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THE PRECARIOUS ROLE OF THE COURTS: SURROGATE HEALTH CARE DECISIONMAKING

JOHN F. FADER II*

INTRODUCTION

The Maryland Health Care Decisions Act of 1993\(^1\) should decrease the amount of court involvement in health care decisionmaking. However, even though the Maryland Legislature has created a broad, workable, and practical structure to facilitate health care decisionmaking, disputes will continue to occur. No decision is more important to most individuals than one that affects their right to autonomy in medical decisionmaking, particularly when the decision involves the ultimate issue of whether they live or die. Hopefully and expectedly, most of these disputes will be resolved without court intervention. Virtually every court that has considered the subject of health care decisionmaking has commented that courts should not be involved in these decisions unless absolutely necessary.\(^2\)

Both in Maryland and throughout the country, most life and death decisions are made, as they should be, by the patient and/or his loved ones following consultation with family, physicians, and clergy. This is so even though most individuals have not made advance medical directives.\(^3\) It is likely, however, that litigation will arise when there is a dispute concerning whether a specific individual was competent to

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2. For example, in In re Jobes, 529 A.2d 434, 451 (N.J. 1987), the court stated: “Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient.” Cf. In re Grant, 747 P.2d 445, 456 (Wash. 1987); In re Hamlin, 689 P.2d 1372, 1377 (Wash. 1984).

3. In In re L.W., 482 N.W.2d 60, 67-68 (Wis. 1992), the court commented that “[r]elatively few individuals provide explicit written or oral instructions concerning their treatment preferences should they become incompetent.” The L.W. court noted that in a 1982 poll only 36% of those surveyed had given instructions regarding how they would like to be treated if they ever became too sick to make decisions, and only 23% had put those instructions in writing. Id. at 68 n.8 (citing 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 241-42 (1982)). In another poll, 56% of those surveyed had told family members of their wishes concerning the use of life-sustaining treatment if they entered an irreversible coma, but only 15% had filled out a living will specifying those wishes. Id. (citing American Medical Association Surveys of Physician and Public Opinion on Health Care Issues 29-30 (1988)); see also Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 289 n.1 (1990) (O'Connor, J. concurring) (citing the same surveys).
make a medical directive. Courts also will be called upon to interpret both written and verbal directives. At times, it will be necessary for courts to attempt to ascertain the wishes of an incompetent patient or to determine what steps are in a patient's best interest. There will be other disputes. The potential for statutory and constitutional challenges in "furtherance" of the interests of a patient (or of society)—depending upon the individuals and issues involved—is as open-ended as the initiative of the human mind.

The legal framework with which individual health care decision-making occurs will continue to be influenced by advances in medical science. Tomorrow's scientific achievements will add clarity in some situations and will create problems in others. As always, courts will be called upon to adjudicate controversies and to resolve disputes, including those that involve issues on the cutting edge of life. Moreover, courts will continue to be thrust into health care decisionmaking disputes by virtue of their important and historic role as the ultimate guardian of the person.

This Article attempts to delineate the areas of court involvement in health care decisionmaking, both in the role of guardian and in the role of settler of disputes. It examines relevant case law and the statutory framework provided by Maryland's Health Care Decisions Act of 1993 and seeks to pinpoint areas of concern.

I. THE COURT'S ROLE AS GUARDIAN

A. The Court's General Power to Act as Guardian

Unlike some other states, Maryland has no "public" guardian as such. Any role of public guardian usually is played by the Office on Aging or the Department of Social Services. Courts, however, often play a significant role as well. For some time the circuit court, Maryland's trial court of general jurisdiction, has had the authority to appoint a guardian for a disabled person, or for a minor, either for the

4. The Office on Aging is part of the Executive Department of Maryland Government. It operates at both the state and local government levels. See Md. Code Ann. art. 70B (1988).


