objective, societally shared criteria." *Id.* These objective factors include: "The degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options." *Id.* at 72 (citing *Conroy*, 486 A.2d at 1231). In *In re Quinlan*, the court modified the objective best interest test when it reasoned that if Karen Quinlan was alive to look at her situation she would decide upon discontinuance of her life-support apparatus. *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976).

81. A report by the Hastings Center on termination of life support advocates that for patients who lack decisionmaking capacity, if there is not enough known about the patient's wishes and values, a surrogate should "choose so as to promote the patient's interests as they would probably be conceived by a reasonable person in the patient's circumstances. . . ." THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 28 (1987) [hereinafter HASTINGS CENTER GUIDELINES]. This takes on a specific meaning when dealing with a patient with irreversible loss of consciousness. The report explains that

[p]atients who are permanently unconscious are unaware of benefits or burdens. The only possible benefit to them of life-sustaining treatment is the possibility that [their] diagnosis . . . is wrong and they will regain consciousness. Accordingly, the major considerations are whether a reasonable person in the patient's circumstance would find that this benefit, as well as the benefits to the patient's family and concerned friends (such as satisfaction in caring for the patient and the meaningfulness of the patient's continued survival) are outweighed by the burdens on those loved ones (such as financial loss or emotional suffering).

*Id.* at 29.

82. Rhoden argues that the objective best interest test "is unworkable because it too radically separates the patient's present plight from her past personality." Rhoden, *supra* note 77, at 397. Furthermore, a weighing of the burdens and benefits of treatment to a PVS patient is highly problematic in that nothing benefits or burdens a comatose patient. *Id.* at 399. She goes on to argue that we must reject the present-oriented objective test because viewing the patient "only in the immediate present divides the patient from her past, her history, her values, and her relationships—from all those things that make her human." *Id.* at 418. She offers a family decisionmaking model that "best embodies patient preferences," and argues it should be up to doctors to prove the family is wrong, not up to the family to prove that they are right. *Id.* at 437-41.

In its report to the legislature, the drafting committee explained its proposal prohibiting application of a best interest test to patients in a persistent vegetative state as follows:

Because of their unique situation, these patients are able to live for years, even decades, without experiencing pain. Life-support may be withdrawn from them by a surrogate if it is established that would be the patient's wish. An agent may authorize removal of life support if that is within the agent's authority. If there is no basis for believing the PVS patient would want life-support withdrawn, or if there is no agent with the authority to do so, life-support should not be withdrawn. These very rare cases (where there is neither a living will nor a health care agent and substituted judgment by family members or other surrogates is impossible) deserve the special attention of the General Assembly in separate legislation.<sup>83</sup>

The need for the legislature to address this issue became evident as a result of the case of *Mack v. Mack*.<sup>84</sup> The dispute in that case was over whether feeding tubes could be withdrawn from Ronnie Mack, a young man who had been in a persistent vegetative state for over eight years.<sup>85</sup> In *Mack*, the trial court determined that there was not "clear and convincing" evidence of the patient's wishes, and because Mack was not in pain, the court would not apply the best interest test.<sup>86</sup> The case was appealed and decided by the Court of Appeals.<sup>87</sup> The final decision was issued on February 2, 1993, in the midst of the legislative session in which the Health Care Decisions Act of 1993 was being debated. The Court of Appeals held that

[a] best interest test applied . . . to any patient who is in a persistent vegetative state, who is not in pain, and who is not terminally ill, requires this Court to make a quality-of-life

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For a view supporting the objective best interest test, see Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 374 (1986). Dresser argues for a "systematic assessment of an incompetent patient's contemporaneous interests," *id.* at 374, finding that relying on past preferences and reasonable person values in reality allows third parties to have their interests taken into account without acknowledging that this is the case and thus subordinating the interests of the patient to the interests of others. *Id.* at 389-90. She argues for an inquiry that starts with an assessment of the patient's present situation and interests and then possibly factors in "external considerations" such as the patient's past preferences, the family interest, and others to see how the treatment decision should be effected. *Id.* at 390-92.

83. REPORT OF THE BILL DRAFTING COMM., *supra* note 13, at 9-10.

84. 329 Md. 188, 618 A.2d 744 (1993).

85. *Id.* at 191, 618 A.2d at 746.

86. *Id.* at 195-96, 618 A.2d at 748.

87. *Id.* at 196, 618 A.2d at 748.

judgment under judicially adopted standards, without any legislative guidelines. There are many reasons why it is not appropriate for this Court to do so. . . . Where the values themselves are in a state of flux in society, a legislative body is better equipped to determine, within constitutional limits, whether some lives are not worth living and, if so, how to determine which are the lives that are not worth living.<sup>88</sup>

Thus, the highest state court was looking to the state legislature for some way to deal with this seemingly intractable dilemma.

Despite public opposition, drafters of the committee report urged the legislature, in effect, not to grapple with the inherent difficulties of applying the best interest test to someone in a PVS. Instead they urged the legislature to adopt the position that the test was not applicable. This approach would deprive those in a PVS, who were never competent or never clearly expressed their views on the issue, to a state of "indefinite limbo."<sup>89</sup>

#### *E. Length, Detail, and Complexity*

The last issue of concern to many individuals was the length, detail, and complexity of the committee proposals.<sup>90</sup> For every grant of authority, there seemed to be a caveat, and for every caveat, an exception. This style contributed to the bill's length. An illustration of this was a provision about who could and could not be a health care agent:

(A)(1) Except as provided in subsection (B) of this section, a principal may appoint any competent individual at least 18 years old as a health care agent.

. . .

(B) The following individuals may not serve as a health care agent:

(1) The attending physician of the principal or an employee of the attending physician; or

(2) An owner, operator, or employee of a health care facility from which the principal is receiving health care.

(C) The provisions of subsection (B) of this section do not apply if:

(1) The principal and the agent are related within a degree listed under § 2-202 of the family law article; or

88. *Id.* at 218-19, 618 A.2d at 759-60.

89. *Id.* at 235-38, 618 A.2d at 768-69 (Chasanow, J., concurring and dissenting).

90. *See, e.g.*, Testimony of Wanda Hurt, Health Care For All Coalition, before the Senate Judicial Proceedings Comm. 2 (Feb. 23, 1993) ("In contrast [to SB 664] SB 676 is a lengthy, convoluted piece of legislation. . . . The end result is the creation of an unwieldy and hard to understand set of guidelines for health care decision making.")

(2) The principal and the agent are clergy or other members of the same community of persons who:

(I) Are bound to a religious life;

(II) Conduct or assist in the conduct of religious services; and

(III) Actually and regularly engage in a religious, benevolent, charitable, or educational ministry, or the performance of health care services; or

(3) The principal attaches to the power of attorney for health care decisions an affidavit attesting that the agent is the attending physician of the principal or an employee of the attending physician and:

(I) Has known the principal for at least 2 years;

(II) Is familiar with the personal affairs and religious and moral beliefs of the principal through regular contact; and

(III) Is willing and able to serve as a health care agent.<sup>91</sup>

The provision illustrates another difference between SB 676 and SB 664. The committee proposal appeared to try to cover every possible situation—virtually every concept was defined. Its level of detail was impressive. The detail, however, made SB 676 extremely constraining and overly legalistic. A number of individuals criticized the proposal as “nonuser friendly.”<sup>92</sup> In a letter to Senator Walter Baker, Chair of the Senate Judicial Proceedings Committee, John H. Pickering, Chair of the ABA Commission on Legal Problems of the Elderly, shared his experience in working on the Uniform Health Care Decisions Act drafting committee. He articulated three criteria that the National Conference of Commissioners on Uniform State Laws (NCCUSL) found important for drafting Health Care Decisions Acts.<sup>93</sup> The first criterion was that the Act be “readable, understandable, and usable by the general public.”<sup>94</sup> He went on to say that:

This quality is essential if we are to succeed in getting people to use advance directives and getting providers to comply with them. Even though every state now has some form of advance directive legislation, still less than 20 percent of the

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91. SB 676, § 20A-415.

92. Letter from John H. Pickering, Chair, ABA Comm’n on Legal Problems of the Elderly, to Senator Walter Baker, Chair, Senate Judicial Proceedings Comm. 2 (Mar. 2, 1993) (on file with author) [hereinafter Letter from Pickering].

93. The first was readability, the second, flexibility, and the third, that standing be addressed clearly. *Id.* at 2-3.

94. *Id.* at 2.



adult population has any type of written directive. Applying this criterion, S.B. 676 falls short, primarily because so many issues are addressed in multiple provisions throughout the bill, often with slight nuances in terminology, scope, and meaning. The redundancy engenders more confusion than clarity.<sup>95</sup>

Others expressed similar concerns with the bill's complexity.<sup>96</sup> The drafters of the bill did not appear to take these criticisms seriously as indicated in their final report to the legislature:

[This] bill is a concise treatment of a number of separate but closely interrelated issues in this complex field. While it is true that the bill could be divided into five or six "short bills"

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95. *Id.* Pickering provided several examples of redundancy in the proposal: conscience objections are treated in §§ 20A-208 and -407; rules of construction in sections 20A-102, -103 and -410; liability issues in §§ 20A-209, -409, -421, and -505; prohibited decisions in §§ 20A-418, -419, -503, and -504; portability of advance directives in §§ 20A-412 and -413; revocation in §§ 20A-403 and -420; and decisionmaking standards in §§ 20A-417, -512, and 13-711(B). Each of these issues could be more clearly treated and effectively addressed in single or combined sections of the act.

*Id.*

96. *See, e.g.*, Remarks of John F. Fader II, Judge, Baltimore County District Court, distributed at Judicial Institute and November 18, 1993 conference, on "The Right to Refuse Life-Sustaining Treatment in Maryland" ("This 'people business' we are in requires the use of language less cumbersome, more understandable and better organized. Understanding legislation should not be the prerogative of those trained in the law or medicine . . ."); letter from Diane E. Hoffmann and Karen Rothenberg to Judge John Carroll Byrnes, Conference of Circuit Court Judges 4 (Dec. 8, 1992) (on file with author) ("[W]e and most others we have spoken to, object to the complexity and length of the document. Although many laws are lengthy and complex, for most, attorneys are hired to assist people [sic] comply. In this area, most people are not going to seek the assistance of an attorney to educate themselves about this issue. Yet all people will die and many will face a situation where they will have to decide whether they want life sustaining treatment for themselves or for a family member. This draft has numerous subtleties that most people will not understand. As a result many people may be hurt by their lack of knowledge of the law"); testimony of David S. Davis, M.D., J.D., Maryland Chapter of the American College of Emergency Physicians, before the Senate Judicial Proceedings Comm. 1 (Feb. 23, 1993) ("At this level of decision-making, patients and doctors must feel comfortable with their understanding of the law. Otherwise, they remain in turmoil emotionally. SB 676 is too complex, with too many exceptions and cross-references. Doctors will fear they are 'missing' something technical. They will refer all to the hospital attorney, who is not the best person to advise in this situation. . . ."); Letter from Steven A. Levenson, M.D., to Judge John Carroll Byrnes, Circuit Court for Baltimore City 2 (Jan. 19, 1993) (on file with author) ("[T]his bill is highly legalistic and verbose, and by trying to anticipate and define all possible situations becomes so meandering as to confuse rather than clarify. As written, it will not be usable by ordinary citizens and physicians, but will require more lawyers to interpret. As I see it, a major thrust of ethics decisions in this country in the past decade has been to get the lawyers *out* of these processes, and enable ordinary citizens to take care of these issues themselves in conjunction with their physicians, *not* to make lawyers even more indispensable.")

addressing each of these issues separately, virtually everyone agrees that one bill integrating all related issues is preferable to a piecemeal approach. . . . To "shorten" the bill significantly would require throwing something significant overboard just to lighten the boat. That would likely mean having to build another boat or two later; and that in turn might produce a small flotilla of boats going in different directions and also increase the risk of "accidental drowning" of an important health care right or protection.<sup>97</sup>

### III. SENATE BILL 664

Senate Bill 664, as introduced, covered virtually the same ground as SB 676, in almost half the space. In comparison to SB 676, SB 664 was notable for its brevity, ease of understanding, simplified forms, and exclusion of many of the restrictions of SB 676.<sup>98</sup>

Senate Bill 664 included a single advance directive form that would allow individuals either to appoint an agent, leave instructions for receipt of health care, or do both.<sup>99</sup> This was in contrast to SB 676, which included a restrictive and mandatory living will form and no form for a durable power of attorney for health care.<sup>100</sup> The form in SB 664 was optional and included a check off for individuals to express their preferences regarding various alternatives.<sup>101</sup> Testimony at the legislative hearings on the bill indicated that the inclusion of a single form was of particular importance to elderly groups within the state:

Our senior citizen clients have made it clear to us that they do not want to have to consult an attorney in order to write an advance directive. SB 664 provides a suggested form which combines the terms of a living will and a health care power of attorney. This is an improvement on the current situation in which there are two similar documents which apply to different situations. Our clients often express confusion about what each does and about whether they should sign one or both documents. This bill resolves this confusion by providing one comprehensive form in which the declarant makes treatment choices and chooses an agent if she

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97. REPORT OF THE BILL DRAFTING COMM., *supra* note 13, at 3; *see also* Letter from Judge John Carroll Byrnes, Chairman, Drafting Comm., to Sen. John A. Pica, Chairman, Health Care Decision-Making Subcomm., Senate Judicial Proceedings Comm. 1 (Dec. 13, 1992).

98. *See* SB 664; SB 676, 1993 Md. Regular Session.

99. *See* SB 664, § 5-603.