7. In their article, Statutory Reform in the Administration of Estates of Maryland Decedents, Minors and Incompetents, 29 Md. L. Rev. 85 (1969), Shale D. Stiller and Roger D. Redden referred to the term "guardian" as a generic term. They wrote that the term "guardian" is "used to describe anyone appointed by a court to manage the property of a minor or 'disabled person.' It will replace terms such as 'committee,' which always had an unpleasant connotation, and 'conservator.'" Id. at 117-18.
limited purpose of making one or more decisions related to that person's health care or to act generally. Moreover, even if the court appoints a guardian, the Court of Appeals of Maryland has stated that the circuit court itself, as a court of equity, remains the actual guardian of the ward:

Lest sight be lost of the fact, we remind all concerned that a court of equity assumes jurisdiction in guardianship matters to protect those who, because of illness or other disability, are unable to care for themselves. In reality the court is the guardian; an individual who is given that title is merely an agent or arm of that tribunal in carrying out its sacred responsibility.

Thus it is clear that the circuit court, in the exercise of its equity powers, has authority over the affairs of a disabled individual. The court is bound to exercise that authority in accord with the laws of Maryland and in particular with the directives of the legislature pertaining to guardians.

8. Md. Code Ann., Est. & Trusts § 13-708 (a)(1)&(2) (Supp. 1993). The statute cautions, however, that "only those powers necessary to provide for the demonstrated need of the disabled person" are to be granted to the guardian. Id.

9. Kicherer v. Kicherer, 285 Md. 114, 118, 400 A.2d 1097, 1100 (1979). The Kicherer case involved a "volcanic" family feud of bickering between coguardians, which led the court to direct that the chancellor take immediate steps to put an end to the manner in which the coguardians were performing their duties. Id. at 115, 119, 500 A.2d at 1101.

10. In Bliss v. Bliss, 133 Md. 61, 72, 104 A. 467, 471 (1918), the court quoted with approval a statement by Chief Justice Daly of New York in The Marsee Merchant's Case, 11 Abb. Pr. (n.s.) 209 (N.Y. Ct. C.P. 1871) (also reported sub nom. In re Colah, 3 Daly 529):

The jurisdiction assumed to be inherent in a State over that unfortunate class of persons within its limits, who are deprived of the use of their mental facilities, may be said to rest upon two grounds—First: Its duty to protect the community from the acts of those who are not under the guidance of reason, and secondly, its duty to protect them, as a class incapable of protecting themselves, which has its foundation in the reciprocal obligations of allegiance and protection, which extends to aliens and strangers who, while they are within the limits of a State, are under the obligations of a temporary and local allegiance, and are entitled to its protection.

Id. at 72. Furthermore, in Matter of Eason, Incompetent, 214 Md. 176, 133 A.2d 441 (1957), commenting on the actions of the Maryland legislature, the Court of Appeals observed:

Indeed, the custody of the person and property of those non compos mentis has been so generally recognized and accepted as a legislative responsibility, both in this country and in England, that it is not susceptible to serious challenge. In this country, this responsibility is subject, of course, to constitutional limitations.

Id. at 183, 133 A.2d at 445.

Tracing the common law origins of such state jurisdiction, the Court of Appeals found that upon a jury determination that an individual was non compos mentis, an English court of chancery obtained jurisdiction over that individual's person and estate. Hamilton v. Traber, 78 Md. 26, 29 (1893). The authority under which such an inquisition was con-
Over the past twenty-five years, the legislature generally has expanded the powers of guardians. For example, in 1969 the legislature reformed the law governing decedents' estates and the conservation and administration of property belonging to minors, incompetents, and other legally disabled persons. The purpose of the 1969 revisions was to simplify and standardize the guardianship laws and to acknowledge the legal reality that thousands of trusts, both *inter vivos* and testamentary, already were operating without court involvement. In its introduction to the statutory revisions, the legislature recognized that the then-existing laws relating to guardians were enacted in the eighteenth century, an era of different legal realities.\(^{11}\)

Although the legislature has gradually expanded the types of activities that guardians can perform without specific court authorization,\(^{12}\) some actions by guardians still require court approval. For example, in addition to the general limitation in the Estates and Trusts Article that "only those powers necessary to provide for the demonstrated need of the disabled person are to be given to the guardian,"\(^{13}\) prior to October 1, 1993, the law required that when a medical procedure involved a substantial risk to the life of a disabled person, the guardian had to seek specific authorization from the court before taking any action.\(^{14}\) There were no exceptions to this rule.

\(^{11}\) See Stiller & Redden, supra note 7, at 117 n.159.

\(^{12}\) See Md. Code Ann., Est. & Trusts § 13-708 (1991) (permitting the court to vest in a guardian the authority to, *inter alia*, establish and change places of abode; provide care, education and training; and to bring actions to compel support to be paid for the ward.)


B. The 1993 Amendments to the Estates and Trusts Article: Expansion of the Court's Power to Delegate Guardianship Decisions

By amending the Estates and Trusts Article—as part of the Health Care Decisions Act of 1993—the legislature now has provided that a court may grant a guardian the right to act without further court authorization in some circumstances, even when a substantial risk to the life of the ward is involved. This authorization, however, is limited to (a) when the disabled person failed to appoint a health care agent, but executed an advance medical directive authorizing the guardian to consent to a medical procedure that involves a substantial risk of death; or (b) when the guardian is also the disabled person's spouse, adult child, parent, or adult brother or sister.

16. Id. § 13-708(c)(2)(i).
17. Id. § 13-708(c)(2)(ii). The Estates and Trusts Article prioritizes the individuals who may be appointed as guardian of the person:

(a) Priorities.—Persons are entitled to appointment as guardian of the person according to the following priorities:

(1) A person, agency, or corporation nominated by the disabled person if he was 16 years old or older when he signed the designation and, in the opinion of the court, he had sufficient mental capacity to make an intelligent choice at the time he executed the designation;
(2) A health care agent appointed by the disabled person in accordance with Title 5, Subtitle 6 of the Health-General Article;
(3) His spouse;
(4) His parents;
(5) A person, agency, or corporation nominated by the will of a deceased parent;
(6) His children;
(7) Adult persons who would be his heirs if he were dead;
(8) A person, agency, or corporation nominated by a person caring for him;
(9) Any other person, agency, or corporation considered appropriate by the court;
(10) For adults less than 65 years old, the director of the local department of social services or, for adults 65 years old or older, the director of the State Office on Aging or local office on aging, except in those cases where the department of social services has been appointed guardian of the person prior to age 65.

Id. § 13-707(a).

In Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993), the Court of Appeals noted that the appointment of a guardian rests solely in the discretion of the equity court and that a statutory preference in the appointment of a guardian, although seemingly mandatory and absolute, is always subject to the overriding concern of the best interest of the ward. Id. at 203, 618 A.2d at 752. The case was sent back to the trial court because that court was said to have merged the issue of whether sustenance could be withdrawn from the disabled person with the issue of who should be guardian. The Court of Appeals found that the trial court had improperly passed over the ward's wife, in favor of his father, who was entitled to a lesser statutory priority in appointment as guardian. Id. at 204, 206, 618 A.2d at 752-53.
These recent changes in the court's guardianship powers not only preserve the equity court's historic prerogative and responsibility to care for its wards, but also bring the guardianship laws into concert with the legislature's strong policy pronouncements in favor of personal autonomy, as found in the Health Care Decisions Act of 1993.\(^{18}\)

Indeed, the recent statutory changes to the guardianship laws firmly support the legislature's mandate that whenever possible an individual patient should have the right to make his or her own medical care decisions and to create a binding advance medical directive memorializing these decisions, especially concerning whether and when to provide, withhold, or withdraw life-sustaining measures. An individual now can rely on the advance medical directive being followed should he or she become incapable of voicing a decision. In such a case, the trial court can be expected to grant a guardian the power to act without further court approval. Under the recent statutory changes, moreover, even when the patient has not made an advance medical directive, the court still may permit the decision to rest with a surrogate decisionmaker who is a member of the patient's family.\(^{19}\)

In all other cases—when a statutorily-qualified individual is not available to serve as guardian and when the patient has not prepared an advance medical directive—the appointed guardian must obtain specific court authorization before consenting to the withholding or

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18. For example, under the Act, the decision to approve, withdraw, or withhold life sustaining measures is to be made in accord with the following priorities: first, by following the expressed desires of a competent individual in a written (or oral) advance directive or in the appointment of a health care agent; second, by surrogate decisionmaking based on the known wishes of a patient; and lastly, if the wishes of the patient are unknown, by making a decision based on the best interest of the patient. See infra notes 37-52 and accompanying text.