100. SB 676, § 20A-406.

101. *See* SB 664, § 5-603.

or he wishes. The bill provides that assisting a person in filling out the form does not constitute the practice of law. This means that health care providers, senior center staff, and others may help people fill out the form without the necessity of legal consultation.<sup>102</sup>

Similar sentiments were expressed by other groups.<sup>103</sup> In keeping with the notion that this type of legislation should be user-friendly, John H. Pickering stated that a second goal of the Uniform Health Care Decisions Act's drafters was the inclusion of a "single, flexible advance directive form that enables an individual to appoint a proxy to provide instructions about life-sustaining procedures, and to address any other health related matters."<sup>104</sup> Pickering criticized SB 676 in its effort to "salvage the existing Maryland living will statute and form by tacking on new language" and by requiring that all living wills confirm substantially to the statutory form.<sup>105</sup>

The model forms in SB 664 did, however, present problems for some. Critics contended that "[f]orms set out in a statute, though labeled optional, tend to become the norm. Health care providers become used to seeing the standard form and become wary if something else is presented. Therefore, the specific contents of even an optional statutory form ought to be carefully reviewed."<sup>106</sup>

Senate Bill 664 also expanded the conditions under which a living will would become effective to include not only terminal illness and persistent vegetative state but also an "inevitably fatal condition."<sup>107</sup> This was defined as "an advanced, progressive condition caused by injury, disease, or illness as a result of which an individual: (1) has already suffered severe debilitation; and (2) to a reasonable

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102. Letter from Joan O'Sullivan, Senior Citizens Law Project of the Legal Aid Bureau, Inc., to Walter M. Baker, Chairman, Senate Judicial Proceedings Comm. 2 (Feb. 23, 1993) (on file with author) [hereinafter Letter from O'Sullivan].

103. See, e.g., Testimony of Jane P. Merkin, American Jewish Congress, National Capital Region, before Senate Judicial Proceedings Comm. (Feb. 23, 1993) (quoting the Congress's Bio-Ethics Task Force that the legal requirements for selecting and directing an agent should be simple so as to be accessible to the average person without having to consult a lawyer or participate in a court proceeding).

104. Letter from Pickering, *supra* note 92, at 2.

105. *Id.* at 3.

106. Comments of Judge John Carroll Byrnes, Chair, Bill Drafting Comm., to Senate Judicial Proceedings Comm. 1 (Undated document title: Concerns about SB 664) (on file with author) [hereinafter Comments of Byrnes].

107. SB 664, § 5-603; see Advance Medical Directive Health Care Instructions, Part C. The earliest drafts of SB 664 included no provisions limiting the authority of the surrogate to specific conditions as no such limits were placed on surrogates in similar laws in Virginia and the District of Columbia. See VA. CODE ANN. §§ 54.1-2981 to -2993 (Supp. 1993); D.C. CODE ANN. §§ 6-2421 to -2430 (1989).

degree of medical probability, will suffer further irreversible deterioration until a medically foreseeable death, whether or not life-sustaining procedures are provided.”<sup>108</sup> This provision was unique in state living will statutes, which for the most part limit their application to cases in which a patient is terminally ill or in a persistent vegetative state.<sup>109</sup> Thus, its inclusion was relatively progressive. It had the potential to include the following types of conditions:

- Degenerative neurological disorders, such as advanced Alzheimer’s disease, ALS (Lou Gehrig’s disease), advanced multiple sclerosis, major stroke, or head injury with damage to critical vegetative function centers;
- Heart diseases such as advanced congestive cardiomyopathy and severe heart damage from multiple or extensive heart attacks;
- Renal disease, in particular advanced chronic renal failure;
- Liver disease such as alcoholic cirrhosis with liver failure;
- Pulmonary disease such as advanced emphysema; and
- Multisystem organ failure including general deterioration or decline due to the failure of multiple organs or organ systems as a result of the cumulative effects of age and multiple illnesses.<sup>110</sup>

Although considered important by many groups, in particular the state chapter of the AARP and the Alzheimer’s Association, this provision also evoked considerable criticism. The Maryland Catholic Conference argued that inclusion of those patients with “inevitably fatal conditions” was the most “frightening aspect” of the bill.<sup>111</sup>

Acceptance of this concept, in our view, would embrace the . . . “ethic of euthanasia.” *We urge that you not take this perilous leap.* Leaping to final decisions in the matters of living will, durable power of attorney, and surrogate decision-

108. MD. CODE ANN., HEALTH-GEN. § 5-601(k).

109. See *supra* note 56 and accompanying text.

110. See Facsimile of Summary of Maryland Medical Directors Assoc., Position on Bills Related to Health Care Decision Making, to Professor Diane E. Hoffmann, University of Maryland School of Law 3 (Feb. 21, 1993) (on file with author) (explaining the definition of “inevitably fatal conditions” and supporting SB 664 in part because such conditions are included).

111. Letter from Richard J. Dowling, The Maryland Catholic Conference, to Hon. Stephen J. Braun, Chairman, Durable Power of Attorney Work Group, House Environmental Matters Subcomm. and Subcomm. Members 7 (Mar. 16, 1993) (on file with author) (“Perhaps the most frightening aspect of [SB 664 and its complement] HB 1432 . . . is the measure’s endorsement of decisions to prematurely end the lives of individuals who, though they have suffered ‘severe debilitation’ and face ‘further deterioration,’ do not have terminal conditions, do not face imminent death, and are not in a permanent vegetative state.”).

making are perilous enough and these matters have been the subjects of study and debate for more than a decade. This new concept—appealing to some, so very frightening to others—needs a good deal more cooking before it should merit consideration as public policy.<sup>112</sup>

SB 664 also expanded the conditions under which a surrogate could make a decision to withhold or withdraw life support to include not only terminal illness and persistent vegetative state but also “inevitably fatal condition.” The controversy generated by this provision appeared to reflect different views of the role of the family in decisionmaking for incapacitated patients. The two comments below illustrate the contrasting views on the issue:

The bill presupposes and expresses belief in the good faith of individuals, their families and close friends. This means that by and large, medical decision making is left to private citizens in consultation with their doctors. If there is dissension among those persons, the decision may go to an institution’s ethics committee. The presumption of good faith will allow these decisions to be made by those closest to the patient, without interference from outside decisionmakers, such as the court system.<sup>113</sup>

It is too easy for healthy people, even with the best of motives, to look at someone with a physical or mental impairment and conclude that since the healthy person would not want to have so diminished a quality of life, it must be in the patient’s best interest to forgo treatment. And, the sad truth is, some families are dysfunctional, and surrogate decisions made by members of those families deserve careful scrutiny. Without a definition of “best interest” that is limited to the patient’s medical circumstances and without a state role for health care providers, how are misguided decisions to be averted?<sup>114</sup>

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112. *Id.* Drafters of the committee proposal also criticized this aspect of the bill. See Comments of Byrnes, *supra* note 106, at 2 (“The advanced directive in § 5-603 contains a paragraph . . . allowing someone to say, often far in advance of the actual situation, that if he or she has an inevitably fatal condition, ‘I direct that my life not be extended by life prolonging procedures, including the administration of nutrition and hydration through tubes.’ A person without the benefit of anything remotely like an informed consent discussion will thus be refusing in advance even minimally burdensome life-sustaining procedures like antibiotics, when so simple a treatment might prolong the person’s life significantly.”).

113. Letter from O’Sullivan, *supra* note 102, at 2.

114. Comments of Byrnes, *supra* note 106, at 1.

Senate Bill 664 also reduced burdens on surrogate decisionmakers and gave a clearer priority for decisionmaking to those most likely to be closest to the patient.<sup>115</sup> Under SB 676, if someone farther down the list of surrogates disagreed with someone higher on the list, a physician could not follow the instructions of the person with decisionmaking priority.<sup>116</sup> The result of such a rule would be that a patient's fairly distant relative, his nephew for example, could veto the decision of the patient's spouse, even though the patient had been married for many years and had expressed his views on life support to his spouse. In contrast, under SB 664, the presumption was that the family member higher on the list was acting in good faith in making a decision to withhold or withdraw treatment. If a more distant family member disagreed, the burden would be on that distant family member to take the case to court. Senate Bill 664 also included a provision allowing for resolution of disputes among surrogates of the same class—adult children or siblings—by the attending physician referring the case to the health care institution's patient care advisory (ethics) committee.<sup>117</sup>

In contrast to SB 676, Senate Bill 664 bolstered the authority of surrogates and agents by prohibiting a health care provider from overriding the instructions of the surrogate or agent<sup>118</sup> without going to court and proving that the agent or surrogate was not following statutory guidelines for decisionmaking.<sup>119</sup> The bill also allowed a surrogate or agent to apply a best interest test to someone in a persistent vegetative state.<sup>120</sup> The difficulties of applying the test to someone unable to experience benefits or burdens was indirectly dealt with by the definition given to the term. The coalition proposal and SB 664 provided that "in determining what is in the patient's best interest a surrogate shall consider: (I) the prognosis of the patient for recovery; (II) the risks, benefits, and burdens of any proposed procedure, and the alternatives to any proposed procedure; and (III) the religious beliefs and basic values of the patient receiving treatment."<sup>121</sup> The definition, thus, was not purely objective.

Also, unlike early versions of SB 676, SB 664 made no distinction between artificial nutrition and hydration and other forms of life-sus-

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115. Compare SB 664, § 5-605(A) with SB 676, § 20A-501(C).

116. SB 676, § 20A-503(B)(1).

117. See SB 664, § 5-605(B).

118. *Id.* § 5-610(B).

119. *Id.* § 5-605(H).

120. *Id.* § 5-603.

121. *Id.* § 5-605(C)(2).

taining medical treatment other than to allow individuals to make that distinction, if they wished, in their advance directive form.<sup>122</sup>

In line with a new trend in health care decisionmaking statutes, SB 664 included a provision allowing emergency medical technicians to honor "Do Not Resuscitate Orders" in the prehospital setting.<sup>123</sup> SB 676 included no such provision.

Senate Bill 664 also modified the existing guardianship law to allow a guardian to authorize the withholding or withdrawal of life-sustaining treatment without court approval if the patient had executed an advance directive expressing a desire not to receive life support under the circumstances at issue or if the guardian was a close relative of the patient.<sup>124</sup> These provisions would be effective unless the court, upon appointment of the guardian, expressly stated that the guardian did not have this authority.<sup>125</sup>

Lastly, SB 664 was perceived as short, understandable, and user oriented. Numerous individuals who testified at hearings on the two proposals made comments to this effect. The comments of Joan O'Sullivan, a Legal Aid attorney, are illustrative of the comments made:

One of the best things about this bill, and a prime reason we support it instead of the competing SB 676 is that it is easily understandable. SB 664 clearly and concisely sets standards in a very complex area. It is a piece of legislation that when codified will be readily accessible to the many lay people and health care providers who will seek it out. People who read it will be faced with very difficult, emotional, personal decisions that often must be made quickly. Those consulting it will not have to seek out the hospital attorney, their own attorney, or look to interpretive material to understand what their rights are, because they are clear on the face of the bill. This is not tax law; this is law that one way or another will touch each of us and our loved ones. Therefore, it is imperative that it be comprehensible, and this bill makes it so.<sup>126</sup>

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122. Both bills allowed patients to specify in their declarations what type of feeding and hydration assistance they wished to refuse. See SB 664, § 5-603; SB 676, § 20A-407.

123. SB 664, § 5-606, at 10. Approximately 22 states now authorize paramedics to follow patient preferences outside of the hospital regarding CPR. Choice in Dying, Inc., *State Statutes Governing Non-Hospital Do-Not-Resuscitate Orders*, RIGHT TO DIE DIGEST (June 1994).

124. SB 664, § 13-708(c)(2)(F). Cf. MD. CODE ANN., EST. & TRUSTS § 13-708(c) (Supp. 1992).

125. *Id.* § 13-708(c)(2).

126. Letter from O'Sullivan, *supra* note 102, at 2; see also Testimony of Stephanie M. Lyon, Alzheimer's Association, before the Maryland House of Delegates Env't'l Matters Comm. 1 (Mar. 3, 1993) [hereinafter testimony of Lyon] ("House Bill #1432 [SB 664] is

## IV. PHILOSOPHY

At one point in the legislative debate, the chair of the group that drafted the committee proposal asserted that the two legislative proposals reflected two philosophical schools:

One [school] is very cautious about giving other persons life and death decisions over others and thus is anxious to establish some limits, safeguards, and articulated objective legal standards . . . . The other school of thought takes the opposite tack. It argues for virtually absolute autonomy, brooking no interference by anyone at any time for any reason.<sup>127</sup>

While superficially this characterization of the two bills might have seemed accurate to a few, it significantly misrepresented the different perspectives on the issues. The differences were much more subtle and complex and reflected very different views of some fundamental issues regarding (a) the role of the state in these types of decisions; (b) the purpose of this type of legislation; (c) the role of the courts and families in making decisions for incapacitated patients; and (d) the role of legislation more generally.

A. *Role of the State*

Perhaps the greatest philosophical difference between the two proposals was the drafters' view of the role of the state and what constitutes legitimate state or societal interests in these life and death decisions. The crux of the difference might be characterized as a disagreement over whether the states' interest in these cases should be limited to a protective stance vis-a-vis the patient or whether the state

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relatively simple and understandable. Bill #676 is still twice as long and difficult to understand. My father [the husband of an Alzheimer's victim] would have trouble interpreting it and I question the ability of any one [sic] outside the legal profession to do so. Most importantly, I wonder how many health care professionals and providers will take the time to understand it."); Testimony of Harold P. Gross, National Assoc. of Retired Fed'l Employees, before the Senate Judicial Proceedings Comm. 1 (Feb. 23, 1993) ("We support SB 664 as the better of the two bills because it is less cumbersome and complex than is SB 676."); Letter from Ruth A. Bristol and Ralph K. White, Subcommittee on Legislation, Broadmead Residents Association, to Chairman and Members of the Senate Judicial Proceedings Comm. 1 (Feb. 19, 1993) (on file with author) ("We commend 664 for its conciseness, brevity, and understandability. We are especially pleased that it simplifies the execution of advance medical directives by proposing the use of a single, easy-to-execute model instrument.").

<sup>127</sup> Letter from the Hon. John Carroll Byrnes, Circuit Court for Baltimore City, to M. Lark Schülze, Esq., Chairperson, Health Law Section, Maryland State Bar Association 2 (Jan. 11, 1993) (on file with author).



should impose a result based on an interest wholly its own, apart from and perhaps hostile to that of the patient.<sup>128</sup>

Virtually every court that has heard a case involving the termination of life-sustaining treatment has paid "lip service" to the four state interests thought to be first articulated in *Superintendent of Belchertown State School v. Saikewicz*.<sup>129</sup> "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."<sup>130</sup> Despite the courts' consistent articulation of these interests, they have only rarely used them to override an individual's right to refuse life-sustaining treatment.<sup>131</sup>

The articulation of these state interests in *Saikewicz* by virtually all courts is puzzling, given their general inattention to them, and raises questions as to their basis and evolution. *Saikewicz* enumerated these interests without providing "any historical, philosophical or legal anal-

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128. See Sallyanne Payton, *The Concept of the Person in the Parens Patriae Jurisdiction over Previously Competent Persons*, 17 J. MED. & PHIL. 605, 640-41 (1992) (stating that "[w]hile most state courts and legislatures have taken seriously in good faith their fiduciary obligation to manage the affairs of an incompetent under the *parens patriae* jurisdiction only for his own benefit, some others have sought to use the powers granted to them under the *parens patriae* jurisdiction to impose on incompetents policies of their own deciding, policies that are hostile to the interests of the incompetents.").

129. 370 N.E.2d 417 (Mass. 1977).

130. *Id.* at 425. The *Saikewicz* court identified these four state interests in relevant case law. In particular, the court relied on the opinion in *In re President of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied sub nom. Jones v. President of Georgetown College, Inc.*, 337 U.S. 978 (1964), in which Judge Skelly Wright ordered a blood transfusion over the objection of a young mother. *Id.* The *Georgetown College* court "justified its decision by reasoning that its purpose was to protect three state interests, the protection of which was viewed as having greater import than the individual right: (1) the state interest in preventing suicide; (2) a *parens patriae* interest in protecting the patient's minor children from 'abandonment' by their parent; and (3) the protection of the medical profession's desire to act affirmatively to save life without fear of civil liability."

131. The exceptions have each concerned blood transfusions to Jehovah's Witnesses. See, e.g., *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965) (granting motion to dissolve a temporary restraining order initially issued by the court when "the [Jehovah's Witness] patient voluntarily submitted himself to and insisted upon medical care [yet] [s]imultaneously . . . sought to dictate to treating physicians a course of treatment amounting to medical malpractice"); *Powell v. Columbian Presbyterian Medical Ctr.*, 267 N.Y.S.2d 450, 451 (Sup. Ct. 1965) (granting order permitting hospital to administer blood transfusions to save the patient's life when a Jehovah's Witness did not object to blood transfusions but objected, on religious grounds, to signing a written authorization for the transfusion of blood); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 201 A.2d 537, 538 (per curiam), *cert. denied*, 377 U.S. 985 (1964) (holding that, because the welfare of the unborn child and the mother "are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them[,] . . . blood transfusions may be made if necessary to save her life or the life of her child").

ysis of their inclusion."<sup>132</sup> Yet courts routinely base their decisions upon them. Some insights for their inclusion, however, can be gleaned from the role of the courts in guardianship cases. It has been well established that "within the terms of the *parens patriae* jurisdiction itself the state ha[s] a duty to protect the lives of its wards and therefore ha[s] an interest in doing so."<sup>133</sup> Yet, the doctrine of *parens patriae* has its roots in a period of history well before the advent of modern medical technology, when criteria for a patient's best interest was not so challenging to determine. Today, it is frequently questionable whether maintaining a person on life support protects their interests at all. In fact, "[t]here is widespread acknowledgment that, for some persons facing fatal afflictions, nonexistence may be preferable to medical maintenance."<sup>134</sup> Thus, the application of a state interest in the preservation of life<sup>135</sup> raises the thorny question of whether this interest would be consistent with the state interest in protecting the

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132. Ben A. Rich, *The Assault on Privacy in Healthcare Decisionmaking*, 68 DEN. U.L. REV. 1, 11 (1991). Rich argues that "the urgent circumstances of the Georgetown case precluded a careful study of the legitimacy of the state's interests in this situation." *Id.* at 12 ("In the interval of about an hour and twenty minutes between the appearance of the attorneys at his chambers and the signing of the order at the hospital, the judge had no opportunity for research as to the substantive legal problems and procedural questions involved. He should not have been asked to act in these circumstances.' Sadly, many appellate courts have reviewed similar hasty trial court rulings and have not bothered carefully and critically to analyze the dubious origins of these four state interests which remain obstacles to patients who wish to refuse necessary medical treatment."). According to Rich, another perplexing aspect of the recitation of the interests is that they are incorporated into cases in which there is apparently no party representing the state involved in the case. Yet, "[t]here are . . . no reported decisions in which a court has refused to accept jurisdiction on the grounds that a private physician has no legal right to force treatment on a competent patient, or that the state is not a party to the proceeding so as to properly invoke either the *parens patriae* power or the four state interests." *Id.* at 13. In view of the courts' willingness to consider these cases, Rich questions the justiciability of the cases and the standing of health care providers to bring them to the courts. *Id.* at 21. While there may be a question about the standing of health care providers to bring these cases when a patient is competent, in most instances, the patient is not competent and the case comes to the courts in the form of a guardianship proceeding. In many states, including Maryland, the court is in fact the guardian and obviously is an arm of the state. In these cases, the courts are asked to exercise their *parens patriae* powers to make a decision that is in the best interests of the patient.

133. Payton, *supra* note 128, at 609.

134. CANTOR, *supra* note 56, at 9; see also Robert A. Pearlman et al., *Insights Pertaining to Patient Assessments of States Worse Than Death*, 4 J. CLINICAL ETHICS 33 (1993).

135. This state interest has included two separate concerns: (1) an interest in preserving the life of a particular patient; and (2) an interest more generally in the sanctity of life. The assumption justifying this state interest in treatment refusal cases is that "if the state, through its licensed medical practitioners, hospitals and courts, allowed patients to decide to refuse life-sustaining treatment, it would inevitably result in a widespread trend which would ultimately undermine the proposition that life is sacred." CANTOR, *supra* note 56, at 13.

patient or instead would constitute a "hostile . . . state interest in the 'sanctity of life'" at odds with the interests of the patient.<sup>136</sup>

For the most part, courts seem to be aware of the limitations of this state interest and have therefore "squashed" its application in life and death cases.<sup>137</sup> Instead they have opted for fashioning a resolution to the cases that they deemed consistent with the best interests of the patient though often ending that patient's life.<sup>138</sup> Most courts seem to follow the general lead of *Quinlan* on this issue announcing that the "State's interest *contra* [termination of life support] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."<sup>139</sup>

An exception to this general line of reasoning was recognized by the Supreme Court of Missouri in the case of Nancy Cruzan, which stated that the state's interest is an "unqualified interest in life," no matter what its quality.<sup>140</sup> Professor Sallyanne Payton argues that courts such as the Missouri Supreme Court in *Cruzan* that announce a "paramount state interest in the 'sanctity of life' quite apart from the interests of the protected person" depart from their traditional role as patient protectors under a *parens patriae* doctrine.<sup>141</sup> She warns that *Cruzan* might not be the last case to address the issue of the weight to be given state interests and that the issue is also likely to surface in state legislative debates given dominant political forces in some jurisdictions.<sup>142</sup>

Professor Payton's remarks shed significant light on the debate in Maryland between the drafters of the two opposing bills. While both "sides" characterized their position as based on concerns for protecting the rights of incapacitated patients,<sup>143</sup> the drafters of the coalition

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136. Payton, *supra* note 128, at 610.

137. *See, e.g., Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986) ("We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure for '15 to 20 years.' We cannot conceive it to be the policy of this State to inflict such an ordeal upon anyone.").

138. "State courts other than the Supreme Court of Missouri [have] asserted a state interest in the 'preservation of life' [but have] construed it as a protective interest in the person." Payton, *supra* note 128, at 610.

139. *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

140. *See Cruzan v. Harmon*, 760 S.W.2d 408, 420, 422 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

141. Payton, *supra* note 128, at 610.

142. *Id.* at 612-13.

143. *See, e.g., Letter from the Hon. John Carroll Byrnes, Circuit Court for Baltimore City, to Consultants 1* (May 5, 1992) (on file with author) ("We share with you the objective

proposal were suspicious that the drafters of the committee proposal were in fact advocating a stance hostile to the best interest of the patient.<sup>144</sup> The language of the proposed preamble illustrates the concern. While some aspects of the preamble were clearly written for the protection of patients, others were clearly of a hostile nature.<sup>145</sup>

### B. Purpose of Legislation

The proposed bills appeared to be based on a different understanding of the problem they were intended to address. The proponents of both bills seemed to agree that there were problems with abuse in patient treatment. But each defined abuse differently. The

of crafting a law which permits a principled withholding or withdrawal of LSMT, which is often unnecessary or futile and also painful and burdensome, without a descent into what I term an 'inadvertent holocaust,' by so liberalizing these decisions as to put in jeopardy the lives of the elderly or those suffering from an intellectual, physical, psychological or psychiatric disability, or those whose health care preferences are not clearly understood.").

144. Judge Byrnes's letter accompanying the April 30th draft of the committee proposal confirms this suspicion. He stated: "Three principles, or perspectives, have guided our work: (1) The importance of every life, no matter its 'quality;' (2) the importance of individual health care decisionmaking; (3) the importance of compromise in all but core values, that is, not insisting upon only one interpretation or implementation of the first two principles in this proposed legislation." *Id.*

Several individuals testified that the focus on state interests was inconsistent with the interests of the individual. A spokesperson for the Maryland members of the National Academy of Elder Law Attorneys stated:

The State exists for us, and not we for the State. We all agree that there are few—some would add, if any—situations where the State has the power to tell a free person that he or she must submit to physical intrusions that are not wanted. It is not the province of the State or any State official to tell me or you or anyone that he is required to be maintained or keep alive [sic], in the face of incurable illness, because it serves the interests of the State.

Testimony of Ron M. Landsman, National Academy of Elder Law Attorneys, before Senate Judiciary Comm. 3 (Dec. 18, 1992).

145. In particular, the following provisions were problematic:

WHEREAS, the constitutional law of this nation recognizes an individual's right to both personal health care decision making, complementing the common law doctrine of informed consent, and the preservation of life; and

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WHEREAS, the State of Maryland on behalf of all of its people, has an interest in assuring that legislation to safeguard personal health care decisionmaking also reflects our societal concern for life preservation, for the needs of minor dependents who may be affected by a health care decision, and for the professional and ethical integrity of the health care community; and

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WHEREAS, the balance struck by this law furthers the preeminent societal value that the life of every individual has worth in and of itself and is not to be devalued by reason of an individual's incapacity or perceived diminished "quality of life," whether because of emotional, mental, or physical disability or because of advanced age or economic disadvantage . . . .

October 5, 1992 Draft at 4.

advocates of the coalition bill saw the abuses in terms of overtreatment, or continuing to provide treatment to patients against their will or desires or inconsistent with their best interests. Although the advocates of the committee bill also sought to address the problem of overtreatment, they were at the same time preoccupied with the problem of undertreatment; or prematurely terminating or withholding treatment from patients who would otherwise want to be treated or for whom treatment would be in their best interest.

The two groups also seemed to have different assessments of the extent of the two types of abuse and placed different weights on their importance. Advocates of the committee bill appeared to believe that undertreatment occurred fairly often. They also focused more on undertreatment than did drafters of the coalition proposal, and appeared to believe that overtreatment was not necessarily undesirable or at least not reprehensible. On the other hand, proponents of the coalition bill felt that both types of abuse were equally intolerable, but that undertreatment was rather rare whereas overtreatment was pervasive.

Although there are few empirical studies of the extent to which these abuses occur, the minimal literature available on the subject appears to support the latter view. For example, a recent study of 1400 physicians and nurses found that four times as many of those surveyed were concerned about burdensome overtreatment as were concerned about undertreatment, and that thirty-four to thirty-eight percent of attending physicians, fifty percent of nurses, and seventy percent of residents reported that they were acting against their consciences by overtreating terminally ill patients.<sup>146</sup>

### C. *Role of Courts vs. Role of Family*

A third significant difference between the proponents of the two bills was their view of the role of the family in making treatment decisions for cognitively impaired relatives. In general, advocates of the committee bill appeared more distrustful of family members than advocates of the coalition bill and seemed concerned about the possibility that some families might "do in" their relatives out of greed or some other ill motive. They referred frequently to the "dysfunctional family." As a result, their bill placed significant roadblocks in the way of family members and surrogates in making medical treatment decisions, in particular, decisions to withhold or withdraw life support.

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146. Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 16 (1993).