19. It is important to note that the Estates & Trusts Article provides that courts "may," but are not required to, authorize guardians to make decisions regarding medical procedures without specific court authorization:

(c) Medical procedures.—

(2) The court may, upon such conditions as the court considers appropriate, authorize a guardian to make a decision regarding medical procedures that involve a substantial risk to life without further court authorization, if:

(i) The disabled person has executed an advance directive in accordance with Title 5, Subtitle 6 of the Health-General Article that authorizes the guardian to consent to the provision, withholding or withdraw of a medical procedure that involves a substantial risk to life but does not appoint a health care agent; or

(ii) The guardian is also the disable person's spouse, adult child, parent, or adult brother or sister.

Md. Code Ann., Est. & Trusts § 13-708(c) (Supp. 1993). The court still can refuse to grant such power to the guardian, and thereby continue to exercise its own power as guardian in the matter.
withdrawal of a life-sustaining medical procedure. That court approval is the same "equity" oversight that has been required for hundreds of years under English and American common law.

The 1993 revisions to the Estates & Trusts Article permit courts to authorize guardians to withhold or withdraw life-sustaining procedures on two grounds. First, the guardian may make a treatment decision on the basis of "substituted judgment," which is defined in the Act as the decision that the disabled person would have made if competent.20 Second, the guardian may base the decision on his or

20. Id. § 13-712(a). "Substituted judgment" is defined by § 13-711(d) to take into account any information that may be relevant to the decision, including:

(1) The current diagnosis, prognosis with and without the life-sustaining procedure, and life expectancy of the disabled person;
(2) Any expressed preferences of the disabled person regarding the provision of, or the withholding or withdrawal of, the life-sustaining procedure at issue;
(3) Any expressed preferences of the disabled person about the provision of, or the withholding or withdrawal of, life-sustaining procedures generally;
(4) Any religious or moral beliefs or personal values of the disabled person in relation to the provision of, or the withholding or withdrawal of, the life-sustaining procedure;
(5) Any behavioral or other manifestations of the attitude of the disabled person toward the provision of, or the withholding or withdrawal of, life-sustaining procedures;
(6) Any consistent pattern of conduct by the disabled person regarding prior decisions about health care;
(7) Any reactions of the disabled person to the provision of, or the withholding or withdrawal of, a comparable life-sustaining procedure for another individual; and
(8) Any expressed concerns of the disabled person about the effect on the family or intimate friends of the disabled person if a life-sustaining procedure were provided, withheld, or withdrawn.

Id. § 13-711 (d). This provision in the Estates & Trusts Article is essentially the same as the section in the Health-General Article that lists the factors to be considered by a surrogate decisionmaker who is to base his or her decision on the "wishes" of the patient. See Md. Code Ann., Health-Gen. § 5-605(c) (1994).

In Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993), the Court of Appeals commented on the "substituted judgment" rule, concluding that an individual entitled to self-determination who becomes incapable of expressing his opinion is entitled to have the courts recognize his right to make a decision according to the "substituted judgment" test:

Where court authorization is sought to withdraw from an incompetent person artificially administered sustenance, viewed as a medical treatment, the standard to apply is determined by the right for which judicial protection is sought. The right is one of self-determination, but, if the person who enjoys the right is in a persistent vegetative state, that person cannot make the determination. To protect the right for incompetent persons, and to permit its exercise, courts apply a rule of "substituted judgment."