Their bill required, in many cases, that family members go to court and bear the burden of proving that their ill relative would want to discontinue life support or that its discontinuation or denial would be in the patient's best interest.

Conversely, advocates of the coalition bill felt that family members were in a better position to make these decisions and should be authorized to do so. To the extent that safeguards were put in place, these advocates felt that they should not interfere with or burden caring, loving family members making health care decisions for incapacitated patients. This sentiment was expressed by several individuals who testified on the bills:

[B]ill #1243 [SB 676] feels burdensome to families. It seems to place its emphasis on the interests of the state, not those of the family. It seems to expect families to make bad decisions and it therefore goes to great lengths to tell families how to make them. We know that someday we will probably have to make some painful decisions about my mother's care. We know how she would like us to make those decisions, and what she would want them to be. We knew her better than anyone else, we are a part of her. The state must trust us to make the right decisions.<sup>147</sup>

Most courts have recognized family members as appropriate decisionmakers in these cases<sup>148</sup> and a number of authors have written on the appropriateness of family members as decisionmakers for incapacitated patients with regard to the withholding or withdrawal of life-

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147. Testimony of Lyon, *supra* note 126, at 1-2. Ms. Lyon's mother has Alzheimer's disease.

148. *See, e.g., In re Jobes*, 529 A.2d 434, 445 (N.J. 1987) ("Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care and best interests, and they who treat the patient as a person, rather than a symbol of a cause.") (citations omitted). *But see In re Pflieger*, 62 N.Y.S.2d 899, 901 (N.Y. Sup. Ct. 1946) ("From the earliest times, the rights of the relatives of incompetents to act as or participate in the selection of [a guardian] have been the subject of much discussion and comment by the courts. It was the ancient rule that heirs and next of kin were to be looked upon with suspicion, since their interests were presumably adverse to those of the incompetent. However, in 1774 this theory was criticised [sic], and in *Dormer's Case*, 2 P.Wms. 262, an uncle of the lunatic was appointed. In 1815, in one of the early New York cases, Chancellor Kent in appointing a daughter committee of her mother stated: 'I agree with what was said by Lord Mansfield in *Dormer's case*, *supra*, that there is no sufficient reason for the old rule against committing the custody of the person and estate of a lunatic to the heir at law.' *Matter of Livingston I Johns*. Ch. 436.").

sustaining treatment.<sup>149</sup> Similarly, most bioethicists argue that the family should be given a great deal of discretion in making decisions for their incapacitated relatives. As Leslie Francis states:

In addition to their knowledge, family members may also be better motivated than others to be sure that standards for decision-making—either substituted judgment or the patient's best interests—are applied carefully and accurately. Family members may be motivated to seek out information about the patient's expressed preferences. Similarly, they may be more motivated than others to pursue the information needed to decide what is in the patient's interest—for example, information about various sources of financing for care or about alternative facilities for treatment.<sup>150</sup>

Although most experts in bioethics and law have argued for greater family authority in these cases, there is some empirical evidence that indicates that surrogates often do not make the same decision that the patient would have made for him or herself.<sup>151</sup> On the other hand, there are those who argue that in spite of this many individuals would prefer that their family members make this decision over other possible decisionmakers, such as physicians, judges, etcetera.<sup>152</sup>

#### D. Role of Legislation More Generally

Finally, the two groups had a fundamental difference of opinion about the more general role of legislation. The drafters of SB 676 seemed to believe that legislation should be designed for the “bad

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149. See, e.g., Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 160-68 (1993) (discussing advantages of family decisionmaking).

150. Leslie P. Francis, *The Roles of the Family in Making Health Care Decisions for Incompetent Patients*, 1992 UTAH L. REV. 861, 870; see also *In re Farrell*, 529 A.2d 404, 414 (N.J. 1987) (“Our common experience teaches us that family and close friends care most and best for a patient. They offer love and support and concern, and have the best interest of the patient at heart. The importance of family in medical treatment decisions is axiomatic.”).

151. See, e.g., Nancy R. Zweibel & Christine K. Cassel, *Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies*, 29 GERONTOLOGIST 615 (1989); Richard Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY 115 (1988). Studies have shown that in fact most people would provide more aggressive treatment to others who are terminally ill than they would want for themselves. Peteris Darzins et al., *Treatment for Life-Threatening Illness*, 329 NEW ENG. J. MED. 736 (1993) (letter) (reporting survey's result that “[r]espondents chose more aggressive treatment for a[n] [older incompetent adult] they did not know than for a family member and, in turn, more aggressive treatment for a family member than for themselves.”).

152. See Dallas M. High, *Who Will Make Health Care Decisions for Me When I Can't?*, 1990 J. AGING & HEALTH 291, 300 (finding that “elderly persons with relatives consistently expressed preferences for family members to serve as surrogate decision makers”).

actors" in our society. Leslie Bender has described the result of this approach to legislation:

Although there are, and always will be, a number of bad actors, most of us do not fall in that category. If we write our laws or set our standards to curtail the actions and improper motivations of a small contingent of people on the margin, we may disempower the majority of us in the center from acting on noble and virtuous impulses. . . . [W]e [also] prohibit family members from mercifully ending the suffering of loved ones or create high legal barriers to families asking for termination of life-support decisions for incompetent loved ones based on our fear of bad families. The social and ethical price of designing our laws and rules for the bad actors is significant suffering and indignity to innocent, humane people because of unnecessary restraints on their freedom to act out of care in a manner responsive to particularized circumstances of need.<sup>153</sup>

Consistent with this view, drafters of the committee bill required much in the way of written certification and justification of actions by clear and convincing evidence. An example of this perspective in early drafts was that artificial nutrition and hydration could not be withdrawn or withheld from an incapacitated patient unless that patient had previously stated expressly in writing or orally their desire not to be kept alive by artificial nutrition and hydration. Many critics of the proposal saw such a requirement as unrealistic because it assumed that common citizens are aware of conditions such as persistent vegetative state and the use of artificial nutrition and hydration and that they can clearly articulate their views about specific types of treatment.<sup>154</sup> In response to such requirements, Professor Karen

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153. Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519, 532 (1992).

154. In *Mack v. Mack*, Judge Chasanow expressed some of this skepticism toward judicial inquiries into what the PVS patient had expressed while competent in his discussion of the intent of Ronald Mack:

First, I doubt that very many healthy, robust young people, like Ronald was, ever seriously consider that they may someday be in an accident and be reduced to a persistent vegetative state. Even if some did contemplate such a horrible event, how many would have clearly and convincingly formed and evidenced their views that, if in a persistent vegetative state, they would at some point choose to terminate artificial life support or, alternatively, that they would choose to remain in that state until they die of "old age."

*Mack v. Mack*, 329 Md. 188, 236, 618 A.2d 744, 768 (1993) (Chasanow, J., concurring in part and dissenting in part); see also Hamann, *supra* note 149, at 105-06 (reporting that, despite the development of living wills and durable powers of attorney, "studies suggest that as few as nine percent of the population have executed living wills").



Rothenberg testified on the overly legalistic tone of SB 676, arguing that the "proposal . . . ignores reality . . . [because] not all feelings and contingencies can be codified."<sup>155</sup>

Drafters of the committee bill had a different perspective and were critical of SB 664 for its lack of detail. In a letter to Senators on the Judicial Proceedings Committee one member stated:

All citizens, ill and well, physicians, and health care facilities want clarity in the law. Clarity is best served by having distinct sections governing living wills, powers of attorney, surrogates, provider authority, and guardianships. [SB 664] collapses these distinctions, perhaps in pursuit of brevity.

But while combining different subjects may give the appearance of a "simple bill," the mixing may serve only to confuse in the long run. We thought it was everyone's objective to keep these intimate questions out of the court. To accomplish that, the law should cleanly delineate the roles and responsibilities of the various decisionmakers. Potential questions have to be answered, not left unanswered. When they are answered, the bill naturally becomes longer; but those answers and that length will help citizens and doctors and nurses make health care decisions without the uncertainty that leads to court involvement.<sup>156</sup>

The critics were especially concerned about undefined or underdefined terms such as medically ineffective treatment<sup>157</sup> and best interests.

## V. TRANSLATION OF PHILOSOPHY INTO POLICIES

In its deliberations, for the most part the legislature seemed to accept the philosophies underlying the coalition proposal or to adopt

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155. Testimony of Karen Rothenberg, Professor, University of Maryland School of Law, before the Senate Judicial Proceedings Comm. 1 (Dec. 18, 1992).

156. Letter from Jack Schwartz, Chief Counsel, Opinions & Advice, Office of the Attorney General, to Senators Walter M. Baker and John A. Pica 3 (Feb. 3, 1993) (on file with author).

157. As stated by one group:

There is an additional violation of personal autonomy in SB 664. It is section 5-609. . . . Physicians would not have to provide treatment that physicians determine to be "medically unnecessary" or "ethically inappropriate." Astonishingly, neither term is defined. It is entirely up to the subjective judgment of the physician. This is an egregious example of physician paternalism trumping patient autonomy. While not the best definition possible, the definition of medically ineffective in SB 676 provides at least some protection for vulnerable patients.

Letter from Roger Stenson, Exec. Dir., Maryland Right to Life, Inc., to Senator Walter M. Baker, Chairman, Senate Judicial Proceedings Comm. 1-2 (Feb. 26, 1993) (on file with author).

a compromise approach reflecting concerns of both schools of thought.

A. *Personal Autonomy/State Interests/Preamble*

Ultimately, with respect to the state interest debate, the legislature rejected an approach that could be construed as hostile to patients and adopted a protective stance. Although the ultimate legislation includes a brief preamble, it makes no mention of the state's interest in life, only in protecting the lives of the vulnerable from abuse.<sup>158</sup> Consistent with this view was the deletion from the bill of the restrictions on a competent patient with minor children to refuse life-sustaining treatment. In omitting this provision, key legislators may have recognized the inconsistency of such a provision<sup>159</sup> and the repugnancy of its implementation.<sup>160</sup> The implementation of such a rule might require that the court either hold the patient "in contempt of court" and placed in jail "for failing to submit to treat-

158. While the preamble does refer to a "societal value" that the life of every individual has worth in and of itself and is not to be devalued by reason of an individual's incapacity or perceived diminished "quality of life," that sentiment was tied to a concern about discrimination toward individuals who are emotionally, mentally, or physically disabled or because of their age or economic disadvantage. Thus, it reflects the protective perspective.

A small minority viewed this compromise as unbalanced: "In the best of this legislation, the attempted balance, between a medically incompetent person's right to die and the state's interest in preserving life, is weighted on the side of an effort to help someone get out of the way." Testimony of Steve Shaneman, Director, Family Protection Lobby, before the Senate Judicial Proceedings Comm. 1 (Feb. 23, 1993).

159. Ben Rich has pointed out that a provision limiting a competent adult's right to consent or refuse to consent to treatment on the basis of the rights of a minor child, if taken to its logical conclusion,

would be to assert that a . . . minor child could prevent the . . . adult parent from engaging in any inherently dangerous activity, such as skydiving, hang-gliding, or mountain-climbing, on the grounds that he or she created an unreasonable risk of death or grave injury that could deprive the family of its "right" to his or her continued existence in the home. We have never, as a society founded upon the principles of liberty and self-determination, embraced such a proposition.

. . . .

. . . Fathers and mothers of minor children can engage in the full range of lawful but nevertheless inherently dangerous activities—they can use tobacco products and consume alcoholic beverages, they can even separate, divorce, and permanently remove themselves from the minor child's life, subject only to state laws governing financial support. Indeed, the state even countenances the ultimate voluntary abandonment, placing the child in an adoptive home. Logically, an individual's right to autonomy, privacy and bodily integrity inherent in the informed consent doctrine should hold with the same vigor for parents of minor children as it does for any other competent adult.

Rich, *supra* note 132, at 14-15.

160. This provision actually was deleted by Senator Pica from the committee proposal before he introduced SB 676.

ment” or “have the patient taken from his home by the police, hospitalized in a locked unit, and perhaps even placed in four-point restraints for purposes of the actual administration of [treatment].”<sup>161</sup>

*B. The Problem of Abuse, the Role of the Family,  
and the Need for Safeguards*

Concerning the issue of abuse and the related role of the family, the legislature attempted to balance the two schools of thought. The ultimate legislation included fewer restrictions on surrogates than were included in the committee bill, but more than were included in the coalition proposal.

The final bill included a provision mandating physicians who believe that the instruction of a surrogate or agent is not consistent with “generally accepted standards of patient care” to bring the case to the institution’s ethics committee or to a court of competent jurisdiction.<sup>162</sup> There was some debate among drafters of the two bills over the appropriate standard for the physician “override.” Three options were considered. A physician would be required to bring the issue to the attention of some higher authority if (1) the decision was “not reasonable and prudent”; (2) it was inconsistent with generally accepted standards of patient care; or (3) it was made in bad faith. Drafters of the coalition bill favored the third option as it gave the broadest discretion to surrogates in making a decision for a patient. It would allow a challenge to a surrogate’s determination of what was in the patient’s best interest, but would require the health care provider to show that the surrogate was making a decision that was clearly in bad faith, e.g., in the interest of the surrogate rather than of the patient. The drafters of the committee bill rejected this option because it seemed to require the physician to determine the intent or motive of the surrogate. Instead, they preferred the first option, which was consistent with the language in the then-current substituted consent statute.<sup>163</sup> This option was objectionable to the coalition drafters because it gave the physician the option of determining what was reasonable. John Pickering of the ABA provided further reason to reject the standard:

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161. Rich, *supra* note 132, at 26.

162. MD. CODE ANN., HEALTH-GEN. § 5-612(a) (1994).

163. MD. CODE ANN., HEALTH-GEN. § 20-107(f) (1990) (repealed by Maryland Acts 1993, ch. 372, § 1 (effective Oct. 1, 1993)). The statute stated in part: “The substituted consent . . . may not be given: . . . (3) If the health care provider knows that the individual giving substituted consent is not acting in a reasonable or prudent manner . . . .” *Id.*

The use of a “reasonable and prudent” standard as proposed in [SB 676] would provide an unsatisfactory standard for health care decisions. It is a much broader standard than “accepted medical standards.” A more even balancing of interests would affirm that physicians may not be forced to act against generally accepted medical standards, nor against their consciences. The bulk of health decisions litigation since *Quinlan* has at least made clear that a patient’s notion of reasonableness sometimes conflicts with physicians’ notions; and physicians are not the societal arbiters of reasonableness and prudence.<sup>164</sup>

Ultimately, the drafters agreed upon the standard of generally accepted standards of patient care, in large part because it was a medically based standard, rather than one requiring the physician to assess the motive or the value of a particular decision.

The legislature also adopted the approach of SB 664 in allowing an expanded role for surrogate decisionmakers. The final statute allows surrogates to make a decision to withhold or withdraw life support from a patient who is either in a terminal condition, a persistent vegetative state, or has an “end-stage condition.”<sup>165</sup> The term “end-stage condition” replaced the term “inevitably fatal condition” initially used in SB 664.<sup>166</sup> The definition of the term was also somewhat modified.<sup>167</sup>

*C. Role of Legislation—For the Common Person or Lawyer?; To Deter Bad Actors or Enable the Good Ones?*

The legislature opted for the less complex, shorter SB 664 as a starting point for the legislation. Thus, legislators were persuaded by those concerned about the length and difficulty of SB 676. However, they were reluctant to leave many of the terms in the bill undefined and chose instead to clone onto SB 664 several of the definitions included in SB 676, ostensibly to provide more guidance to physicians having to put the legislation into effect. Specific definitions added included: substituted judgment, best interest, unavailable, and medically ineffective treatment.<sup>168</sup>

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164. Letter from Pickering, *supra* note 92, at 3.

165. See MD. CODE ANN., HEALTH-GEN. § 5-601(i) (1994).

166. See SB 664, § 5-601(k).

167. See *infra* notes 196-203 (comparing MD. CODE ANN., HEALTH-GEN. § 5-601(i) (1994) with SB 664, § 5-601(k)).

168. See MD. CODE ANN., HEALTH-GEN. §§ 5-601, 5-605 (1994).

## VI. TRANSLATING POLICIES INTO LEGISLATIVE LANGUAGE; THE ULTIMATE LEGISLATION—A WORKABLE COMPROMISE?

These policy perspectives filtered down into the actual drafting of the bill and the ultimate statutory language. As is typically the case in the legislative process, the approach taken is one of compromise. Some refer to it as striking a delicate balance, and others—more crudely—as the making of sausage. The ultimate question is whether the compromise, although satisfying most constituents, is workable in the real world. In this last section, I touch on some of the compromises made and explore some of the issues that may arise in their implementation.

### A. *Advance Directive Forms*

Ultimately, the legislature included in the final legislation the forms that appeared in both SB 664 *and* SB 676. Thus, the statute includes two forms: (1) a living will form; and (2) an advance directive form.<sup>169</sup> The living will form allows an individual to state whether they want life-sustaining treatment, artificial nutrition and hydration, or all available treatment if they are terminally ill *or* in a persistent vegetative state.<sup>170</sup> The advance directive form is in two parts. Part A, called “Appointment of Health Care Agent,” allows individuals to appoint health care agents to make health care decisions for them if they lack decisionmaking capacity.<sup>171</sup> Part B, called “Health Care Instructions,” allows individuals to leave instructions about their medical care if they become incapacitated.<sup>172</sup> With respect to termination of life support, Part B allows drafters to specify whether they want life-sustaining treatment or artificial nutrition and hydration if they have a terminal condition, are in a persistent vegetative state, or have an end stage condition.<sup>173</sup> Alternatively, it allows them to specify that they want all available medical treatment “in accordance with accepted health care standards” no matter what their condition.<sup>174</sup> It also allows drafters to specify that they do not want medication to relieve

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169. *See id.* § 5-603 (containing sample forms for a living will and an advance directive).

170. *Id.* (Form I).

171. *Id.* (Form II, Part A). Alternatively, the form provides that the document may go into effect immediately upon the signature of the principal. *Id.*

172. *Id.* (Form II, Part B).

173. *Id.*

174. *Id.*

pain and suffering if it would shorten their remaining life.<sup>175</sup> An individual may complete Part A alone, Part B alone, or both parts.<sup>176</sup>

Although the forms are entirely optional and an individual may write their own document custom tailored to their own preferences, the inclusion of the multiple forms in the statute is decidedly confusing and unnecessary. The living will form is superfluous, since the Health Care Instructions form includes all of the options provided in the Living Will form and more. The inclusion of both forms is unfortunate.

Although the forms allow individuals more choices and options than under previous law, they may create other problems. Attorneys who have had some experience with the forms, in particular the Health Care Instructions form, assert that a number of their clients have completed the form incorrectly. They check items that are mutually exclusive.<sup>177</sup> Thus, the effort to give people more choices in their execution of these documents may mean that there are some mistakes in their completion. As a result, health care providers who review advance directives on a patient's admission to a hospital or nursing home or upon enrollment in an HMO under the requirements of the federal Patient Self Determination Act<sup>178</sup> will need to peruse these documents more diligently, checking for inconsistencies.

At a conference on the new law,<sup>179</sup> the question was also raised as to whether by completing Parts A and B of the advance directive form, an individual would be limiting the ability of an agent to refuse life-sustaining medical treatment to those situations specified in the instructions. The concern might materialize if an individual had specified that she did not want life-sustaining treatment if terminally ill, in a persistent vegetative state, or in an end stage condition, but in fact, did not meet the criteria for any of these conditions. Instead, such an individual might be seriously debilitated and have indicated to her agent that if, for example, she had a cardiac arrest she would not want to be resuscitated. If the patient had simply completed Part A of the

175. *Id.*

176. *Id.* (Form II, Parts A & B).

177. This appears to occur when an individual indicates that he or she does not want life-sustaining treatment or artificial nutrition and hydration under any of the three scenarios enumerated in the form, but then initials the statement that he or she wants all available medical treatment no matter what his or her condition.

178. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206(a), 104 Stat. 1388-115 (1990) (codified at 42 U.S.C. § 1395cc(f) (1988 & Supp. IV 1992)).

179. Law & Health Care Program of the University of Maryland School of Law and The Maryland Office of the Attorney General, Implementing the Maryland Health Care Decisions Act: Questions and Answers (Sept. 14, 1993).

form—Appointment of Health Care Agent—the agent would have the authority to authorize a DNR order. With the completion of the instructions, a question arises as to whether the principal only wanted life support withheld in the three scenarios described. There is certainly a strong argument that such an interpretation is too limited. The Appointment of a Health Care Agent form states expressly that an agent has “full power and authority to make health care decisions for” the principal, including the power to “[c]onsent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.”<sup>180</sup> There is no language indicating what constitutes “appropriate circumstances” but the interpretation would appear to be up to the agent. Given this plenary language, it would be inappropriate to limit the application of the health care instructions to those situations listed in the form.

The limitations in the form reflect the statute’s restrictions regarding the implementation of a living will or health care instructions when an agent has not been appointed. In those circumstances, life-sustaining treatment may not be withheld or withdrawn from a patient unless the patient is terminally ill, in a persistent vegetative state, or has an end stage condition, even if the patient had clearly indicated a desire not to receive such treatment.<sup>181</sup> Such limitations are of questionable constitutional validity.<sup>182</sup>

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180. MD. CODE ANN., HEALTH-GEN. § 5-603 (1994) (Form II, Part A).

181. The statute does not place the same limitations on the ability of an agent to withhold or withdraw life support as it does on a surrogate. Section 5-606(b) provides: A health care provider may not withhold or withdraw life-sustaining procedures on the basis of an advance directive where no agent has been appointed or on the basis of the authorization of a surrogate unless:

- (1) The patient’s attending physician and a second physician have certified that the patient is in a terminal condition or has an end-stage condition; or
- (2) Two physicians, one of whom is a neurologist, neurosurgeon, or other physician who has special expertise in the evaluation of cognitive functioning, certify that the patient is in a persistent vegetative state.

MD. CODE ANN., HEALTH-GEN. § 5-606(b) (1994).

182. See CANTOR, *supra* note 56, at 52 (stating that there is “significant doubt about the constitutionality of statutory provisions confining implementation of advance directives to patients ‘in a terminal condition’”); see, e.g., *In re Guardianship of Browning*, 543 So. 2d 258, 267 (Fla. Dist. Ct. App. 1989), *aff’d*, 568 So. 2d 4 (Fla. 1990) (stating that when a person is no longer competent to exercise his or her constitutional right to refuse medical treatment, “the right still exists, but the decision must be delegated to a surrogate decisionmaker”); *State v. McAfee*, 385 S.E.2d 651, 652 (Ga. 1989) (holding that a quadriplegic incapable of spontaneous respiration had the right to refuse medical treatment by a ventilator where the only interest of the state was the general interest in preserving life and there was no state interest in preserving the life of an innocent third party); *In re Drabick*, 245 Cal. Rptr. 840, 841 (Cal. Ct. App. 1988), *cert. denied*, 488 U.S. 958 (1989) (holding that “California law authorizes the conservator of an incompetent person in a vegetative state with no hope of recovery to decide, considering medical advice and the conservatee’s best

### B. Oral Advance Directives

The final legislation includes a provision allowing a competent person to execute an oral advance directive. SB 676 limited the oral advance directive to leaving health care instructions. SB 664 expanded the oral advance directive to include the appointment of an agent. The ultimate legislation reflected the broader authority of SB 664.

Arguments against the broader provision were based in part on concerns about miscommunications. The Office on Aging, for example, stated that

[u]nder the verbal directive provisions a health care agent could be appointed to make life and death decisions without having discussed with the patient either the appointment or the authority granted. All the agent would know could be communicated via "hearsay" by the witnesses. This is both inconsistent with practice and places health care facilities in a precarious position.<sup>183</sup>

These concerns seemed largely unfounded. In most cases, the appointed agent would be a family member or friend who knows the patient well. It would be the patient's responsibility to decide if the agent would be in the best position to carry out the patient's wishes. The agent also has the option to decline the appointment if they wish. A similar criticism could be made of a written appointment. It is possible that one could appoint an agent in a durable power of attorney without telling the individual of the appointment.

Other concerns with the oral advance directive provision were based on the fact that it would make it easier for individuals to "execute" an advance directive:

The oral (or verbal) advance directive concept severely undercuts the very purpose of the legislation, which is to encourage people thoughtfully and in dialogue with their loved ones and physicians to consider what care they should receive when they cannot make on-the-spot decisions for themselves and then, with clarity and precision, to detail their desires in this regard.

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interests, that medical treatment in the form of artificial life support should be withdrawn and the conservatee permitted a natural death."); *Rasmussen v. Fleming*, 741 P.2d 674, 682 (1987) (en banc) (holding that "[t]he right to refuse medical treatment is a personal right sufficiently 'fundamental' or 'implicit in the concept of ordered liberty' to fall within the constitutionally protected zone of privacy contemplated by the Supreme Court.").

183. Testimony of Rosalie S. Abrams, Director, Maryland Office on Aging, before the Senate Judicial Proceedings Comm. 4 (Feb. 23, 1993).



An oral health care directive might easily be given in an emergency, under duress, or in other situations which afford scarce little time for careful consideration. Health care decisionmaking of this kind, especially where a decision relates to life-preservation or to the treatment of especially vulnerable patients, should be severely limited, if not also discouraged.<sup>184</sup>

The incorporation of the oral appointment was considered extremely important by the drafters of the coalition bill. Whereas many of the provisions of SB 676 required written communications, this was perceived by the drafters of the coalition bill to be overly legalistic and not to reflect the way that most people prefer to interact and communicate.

In terms of implementation, the oral advance directive provision requires that a statement be made to the patient's physician, entered into the medical record, and witnessed by one person.<sup>185</sup> This is a change from the previous Maryland law, as interpreted by the Attorney General, allowing an oral advance directive to give health care instructions, but requiring no witness.<sup>186</sup> The new witness requirement will require a change in physician practices. There are no limitations on who can be a witness, except that the witness cannot be the person's agent.<sup>187</sup> Thus, in most cases it is likely that the witness will be a nurse working with a physician or a member of the patient's family who is not the appointed agent.

### C. *Physician Override*

The final legislation requires a physician who determines that the instruction of an agent or surrogate is inconsistent with generally accepted standards of patient care to report that case to the institution's

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184. Facsimile from Jack Schwartz, Office of Attorney General, to Diane Hoffmann, University of Maryland School of Law 3-4 (Mar. 23, 1993) (on file with author) (Comments of Richard Dowling, Maryland Catholic Conference).

It is interesting that the new Uniform Health Care Decisions Act does not allow for oral appointment of an agent. However, the model Act does allow for oral appointment of a surrogate if made directly to a health care provider. Such oral appointment would revoke a previous written appointment of a health care agent. UNIFORM HEALTH-CARE DECISIONS ACT § 5(h) (Draft for Approval 1993) [hereinafter UNIFORM ACT].