From the standpoint of initiating a request to withdraw life-sustaining treatment, the judgment of the guardian or applicant for guardianship is truly substituted for that of the ward. But, from the standpoint of whether the treatment is to be withdrawn, the "substituted judgment" label is a misnomer. The judgment of the guardian is not accepted by the court in lieu of the judgment of the ward.
her own assessment of the "best interest" of a disabled person.21

II. THE COURT AS SETTLER OF DISPUTES

A. The Statutory Scheme of the Health Care Decisions Act of 1993

Although the legislative framework of the Health Care Decisions Act of 1993 is quite encompassing, disputes can be expected to arise in its interpretation. Therefore, it is important to understand the Act's legal background, as well as its contents, to understand the court's role as a settler of these disputes.

Rather, because the right is one of self-determination, the inquiry focuses on whether the ward had determined, or would determine, that treatment should be withdrawn under the circumstances of the case.

Id. at 214-15, 618 A.2d at 757.

21. Md. Code Ann., Est. & Trusts § 13-713 (Supp. 1993). Section 13-711(b) defines "best interest" and lists the factors that are to be considered:

(1) The effect of the treatment on the physical, emotional, and cognitive functions of the disabled person;

(2) The degree of physical pain or discomfort caused to the disabled person by the treatment, or the withholding or withdrawal of the treatment;

(3) The degree to which the disabled person's medical condition, the treatment, or the withholding or withdrawal of treatment, result in a severe and continuing impairment of the dignity of the disabled person by subjecting the individual to a condition of extreme humiliation and dependency;

(4) The effect of the treatment on the life expectancy of the disabled person;

(5) The prognosis of the disabled person 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 disabled person receiving treatment, to the extent these may assist the decisionmaker in determining best interest.

Id. § 13-711(d). This section parallels the provisions of the Health-General Article that define the term "best interest" as guidance for a surrogate decisionmaker. Cf. Md. Code Ann., Health-Gen. § 601(e) (1994). It is clear from a comparison of these two sections that a guardian who makes a decision according to the "best interest" of the ward is to consider the same factors as a surrogate decisionmaker who is not a guardian.

Moreover, the Estates and Trusts Article also permits a court acting as guardian to withhold or withdraw life sustaining measures in accord with the "best interest" of the ward:

(a) In general.—If the court is unable to make a substituted judgment under § 13-712 of this subtitle, the court may approve a request for the withholding or withdrawal of a life-sustaining procedure from the disabled person if the court determines, on the basis of clear and convincing evidence, that the withholding or withdrawal is in the best interest of the disabled person.

(b) Considerations precluded.—The decision of whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic disadvantage.

1. The Legal Background of the Health Care Decisions Act.—Maryland legal history on the issue of consent to medical procedures is limited but fairly complete. It consists of several elements, including prior statutes (both state and federal), opinions of the Maryland Attorney General, and case law from the Maryland courts.22

The Maryland legislature first enacted legislation pertaining to advance medical directives in 1985.23 That legislation was limited in scope and included many restrictions that have been removed by the Health Care Decisions Act of 1993.24 Another statute that made an important contribution to Maryland’s law on patient consent to medical procedures was the federal Patient Self-Determination Act of 1990,25 which became effective on December 1, 1991. That statute requires health care institutions to inform patients about their right to accept or refuse medical treatment. This information is given to competent patients in order to make them aware of their right to make advance directives and to appoint a health care agent to make health care decisions in a surrogate capacity should the patient become unable to make such decisions.26

Further guidance in this area came from an exhaustive and well-written opinion by the Maryland Attorney General in 1988.27 This opinion surveyed the law of informed consent, advance medical directives, and the right to withhold and withdraw life-sustaining measures.

The courts also have provided guidance on the issue of patient autonomy and consent in health care decisionmaking. In Sard v. Hardy,28 the Court of Appeals held that a physician must obtain the patient’s “informed consent” before performing a medical procedure. The court wrote:

22. Two law review articles also have added to the developing understanding of consent to medical procedures. See Kenneth C. Proctor, Consent to Operative Procedures, 22 Md. L. Rev. 190 (1962) (discussing express and implied consent, ineffective consent, persons who were authorized to give consent, and the position of minors, all with regard to consent to operative procedures); Robert E. Powell, Consent to Operative Procedures, 21 Md. L. Rev. 189 (1961) (discussing express consent, implied consent, restrictions and exhaustion of consent, the emergency doctrine, and factors such as fraud, coercion, and mistake that may prevent consent from being effective).
24. For example, this law did not allow a patient to appoint a surrogate to make binding medical decisions on his or her behalf. The Health Care Decisions Act permits such an appointment. Md. Code Ann., Health-Gen. § 5-602(b) (1994).
26. Id.
The doctrine of informed consent, which we shall apply here, follows logically from the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient. In order for the patient's consent to be effective, it must have been an "informed" consent, one that is given after the patient has received a fair and reasonable explanation of the contemplated treatment or procedure.29

The Sard court continued: "By focusing on the patient's need to obtain information pertinent to the proposed surgery or therapy, the materiality test promotes the paramount purpose of the informed consent doctrine—to vindicate the patient's right to determine what shall be done with his own body and when."30 Similarly, in Mercy Hospital v. Jackson,31 the Court of Special Appeals affirmed the patient's right of autonomy by recognizing the right of a Jehovah's Witness to assert freedom of religion as the basis for a refusal to accept a blood transfusion.32

Most importantly, during the 1993 legislative session, the Maryland Court of Appeals decided Mack v. Mack.33 That case involved an application by a guardian to withdraw artificially-administered nutrition and hydration from an individual who was not terminally ill, but who was in a persistent vegetative state.34 In Mack, the court recognized that an individual who has become incompetent has the right to have his or her medical care wishes carried out by medical personnel.35 For cases in which the intent of the patient cannot be ascertained, however, the Mack court declined to adopt a "best interest standard" by which others could make decisions for the patient.36

29. Id. at 438-39, 379 A.2d at 1019.
30. Id. at 444, 379 A.2d at 1022.
32. Id. at 418, 489 A.2d at 1134. In 1989, a similar case concerning a petition to withhold cardiopulmonary resuscitation in the event of cardiac arrest (because of the patient's stroke-induced physical condition) reached the Court of Appeals. The high court bypassed the issue as moot, however, because the patient had died before the court could rule. In re Riddlemoser, 317 Md. 496, 500, 506, 564 A.2d 812, 814, 817 (1989).
33. 329 Md. 188, 618 A.2d 744 (1993).
34. Id. at 191, 618 A.2d at 746.
35. Id. at 200-01, 618 A.2d at 750-51.
36. Id. at 198, 618 A.2d at 749. The "best interest" standard is sometimes referred to as a "reasonable person" or "quality of life" standard.

was against this somewhat involved background that the Maryland legislature crafted the Health Care Decisions Act of 1993.

2. The Health Care Decisions Act of 1993.\textsuperscript{37}—The Health Care Decisions Act recognizes and protects personal autonomy in health care decisionmaking in the following ways. First, a competent individual's written advance medical directive or appointment of a health care agent for decisionmaking purposes is to be honored if the patient later becomes incapable of making his or her own decisions.\textsuperscript{38} The authority of the health care agent is to be respected to the extent and "under the circumstances stated in the advance directive."\textsuperscript{39} Second, a competent individual's \textit{oral} advance directive that authorizes the provision, withholding, or withdrawal of a life-sustaining procedure, or the appointment of a health care agent, also is to be given legal effect.\textsuperscript{40}

Third, the Health Care Decisions Act empowers surrogates to make medical care decisions for a patient based on a "substituted judgment" test.\textsuperscript{41} The Act authorizes individuals (in a specified order


\textsuperscript{38} Md. Code Ann., Health-Gen. § 5-602(a)-(b) (1994). The statute contains a number of suggested forms to serve as guidelines to those making advance medical directives. Id. § 5-603.

\textsuperscript{39} Id. § 5-602(b)(1). The Act also provides: "An agent appointed under this subtitle has decision making priority over any individuals otherwise authorized under this subtitle to make health care decisions for a declarant." Id. § 5-602(b)(3).

\textsuperscript{40} Id. § 5-602(d). A properly made advance oral directive has the same effect as a written advance medical directive "if made in the presence of the attending physician and one witness and documented as part of the individual's medical record. The documentation shall be dated and signed by the attending physician and witness." Id.