185. MD. CODE ANN., HEALTH-GEN. § 5-602(d) (1994).

186. 73 Op. Att'y Gen. 162, 185 (1988) ("A person need not execute a formal document to make a choice about artificially administered sustenance. Instead, a person who is competent to make medical decisions at the time of decision about insertion of a feeding tube can decide whether to allow that procedure or not by simply telling the attending physician, who should document the decision in the patient's record.")

187. MD. CODE ANN., HEALTH-GEN. § 5-602(c)(2)(iii) (1994).

patient care advisory committee or to a court of competent jurisdiction.<sup>188</sup> What constitutes “generally accepted standards of patient care” is left to the judgment of the individual treating physician. Thus, physicians have a great deal of discretion to implement this provision. Although the trigger for referral to one of these higher forums of scrutiny is “generally accepted standards of patient care,” that is not the basis upon which the case would then be reviewed by the advisory committee or a court. For example, in reviewing a petition filed by a health care provider, a court must decide if the agent’s or surrogate’s instruction is consistent with the patient’s preferences and values or, if that is indeterminable, with the patient’s best interest.<sup>189</sup> It is not the role of the committee or court to second guess the physician’s determination of whether the instruction is consistent with general standards of medical practice.

A physician would have the option of following the recommendation of the patient care advisory committee, but the committee’s recommendation is not binding.<sup>190</sup> And, as has been the case since the implementation of the Maryland Patient Care Advisory Committee Act,<sup>191</sup> the physician is still free to make his or her own decision and would be liable for the decision made.<sup>192</sup>

This physician override provision has three relatively unique aspects. The trigger for review—consistent with “generally accepted standards of patient care”—appears unique to Maryland law. In other states, physicians who do not wish to comply with the instructions of an agent or surrogate can rely on a “conscience clause” that they do not have to continue to treat patients if it would be in conflict with their own morals or beliefs about what is appropriate care.<sup>193</sup> Although the provision does not appear in other state statutes, the new Uniform Act states that a health care provider or institution need not provide “health care contrary to accepted health-care standards applicable to that provider or institution.”<sup>194</sup> The second unique fea-

188. MD. CODE ANN., HEALTH-GEN. § 5-612(a)(1) (1994).

189. *Id.* § 5-612(a)(2).

190. *See id.* § 5-612(a)(1)(i) (stating that the health care provider may “[p]etition a patient care advisory committee for advice concerning the withholding or withdrawal of life-sustaining procedure”).

191. *Id.* §§ 19-370 to -374.

192. *Id.* § 19-374(f).

193. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3205(c)(1) (1993); FLA. STAT. ANN. § 765.308 (West 1993); HAW. REV. STAT. § 327D-11(b) (1993); ILL. ANN. STAT. ch. 755, para. 40/35 (Smith-Hurd 1992); KY. REV. STAT. § 311.634(2) (Baldwin 1991); N.H. REV. STAT. ANN. § 137-H:6(II) (Supp. 1992); N.J. STAT. ANN. § 26:2H-62(b) (West Supp. 1992); PA. STAT. ANN. tit. 20, § 5409(a) (Supp. 1992); TENN. CODE ANN. § 32-11-108(a) (1991).

194. UNIFORM ACT, *supra* note 184, § 13(e).

ture of the override provision is the *mandatory* reporting by the physician to an ethics committee or court.<sup>195</sup> No other state statute includes such an affirmative duty on the part of physicians. The third distinct aspect of the provision is the referral to the patient care advisory committee or ethics committee.<sup>196</sup> Although a few other state statutes make reference to the use of an ethics committee,<sup>197</sup> these states do not require use of the committee in this type of situation. The Maryland requirement essentially elevates the role of ethics committees to an alternative to judicial review.

#### D. *Surrogate Decisionmaking*

The final legislative approach reflects a basic trust in the ability of family members to make the "right" choice for their incapacitated relatives. Few burdens obstruct family decisionmaking, although standards for those decisions are provided. Perhaps the most controversial aspect of the legislation was the expansion of family authority to withhold or withdraw life support from a patient lacking decisionmaking capacity in those circumstances where the patient has an "end-stage condition."<sup>198</sup> As stated above, initially SB 664 used the term "inevitably fatal condition."<sup>199</sup> This term was changed during the legislative process to "end-stage condition" and the definition was tightened to narrow its application. The initial definition of the term "end-stage condition" was:

an advanced, irreversible condition caused by injury, disease or illness that:

- (1) has caused severe and progressive deterioration; and
- (2) to a reasonable degree of medical probability, will cause the individual to suffer further progressive deterioration until a medically foreseeable death, whether or not life-prolonging procedures are provided.<sup>200</sup>

The definition was amended in the House by a working group of the Environmental Matters Committee<sup>201</sup> in response to suggestions made

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195. MD. CODE ANN., HEALTH-GEN., § 5-612(a) (1994).

196. *Id.*

197. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3231(B) (1992); COLO. REV. STAT. § 15-18.5-103(6) (1992); NEW YORK TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY, (supp. to report and proposed legislation) (1993).

198. *See* MD. CODE ANN., HEALTH GEN. § 5-606(b)(1).

199. *See* SB 664, § 5-601(K), 1993 Md. Regular Sess. 3.

200. SB 664, § 5-601(I) (Committee Reprint, Mar. 22, 1993).

201. Delegate Stephen Braun chaired the working group.

by the Maryland Catholic Conference. The final definition reads as follows:

“End-stage condition” means an advanced, *progressive*, irreversible condition caused by injury, disease, or illness:

(1) That has caused severe and *permanent* deterioration indicated by incompetency and *complete* physical dependency; and

(2) For which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.<sup>202</sup>

The changes are significant. The inclusion of the term “progressive” was an effort to distinguish the condition from conditions of severe cognitive impairment and other physical disabilities that are not progressive but constant, such as quadriplegia accompanied by brain damage; severe mental retardation; brain damage and physical incapacities due to a stroke. The concern was that individuals in these last categories who are severely disabled not be denied life support solely because of their disability.<sup>203</sup> However, severely disabled individuals who also have a progressive condition that will lead to continued decline and ultimately death would fit within the category.

The other important amendment was the inclusion of the term “complete” before “physical dependency.” An Opinion of the Attorney General interpreting the term “end-state condition” emphasizes this feature of the definition:

According to the Senate Floor Report on House Bill 1243, the Senate’s intent in insisting on the language “*complete* physical dependency” was “to emphasize that the category of ‘end-stage condition’ only applies to patients who have suffered severe and permanent generalized infirmity from an untreatable irreversible condition.”

Thus, on the one hand, a patient with Alzheimer’s disease who needs help with some aspects of personal care<sup>204</sup>

202. MD. CODE ANN., HEALTH-GEN. § 5-601(i) (1994) (emphasis added).

203. This concern was consistent with another provision of the statute, which prohibited a surrogate from making a decision to withhold or withdraw life support on “either a patient’s preexisting [sic], long-term mental or physical disability, or a patient’s economic disadvantage.” MD. CODE ANN., HEALTH-GEN. § 5-605(c)(3) (1994).

204. “Personal care” means “a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation.” MD. CODE ANN., HEALTH-GEN. § 19-301(k)(1) (Supp. 1993). “Personal care” includes: “(i) Help in walking; (ii) Help in getting in and out of bed; (iii) Help in bathing; (iv) Help in dressing; (v) Help in feeding; and (vi) General supervision and help in daily living.” *Id.* § 19-301(k)(2) (Supp. 1993).

but who is able to engage in other activities independently is not in an "end-stage condition." On the other hand, an Alzheimer's disease patient who has deteriorated to the point where the patient needs help in *all* aspects of personal care might be determined to be in an "end-stage condition." A representative of the Medical and Chirurgical Faculty of Maryland well summarized the legislative objective underlying this language:

"With regard to the 'end-stage condition' definition, the use of 'complete' to modify 'physical dependency' is evidently aimed at describing victims of Alzheimer's Disease and other conditions, who are bed-ridden and suffering from a generalized infirmity that will not improve. A physician who is asked to evaluate whether a patient has experienced 'complete physical dependency' would look to the range of ordinary physical abilities and assess the patient's ability to conduct them independently."<sup>205</sup>

The interpretation makes it clear that the condition will only apply to those who cannot perform *any* of the generally accepted list of activities of daily living without assistance, such as bathing, dressing, eating, walking, toileting.

The second part of the amended definition, however, is somewhat confusing. It states that treatment of the condition must be "medically ineffective."<sup>206</sup> The definition of "medically ineffective" in the statute is treatment that, "to a reasonable degree of medical certainty," will neither "[p]revent or reduce the deterioration of the health of an individual" nor "prevent the impending death of an individual."<sup>207</sup> The Attorney General's Opinion describing "end-stage condition" simply states that "[i]f a treatment would likely 'prevent or reduce the deterioration' in the patient's health that the condition would otherwise cause, then the patient is not in an 'end-stage condition.' . . . But if the underlying condition is, in the phrase of the Senate Floor Report, 'untreatable,' the last element of the definition will have been met."<sup>208</sup> What the Opinion does not do is state how the last part of the definition of "medically ineffective treatment," "that

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205. 78 Op. Att'y Gen. 1155-56 (1993) [Opinion No. 93-019 (June 1, 1993)] (citations omitted).

206. MD. CODE ANN., HEALTH-GEN. § 5-601(i)(2) (1994).

207. *Id.* § 5-601(n).

208. 78 Op. Att'y Gen. at 1156.

which neither prevents deterioration of health or impending death," would be applied to the end stage condition.

In a subsequent letter interpreting the Health Care Decisions Act, the Chief Counsel of Opinions & Advice with the Office of the Attorney General states that the requirement that treatment be medically ineffective refers to the "irreversible condition' itself, not some emergent medical problem," and furthermore that the portion of the definition regarding prevention of impending death, is only pertinent when an individual "faces impending death," and that individuals with an end stage condition, by definition, cannot be facing death.<sup>209</sup> Thus, this prong of the definition of medically ineffective treatment is not relevant to the definition of end stage condition.

In spite of the concerns of a few that the end stage condition provision "goes too far" in allowing surrogates to make decisions to terminate life support, it is consistent with the trends in state law generally. In Virginia<sup>210</sup> and the District of Columbia,<sup>211</sup> there are no limitations tied to the patient's condition on the ability of a surrogate to make a decision to terminate life support for an incapacitated family member. The surrogate must simply act based on the patient's preferences and values or best interests.<sup>212</sup> The new Uniform Health Care Decisions Act, similarly, does not limit surrogate decisionmaking to narrow categories of the patient's condition.<sup>213</sup> Also, many other states have modified the definition of "terminal condition" in their advance directive and surrogate decisionmaking statutes so that it is much broader.<sup>214</sup> In some jurisdictions, for example, the definition

209. Letter from Jack Schwartz, Chief Counsel, Opinions & Advice, Office of Attorney General, to Patricia Kelly, Director, Maryland Catholic Conference 2 (Aug. 11, 1993) (on file with author). The letter further states that the

"end-stage condition" elements of the Act matter only when a patient is not facing impending death. If the patient were facing impending death, the patient would be in a "terminal condition," . . . . To read an "impending death" requirement into the definition [of] "end-stage condition" would make the Act's provisions allowing for advance directives and surrogate decision-making concerning end-stage condition utterly meaningless, adding nothing that could not be done under the rubric of "terminal condition."

*Id.* The letter concludes that this could not have been the intent of the legislature given that the "policy argument over end-stage condition was waged with great intensity precisely because everyone recognized that the category extended beyond those who were on the verge of death." *Id.*

210. VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1993).

211. D.C. CODE ANN. §§ 21-2201 to -2213 (1989).

212. VA. CODE ANN. § 54.1-2986 (Michie Supp. 1993); D.C. CODE ANN. § 21-2206(c) (1989).

213. UNIFORM ACT, *supra* note 184, § 5(f).

214. *See supra* note 56.

of "terminal condition" can be interpreted to include advanced Alzheimer's Disease.<sup>215</sup> Thus, the trend seems to be away from tight constraints on family decisionmaking. Moreover, some authors are critical of the general effort to limit surrogate decisionmaking to categories such as terminal condition and PVS, arguing that these categories are arbitrary and not meaningful and that the focus should be on making decisions that are consistent with what the patient would have wanted or are in the patient's best interest.<sup>216</sup>

1. *Priority of Surrogates/Close Friend.*—The new Maryland law sets forth a list of individuals in order of priority who may make health care decisions for an incapacitated patient. The list includes:

- (i) A guardian for the patient, if one has been appointed;
- (ii) The patient's spouse;
- (iii) An adult child of the patient;
- (iv) A parent of the patient;
- (v) An adult brother or sister of the patient; or
- (vi) A friend or other relative of the patient who meets [certain requirements].<sup>217</sup>

Health care providers must consult these individuals in order of priority.<sup>218</sup> A provider may consult someone lower on the list only if everyone in the higher categories is unavailable.<sup>219</sup>

215. See, e.g., ALASKA STAT. § 18.12.100(7) (1991); COLO. REV. STAT. § 15-18-103(10) (Supp. 1992); KY. REV. STAT. § 311.624(8) (Baldwin 1991); MINN. STAT. § 145B.02 (Supp. 1993); MISS. CODE ANN. § 41-41-113 (1993); NEB. REV. STAT. § 30-3402(13) (Supp. 1992); S.D. CODIFIED LAWS ANN. § 34-12D-1(8) (Supp. 1993); TEX. HEALTH & SAFETY CODE ANN. § 672.002(9) (West 1992).

216. See, e.g., GUIDELINES FOR STATE COURTS, *supra* note 3, at 58, n.82 ("[t]here is . . . an emerging medical/ethical consensus that the use of terms such as 'terminal illness,' 'terminal condition,' and 'imminently dying' often create more confusion than clarity in LSMT decisions, and that regardless of the patient's condition, the overriding concerns for the health care provider in the forgoing of LSMT are: (1) respecting patient autonomy (self determination), and (2) improving patient well being (the weighing of benefits and burdens of one plan of care in comparison with alternatives)").

217. MD. CODE ANN. HEALTH-GEN. § 5-605(a)(2) (1994).

218. *Id.* § 5-605(a)(2) (1994).

219. *Id.* "Unavailable" is defined as

- (i) After reasonable inquiry, a health care provider is unaware of the existence of a surrogate decision maker;
- (ii) After reasonable inquiry, a health care provider cannot ascertain the whereabouts of a surrogate decision maker;
- (iii) A surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider;

An innovation of the final law is the provision allowing a "close friend" to act as surrogate if the patient has no close family members.<sup>220</sup> To serve as a surrogate, someone in this category must complete an affidavit to the patient's attending physician stating: "1. That the person is a relative or close friend of the patient; and 2. Specific facts and circumstances demonstrating that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activities, health, and personal beliefs."<sup>221</sup> The provision was designed to allow individuals other than close family to make medical treatment decisions for incapacitated patients, but to ensure that such individuals actually know the patient well and would be in a position to provide an indication of the patient's preferences regarding medical treatment. Although this provision will undoubtedly be useful in a number of situations where close family members are not available, there are no standards for determining whether the close friend is "close enough." This determination is, in effect, left to the health care providers and the institution. In most cases, there will not be a question of qualifications, but certainly cases will arise where the "close friend" had known the patient at an earlier period in their lives, but had not been in touch with the patient for several years. Will this be sufficient contact? Because the statute does not provide guidance here, health care institutions may want to draft guidelines for consideration in determining the appropriateness of a close friend to act as surrogate or have the institution's patient care advisory committee review affidavits that are problematic on their face.

2. *Standards for Surrogate Decisionmaking.*—As stated above, the legislation reflects the somewhat legalistic approach of defining all terms and providing express standards for decisionmaking.<sup>222</sup> The law provides that surrogates must first base a decision on the wishes of the patient and sets forth expressly what factors the surrogate shall consider in making that determination.<sup>223</sup> These factors include the patient's:

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- (iv) A surrogate decision maker is incapacitated; or
  - (v) A surrogate decision maker is unwilling to make decisions concerning health care for the individual.

*Id.*

220. MD. CODE ANN., HEALTH-GEN. § 5-605(a)(2)(vi) (1994); *see also* ARIZ. REV. STAT. ANN. § 36-3231(A)(6) (1992); FLA. STAT. ANN. § 765.401(1)(g) (West 1992); ILL. ANN. STAT. ch. 755, para. 40/25 (Smith-Hurd 1992).

221. MD. CODE ANN., HEALTH-GEN. § 5-605(a)(3)(iii) (1994).

222. *See id.* §§ 5-601, -605.

223. *Id.* § 5-605(c).



- (i) Current diagnosis and prognosis with and without the treatment at issue;
- (ii) Expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments;
- (iii) Relevant religious and moral beliefs and personal values;
- (iv) Behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;
- (v) Reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and
- (vi) Expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.<sup>224</sup>

If the patient's wishes are unknown or unclear, the surrogate is to make a decision based on the patient's best interest.<sup>225</sup> "Best interest" means that

the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment, taking into account:

- (1) The effect of the treatment on the physical, emotional, and cognitive functions of the individual;
- (2) The degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment;
- (3) The degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and dependency;
- (4) The effect of the treatment on the life expectancy of the individual;
- (5) The prognosis of the individual for recovery, with and without the treatment;
- (6) The risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and
- (7) The religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.<sup>226</sup>

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224. *Id.* § 5-605(c)(2).

225. *Id.* § 5-605(c).

226. *Id.* § 5-601(e).

Other states' health care decisionmaking statutes generally lack such elaborate definitions. Most require that surrogates and agents make decisions that are consistent with the patient's wishes and values or best interests, but go no further than that.<sup>227</sup> The question is whether such definitions will be helpful or confining. Although definitions in general have a tendency to be confining, these definitions are quite expansive when compared to their treatment in judicial opinions and in the literature.<sup>228</sup> It is more likely that they will force surrogates and health care providers to explore all possible evidence of the patient's intent as well as all aspects of his or her best interest.

One noteworthy aspect of the definition of "best interest" is the provision allowing consideration of the patient's religious beliefs and basic values.<sup>229</sup> This provision changes the best interest standard from a purely objective one to at least a "limited-objective" test, allowing consideration of these values in conjunction with objective medical criteria.<sup>230</sup>

A second noteworthy aspect of the standards and their application is that surrogates are not required to meet a "clear and convincing evidence" test. Although this is the standard for judicial decisionmaking,<sup>231</sup> it is not applied in the context of surrogate decisionmaking outside of court. Thus, surrogates need not articulate precise statements by the patient with regard to her preferences for artificial nutrition and hydration or other types of life support. They may, instead, rely on their intuitive knowledge of what the patient would want in the circumstances presented.

3. *Disputes Among Surrogates.*—Although the law sets forth a priority listing of individuals who have surrogate decisionmaking author-

227. See, e.g., ME. REV. STAT. ANN. tit. 18-A, § 5-707(d) (West Supp. 1993); MINN. STAT. § 145B.06 (Supp. 1994); N.H. REV. STAT. ANN. § 137-J:2 (Supp. 1993); VA. CODE ANN. § 54.1-2986(A) (Michie Supp. 1993); WIS. STAT. ANN. § 155.20(5) (West Supp. 1993); UNIFORM ACT, *supra* note 184, § 5(f).

228. See, e.g., Conservatorship of Drabick, 245 Cal. Rptr. 840, 861 (Cal. Ct. App. 1988) (stating that under a good faith standard, a conservator must consider information relevant to the conservatee's best interest); Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987) ("Under the best interest standard, the surrogate decisionmaker assesses what medical treatment would be in the patient's best interest as determined by such objective criteria as relief from suffering, preservation or restoration of functioning, and quality."). See generally Jeffrey Delaney, Comment, *Specific Intent, Substituted Judgment and Best Interests: A Nationwide Analysis of an Individual's Right to Die*, 11 PACE L. REV. 565 (1991).

229. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(7) (1994).

230. See Pollack, *supra* note 77, at 518-25 (reviewing the continuum of substitute judgment and best interest tests applied by courts).

231. See MD. CODE ANN., EST. & TRUSTS § 13-712(b) (Supp. 1993).

ity,<sup>232</sup> disputes are still possible. When the dispute is between individuals of the same rank, e.g., adult children, parents or adult siblings, the law provides a unique dispute resolution process—referral to the institution's patient care advisory committee.<sup>233</sup> The committee then may recommend a course of action to the physician.<sup>234</sup> The physician may act in accordance with the recommendation of the committee without fear of liability for any claim based on lack of consent.<sup>235</sup>

This provision is also unique among state health care decision statutes. Many statutes simply provide that a health care provider may act based on the position of the majority of individuals within the group.<sup>236</sup> Because of Maryland's requirement that all institutions have a patient care advisory committee,<sup>237</sup> the legislature was able to utilize that mechanism for dispute resolution. Although the process may be preferable to a "majority rule," it does raise some issues for ethics and advisory committees and their ability to handle these types of disagreements. The law places increasing authority and responsibility on these committees without concurrent resources or standards for committee process.<sup>238</sup> These new responsibilities should make committees reflect on their capabilities and processes and prepare for their new role. The new responsibilities argue for better education of committee members, more thorough procedures, and more attention to process by these committees.

In terms of disputes among others on the list, someone lower on the surrogate list who disagrees with the authorized surrogate has the burden of taking the case to court and showing, by a preponderance

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232. MD. CODE ANN., HEALTH-GEN. § 5-605(a) (2) (1994).

233. *Id.* § 5-605(b).

234. *Id.*

235. *Id.*

236. *See, e.g.,* LA. REV. STAT. ANN. § 40:1299.58.5(A)(3) (West 1992); N.C. GEN. STAT. § 90-322(b)(iv) (1993); VA. CODE ANN. § 54.1-2986(A) (Michie Supp. 1993). *But see* COLO. REV. STAT. § 15-18.5-103(4)(a) (Supp. 1993) (stating that it is the responsibility of interested persons, as defined in the statute, to make reasonable efforts to reach consensus as to who should make medical treatment decisions on behalf of the patient. If, however, an interested person disagrees with the decision of the proxy decisionmaker, or if consensus cannot be reached as to who the proxy decisionmaker should be, any interested person may seek guardianship of the patient).

237. *See* MD. CODE ANN., HEALTH-GEN. §§ 19-370 to -374 (1990 & Supp. 1993).

238. Ethics committees generally have been criticized for their lack of due process type protections. *See* Diane E. Hoffmann, *Regulating Ethics Committees In Health Care Institutions—Is It Time?*, 50 MD. L. REV. 746 (1991); Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991).

of the evidence, that the surrogate's instructions were not lawfully authorized by the statute or other state or federal law.<sup>239</sup>

### E. Safeguards

Although not taking the route of SB 676—incorporating numerous, burdensome obstacles to surrogate decisionmaking—the law does include several safeguards to protect against surrogates who may be acting out of self-interest. In addition to the provision that requires physicians to bring a case to the patient care advisory committee or court if it is inconsistent with generally accepted standards of patient care,<sup>240</sup> surrogates who do not act in good faith will lose their immunity from criminal and civil liability.<sup>241</sup> Although “good faith” is not defined, this provision is an effort to get at those cases where the surrogate is clearly motivated by self-interest or interests other than the welfare of the patient. Few such cases have surfaced in the courts.<sup>242</sup>

### F. Medically Ineffective Treatment

The final legislation includes a provision that physicians need not provide care that is “medically ineffective.”<sup>243</sup> The concept has long been recognized in medical practice and law that a physician need not offer therapy to a patient that the physician determines will not be effective. Nor does the statute require a physician to obtain informed consent from the patient in this decision. For example, a physician need not offer chemotherapy to a patient when the physician believes the therapy would not be effective in treating her cancer, nor must he offer the option of surgery if it is not deemed to be of any benefit. Although this general principle has long been recognized, problems have arisen in the area of cardio-pulmonary resuscitation (CPR) and the ability of physicians to write Do Not Resuscitate (DNR) orders without patient consent. The literature has framed the debate as one

239. MD. CODE ANN., HEALTH-GEN. § 5-612(b) (1994). This subsection is in contrast to the provisions of Maryland's former substituted consent statute where substituted consent could not be given if the health care provider was informed in writing that one or more of the persons listed in the statute opposed the decision of the surrogate. MD. CODE ANN., HEALTH-GEN. § 20-107(f)(4) (1990).

240. MD. CODE ANN., HEALTH-GEN. § 5-612(a) (1994).

241. *Id.* § 5-609(c).

242. An exception is the oft-cited case of *In re Guardianship of Stone*, No. 90-5867 (Fla. Cir. Ct. 1991) (considering a dispute between second wife of patient and patient's son over termination of life support in which the patient's son said that his step-mother wanted to prolong Mr. Stone's life so that she would gain more monies under an ante-nuptial agreement).

243. MD. CODE ANN., HEALTH-GEN. § 5-611(b) (1994).

of medical futility.<sup>244</sup> While there is some consensus that CPR is medically futile for some categories of patients, the difficulty has come in defining those categories. In the final legislation, the Maryland legislature took the bold step of attempting to define “medically ineffective treatment.” Treatment is considered “medically ineffective” if “to a reasonable degree of medical certainty,” it will not “(1) [p]revent or reduce the deterioration of the health of an individual; or (2) [p]revent the impending death of an individual.”<sup>245</sup> To ensure that the definition is met, two physicians must certify that the treatment meets the criteria before life-sustaining treatment may be withheld or withdrawn.<sup>246</sup> Whether the definition will help or hinder medical providers is uncertain. The medical community appeared somewhat split over the incorporation of the definition into the bill. The state Medical and Chirurgical Faculty supported the inclusion of the definition in order to guide physicians who were increasingly troubled by the situation where a family member wants everything done for the patient including CPR if the patient suffers cardiac arrest, but the physician believes such intervention is useless and perhaps even cruel.<sup>247</sup> Other physicians seemed to want more discretion in defining the term in their own way.

The term “medically ineffective” is narrowly defined to reflect the concept of physiologic futility—the inability of the proposed treatment to achieve the generally accepted goals of that treatment.<sup>248</sup> In the case of CPR, “physiologic futility” would mean the inability of CPR to restore cardio-pulmonary functioning. The definition does not cover the continuation of artificial nutrition and hydration to a patient in a persistent vegetative state,<sup>249</sup> as the nutrition and hydration would prevent the individual’s deterioration and impending death.<sup>250</sup>

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244. See, e.g., CLAIRE C. OBADE, *PATIENT CARE DECISION-MAKING: A LEGAL GUIDE FOR PROVIDERS* § 10.01 et seq. (1993); Steven H. Miles, *Medical Futility*, 20 *LAW, MED. & HEALTH CARE* 310 (1992); Edward R. Grant, *Medical Futility: Legal and Ethical Aspects*, 20 *LAW, MED. & HEALTH CARE* 330 (1992); Stuart J. Youngner, *Futility in Context*, 264 *JAMA* 1295 (1990) (editorial).

245. MD. CODE ANN., HEALTH-GEN. § 5-601(n) (1994).

246. *Id.* § 5-611(b)(2)(i).