\textsuperscript{41} Id. §§ 5-605(a)(2), 5-605(c). The words "substituted judgment" are not used in the statute. Rather, the statute refers to the "wishes of the patient," probably a more instructive phrase. Most courts speak of decisions made on a "substituted judgment" basis, generally meaning "according to the wishes of the patient." See Guardianship of Doe, 583 N.E.2d 1263, 1267 (Mass. 1992) (dealing with life-sustaining health care decisionmaking in guardianship cases and applying the term "substituted judgment"). Similarly, the Estates and
of priority) to make decisions based on their knowledge of what the patient would want in such a situation. The legislature has identified criteria upon which a surrogate may base a "substituted judgment" decision in health care matters. These broad criteria include factors such as the patient's current diagnosis and prognosis with and without the treatment at issue, the patient's expressed the patient's relevant religious and moral beliefs.

Although the legislature has identified criteria for forming a "substituted judgment," there is probably leeway for other factors to be considered. The courts also may have input on this issue. In Mack v. Mack, the Court of Appeals held that

> [t]he scope of the evidence that may be received in the inquiry is as wide as the concepts of relevance and materiality are to the state of mind issue. Oral, as well as written, statements of the ward, made prior to the ward's incompetency, should be considered. Evidence of this character will include any actual, expressed intent or desire to have artificial sustenance withdrawn, but the evidence is not limited to specific, subjective intent evidence. The patient's "philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death" should be explored.

Thus, in "substituted judgment" situations, the evidence that can be used to ascertain the wishes of the disabled patient most likely is limited only by "relevance and materiality."


43. Id. §§ 5-605(c)(2).
44. 329 Md. 188, 618 A.2d 744 (1993).
45. Id. at 215, 618 A.2d at 758 (quoting In re Jobes, 529 A.2d 434 (N.J. 1987)).
46. Id. This conclusion is supported by the legislative pronouncement in the Estates and Trusts Article pertaining to the substituted judgment test, which states:

> (c) Admissibility of evidence required.—Evidence of the intentions or wishes of the disabled person regarding the withholding or withdrawal of a life-sustaining procedure that might otherwise be inadmissible may be admitted, in the discretion of the court, if it is:

1. Material and probative; and
2. The best evidence available.


As the Mack court noted, however, in some cases it is easier to ascertain the wishes of the patient than in others. Mack, 329 Md. at 216-17, 618 A.2d at 758. The Mack court cited as an example the case of Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 632 (Mass. 1986), in which the patient, Mr. Brophy, had made his own wishes clear while dis-
Finally, if the wishes of the patient are not known and cannot be determined, the Health Care Decisions Act authorizes surrogates (in a specified order of priority) to make decisions based solely on the "best interest of the patient." As with a "substituted judgment" decision, the patient's best interest is to be determined according to a statutory list of criteria. These criteria include the effect of the treatment on the physical, emotional, and cognitive functions of the patient; the degree to which the patient's condition and the contemplated treatment would degrade the individual by subjecting him or her to a condition of extreme humiliation and dependency; the effect of the treatment on the patient's life expectancy; the prognosis for recovery with and without the contemplated treatment; the risks and side effects of the contemplated course of action; and the religious beliefs and basic values of the patient.

Unlike a "substituted judgment" situation, however, the Act's list of factors to be considered in determining the "best interest" of the patient probably cannot—and should not—be expanded by court decision. In *Mack*, the Court of Appeals was emphatic in stating that both the determination of a disabled patient's "best interest" and the delineation of factors that go into making that determination are to be left to the legislature.

A best interest test applied to Ronald or 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 judgment under judicially adopted standards, without any legislative guidelines. There are many reasons why it is not appropriate for this Court to do so.

A best interest argument in the subject context presents a complete shift in the substantive legal justification for a court's action. Best interest is not based on the patient's right of self-determination as to whether treatment should be received or rejected, because the absence of any conclusion as to the patient's judgment on that issue is precedent to applying the best interest analysis.