247. See Letter from Louis Breschi, M.D., Chair, Committee on Professional Ethics, to Jose Martinez, M.D., Chair, Legislative Committee 4 (Feb. 3, 1993) (on file with author).

248. OBADE, *supra* note 244, at § 10.01; see also Tom Tomlinson & Howard Brody, *Futility and the Ethics of Resuscitation*, 264 *JAMA* 1276 (1990); HASTINGS CENTER GUIDELINES, *supra* note 81, at 32.

249. See, e.g., *In re Conservatorship of Wanglie*, No. PK-91-283 (Minn. Dist. Ct., Hennepin Co., July 1991).

250. Although an individual in a PVS is not terminally ill and death is not impending, if denied artificial nutrition and hydration, the patient would be expected to die within a very short period of time. The second prong of the definition of “medically ineffective

An effort to expand the definition to include this type of situation would allow the physician, as opposed to the patient or surrogate, to make a decision regarding the quality of life of the patient and the value of keeping that individual alive.

### G. *Transfer Provision*

The provision regarding medically ineffective treatment was somewhat weakened by an amendment to the bill regarding patient transfers. If a patient, agent, or surrogate requests that everything be done for the patient, including CPR, the physician must inform the agent or surrogate of the option to transfer the patient to another provider and must assist in that process.<sup>251</sup> Furthermore, pending the transfer, the provider must comply with the instruction of the patient or the agent or surrogate if failure to comply with the instruction would likely result in the death of the individual.<sup>252</sup> A practical problem may arise in the implementation of this provision if the institution cannot find another physician or institution that is willing to receive the transfer. A question arises regarding how long the institution must continue to provide treatment under these circumstances. The unavailability of a provider willing to take the case would seem to confirm that the proposed treatment is medically ineffective. There are, however, no guidelines for institutions under these circumstances, and most institutions, fearing liability, will opt for the conservative route of continuing to treat the patient. This lack of guidance severely undercuts the ability of a provider or institution to make a decision based on medical ineffectiveness.<sup>253</sup>

### H. *Guardianship*

Regarding the guardianship provisions of the new law, the legislature again chose a middle course somewhat more restrictive than that proposed in SB 664, but less restrictive than that proposed by drafters

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treatment," however, may not be relevant in all cases. For example, would a fetal tissue transplant be medically effective in the treatment of someone with Alzheimer's disease? Probably not since this form of treatment has not been proven effective in reducing the deterioration of the health of an individual with Alzheimer's disease and death is not impending.

251. MD. CODE ANN., HEALTH-GEN. § 5-613(a) (1994).

252. *Id.* § 5-613(a)(3).

253. Since the implementation of the law, the usefulness of the medically ineffective treatment provision has been called into question. The provision was modeled after a similar section in Virginia's Health Care Decision Act. In February 1994, the Fourth Circuit ruled that, in certain circumstances, this aspect of the Virginia law is pre-empted by the Federal Emergency Medical Treatment and Labor Act (EMTALA). *In re Baby K*, 16 F.3d 590 (4th Cir. 1994).

of the committee bill.<sup>254</sup> The initial drafts of SB 664 authorized the guardian to make a decision to withhold or withdraw life-sustaining treatment without court authorization if the patient had made an advance directive instructing that life-sustaining procedures be withheld under the circumstances or if the guardian is the patient's spouse, adult child, parent, or adult brother or sister.<sup>255</sup> The final legislation allows a judge to "authorize a guardian to make a decision regarding medical procedures that involve a substantial risk to life without further court authorization," if the patient has executed an advance directive specifying that the patient did not want life support under the circumstances presented or if the guardian was also the patient's spouse, adult child, parent, or adult brother or sister.<sup>256</sup>

Given the path chosen by the legislature, an attorney representing an allegedly disabled individual in a guardianship hearing will need to petition the court to include a provision in the order authorizing the guardian to make decisions involving the withholding or withdrawal of life support without further court approval.

### I. Court Standards

Finally, the legislation set standards and procedures for judges in hearing cases involving the termination of life support. Unlike the limitations on surrogates, judges are not restricted to approving the withholding or withdrawal of life support when patients are in a terminal or end stage condition or in a PVS. The legislation provides that "[t]he court may approve a request for the withholding or withdrawal of a life-sustaining procedure from a disabled person on the basis of a substituted judgment" and that the court may make such a determination "only on the basis of clear and convincing evidence that the disabled person would, if competent, decide to withhold or withdraw a life-sustaining procedure under the circumstances."<sup>257</sup> This heightened evidentiary standard was consistent with that proposed by the drafters of the committee bill,<sup>258</sup> as well as the recent Court of Appeals decision in *Mack v. Mack*,<sup>259</sup> and numerous other state court opinions.<sup>260</sup> Yet many other states have rejected the clear and con-

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254. Compare SB 676, §§ 13-601 to -713 with SB 664, §§ 13-707 to -708.

255. See SB 664, § 13-708(2).

256. MD. CODE ANN., EST. & TRUSTS § 13-708(c)(2) (Supp. 1993).

257. *Id.* § 13-712.

258. See SB 676, § 13-712(B).

259. 329 Md. 188, 208, 618 A.2d 744, 754 (1993).

260. See, e.g., *McConnell v. Beverly Enters.-Conn., Inc.*, 553 A.2d 596, 605 (Conn. 1989); *In re Guardianship of Browning*, 543 So. 2d 258, 273 (Fla. Dist. Ct. App. 1989), cert. question answered, approved, 568 So. 2d 4 (Fla. 1990); *In re Estate of Greenspan*, 558 N.E.2d 1194,

vincing evidence test<sup>261</sup> and numerous legal scholars have questioned its use in these cases.<sup>262</sup> Despite the controversy over the use of this evidentiary standard, there is considerable authority justifying its use.<sup>263</sup> What is more unusual and troubling, however, is the use of the clear and convincing evidentiary standard in the best interest test of the Health Care Decisions Act. The law provides that

[i]f the court is unable to make a substituted judgment . . . , the court may approve a request for the withholding or withdrawal of a life-sustaining procedure from the [patient] if the court determines, on the basis of *clear and convincing evidence*, that the withholding or withdrawal is in the best interest of the [patient].<sup>264</sup>

The use of the clear and convincing evidence test is somewhat perplexing in this context. As it is stated, it is distinct from a standard that requires that the benefits of the proposed treatment or course of action clearly outweigh the burdens of the treatment, i.e., that there be significantly more evidence of benefit than of burden. Rather, the standard could conceivably be met even if there were only slightly more evidence of benefit than burden, as long as the evidence was clear and persuasive. Moreover, the best interest test is not one that readily lends itself to the quantification of a clear and convincing evidence standard.<sup>265</sup>

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1202 (Ill. 1990); *In re Estate of Longeway*, 549 N.E.2d 292, 300 (Ill. 1989); *In re Swan*, 569 A.2d 1202, 1206 (Me. 1990) (per curiam); *In re Gardner*, 534 A.2d 947, 953 (Me. 1987); *Cruzan v. Harmon*, 760 S.W.2d 408, 425 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Leach v. Akron Gen. Med. Ctr.*, 426 N.E.2d 809, 815 (Ohio Misc. 1980); *In re Peter*, 529 A.2d 419, 425 (N.J. 1987); *In re O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988); *Eichner v. Dillon*, 426 N.Y.S.2d 517, 545 (N.Y. App. Div. 1980).

261. See, e.g., *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988); *In re Guardianship of Doe*, 583 N.E.2d 1263, 1271 (Mass.), *cert. denied*, *Doe v. Gross*, 112 S. Ct. 1512 (1992).

262. See, e.g., Rhoden, *supra* note 77, at 390-91 (arguing that such a high evidentiary standard is unrealistic and inconsistent with the way in which individuals express themselves). Other scholars believe the evidentiary standard has been used not to advance the interests of patients, but rather to advance those of the state. See, e.g., Payton, *supra* note 128, at 613-15.

263. See *supra* note 260.

264. Md. CODE ANN., EST. & TRUSTS § 13-713 (Supp. 1993) (emphasis added).

265. For example, in the context of termination of life support, different individuals may define what constitutes a benefit and what constitutes a burden very differently. For some, a benefit may be death; for others, death may be the ultimate burden.



*J. Application of Best Interest to Patients in a Persistent Vegetative State*

Although the final legislation does not prohibit the application of a best interest test to someone in a PVS, it leaves open the question of how the test would be applied to someone in that condition. The law sets forth seven criteria that an agent, surrogate, or judge must consider in making a best interest assessment/determination regarding the withholding or withdrawal of life support for an incapacitated patient.<sup>266</sup>

Certain of the criteria will not be relevant to someone in a PVS, including that relating to the effect of the treatment on the physical, emotional, and cognitive functions of the patient or that regarding the degree of physical pain or discomfort caused to the patient by maintenance, withholding or withdrawal of treatment.<sup>267</sup> Given the patient's physical condition, medical treatment will not affect the emotional and cognitive functioning of a patient in a PVS. Furthermore, an individual in a PVS cannot experience pain. With respect to the effect on prognosis,<sup>268</sup> the patient will not recover from the PVS no matter what type of treatment is given. The fourth criterion, the effect of the treatment on the life expectancy of the individual,<sup>269</sup> begs the question of whether prolonging the life of a patient with no ability to experience life is a good thing. Similarly, consideration of criterion number six, pertaining to the "risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment,"<sup>270</sup> leaves open the question of what constitutes a risk to someone in a PVS. For example, is risk of death a good or a bad result?

Results obtained by applying the third criterion to a PVS patient, "[t]he degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and depen-

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266. See MD. CODE ANN., HEALTH-GEN. § 5-601(e) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b) (Supp. 1993).

267. See MD. CODE ANN., HEALTH-GEN. § 5-601(e)(1),(2) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(1),(2) (Supp. 1993).

268. See MD. CODE ANN., HEALTH-GEN. § 5-601(e)(5) (1994) (providing that the decisionmaker consider the prognosis for recovery with and without the treatment); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(5) (Supp. 1993).

269. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(4) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(4) (Supp. 1993).

270. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(6) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(6) (Supp. 1993).

gency,<sup>271</sup> depends on the perspective taken. An individual in a PVS cannot experience humiliation or the indignity of extreme dependency. However, if the individual is viewed more holistically—taking into account his prior life and values, then it could more easily be argued that a treatment decision does subject the patient to humiliation or indignity. The seventh provision concerning the religious beliefs and basic values of the patient<sup>272</sup> allows some extrapolation from the patient's earlier life when competent to the patient's existence in a PVS. A broader spectrum of values may be considered when determining best interest than when determining a patient's wishes under a substituted judgment test.<sup>273</sup> These values may include the patient's views about dependency, confinement, medical treatment, illness, and risk-taking.

The factors specified in the statute provide no basis as to how they should be weighed or factored in deciding the patient's best interest. Despite the General Assembly's effort to constrain decisionmakers by defining the parameters of the decision, the definition leaves considerable discretion to those with decisionmaking authority. Given this discretion, the law's definition of "best interest" could allow for a decision to withhold or withdraw life support from someone in a PVS.

#### CONCLUSION

The title of this Article, "The Maryland Health Care Decisions Act: Achieving the Right Balance?" implies that there is a "right" balance in drafting health care decisionmaking legislation. Unfortunately, in a pluralistic society with few universally agreed-upon moral precepts, there is no ethical yardstick by which to measure "rightness" regarding these issues.<sup>274</sup> In the legislative arena, the measure of "rightness" is most often measured by process and satisfaction. In terms of process, the Maryland legislature heard many voices on these issues and made a valiant effort to accommodate them. This law is clearly a step forward for Maryland citizens that will allow them a greater role in decisionmaking regarding their medical treatment. Citizens confronted with a situation similar to that of Nicci Bojanowski

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271. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(3) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(3) (Supp. 1993).

272. MD. CODE ANN., HEALTH-GEN. § 5-601(e)(7) (1994); MD. CODE ANN., EST. & TRUSTS § 13-711(b)(7) (Supp. 1993).

273. Usually in the latter situation involving substituted judgment, the question focuses on a particular treatment and a patient's views regarding that treatment.

274. See, e.g., CANTOR, *supra* note 56, at 98.

and her family will no longer have to go to court to terminate life support for a loved one.

Despite these advances, the passage of this legislation is only one step in the process of assuring that patients will receive the type of treatment they desire at the end of their lives. The implementation of this new law requires that all citizens be educated about their rights and responsibilities under it. Consumers of health care must be made aware of the value of completing advance directives and how to execute them. Health care providers must understand their role under the new law and the rights of their patients and their patients' family members to make health care treatment decisions. Educating health care providers, in particular physicians, about new legal developments in treating patients may prove difficult. Some have attributed it to their general disdain for the law and desire for professional autonomy.<sup>275</sup> In describing a proposed law in New York that is similar to the Maryland Health Care Decisions Act, Jonathan Moreno asserted that "even measures intended to be 'physician-friendly' are greeted by many as another intrusion into clinical reality by amateurs far from the front, along with such objects of scorn as peer review mechanisms and malpractice suits."<sup>276</sup> While the new law undoubtedly reduces physician discretion in some cases, it expands it in others. Moreover, we have reached a point now in the practice of modern medicine where physicians cannot continue to call all the shots. New technologies and procedures raise issues that involve us all as members of a larger community. The initial or continued use of these technologies by the medical profession requires a scrutiny and debate beyond the confines of the medical community. The evolution of the Health Care Decisions Act is an illustration of how such a debate can begin to take place.

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<sup>275</sup>. See Jonathan D. Moreno, *Who's to Choose? Surrogate Decisionmaking in New York State*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 11.

<sup>276</sup>. *Id.*