This guidance from the Court of Appeals is important. Abandoning the anchorage of the patient's right of self-determination sets courts

cussing the case of Karen Ann Quinlan with his wife approximately 10 years prior to the time when a decision had to be made concerning his own life. Brophy had stated emphatically that he did not want to live on a life-support system. *Mack*, 329 Md. at 216-17 n.10, 618 A.2d at 758 n.10. Such a statement could serve as the relevant and material evidence upon which to base a substituted judgment.

48. Id. § 5-601(c).
49. *Mack*, 329 Md. at 218, 619 A.2d at 759.
adrift on a sea of conflicting values and subjective weighing of those values. 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 or are not worth living, and how to tell the difference.  

With the strong case law framework of Mack v. Mack and the equally strong legislative framework of the Health Care Decisions Act, the picture is clear for a court acting as settler of disputes concerning health care decisions. A surrogate, acting in accord with "substituted judgment," or secondarily, acting in accord with the "best interest" of the patient, has a clear list of the factors that are to be considered in making crucial health care decisions. The law, however, is not neutral in this regard. It is biased in favor of life. Therefore, unless and until the wishes of the patient can be determined, a court cannot permit a surrogate to elect to withdraw or withhold life-sustaining measures, even under the Health Care Decisions Act.

B. Is the Act a Limitation on the Patient's Right of Autonomy?

The Health Care Decisions Act of 1993 may seem to restrict the right of autonomy of an incompetent patient because the Act (1) limits the patient to the contents of his or her advance directive if no decisionmaking agent has been appointed, (2) allows a surrogate to make decisions based on listed criteria, and (3) states that no decision may be made unless the patient suffers from a terminal or end-state condition, or unless the patient is in a persistent vegetative state.

It is doubtful, however, that the Health Care Decisions Act will limit a patient's right of autonomy. First, the Act is very broad in scope and seeks to give full effect to the patient's wishes. Second, the Act probably should be interpreted broadly because the right of autonomy in medical decisionmaking most likely qualifies for constitui-

50. Id. at 219, 618 A.2d at 759-60.
51. Id. at 206 n.5, 618 A.2d at 753 n.5.
52. In fact, by limiting a disabled patient's means of obtaining substituted judgment or best-interest surrogate decisionmaking to those avenues and criteria approved by the Act, the Act arguably operates as a limitation on the patient's autonomy. As discussed infra Part II.B., however, when the Act is viewed as a codification and extension of the existing case law structure, it can be interpreted more properly as encouraging the clear expression of the patient's wishes and the consideration of all proper and relevant evidence of those wishes.
54. Id. § 5-605.
55. Id. § 5-606. This section of the Act sets forth physician certification requirements that differ based on the patient's condition. Id.
tional protection. In *Cruzan v. Director, Missouri Department of Health,* the Supreme Court emphasized that there is a constitutional liberty interest associated with the right to refuse life saving procedures. Similarly, the *Mack* court stated unequivocally that "parties who are unable to exercise the right to refuse treatment themselves, nevertheless still enjoy the right" to have treatment withheld in recognition of their exercise of autonomy. The Maryland Court of Appeals held that the right to refuse treatment is a basic common law right of the patient "to exercise control over his own body . . . by deciding for himself whether or not to submit to the particular therapy . . . . A corollary to the doctrine is the patient's right, in general, to refuse treatment and to withdraw consent to treatment once begun."

57. Id. at 278, 281. The Maryland Court of Appeals reiterated this view in *Mack.* The *Mack* majority noted that "all of the justices, save Justice Scalia, either flatly stated or strongly implied that a liberty interest under the Fourteenth Amendment gives rise to a constitutionally protected right to refuse life saving hydration and nutrition." *Mack,* 329 Md. at 211, 618 A.2d at 755-56; *see also* Thomas Wm. Mayo, *Constitutionalizing the "Right to Die,"* 49 Md. L. Rev. 103 (1990).
59. *Mack,* 329 Md. at 210, 618 A.2d at 755. A good summary of the historical development of the doctrine of self-determination is found in *In re L.W.,* 482 N.W.2d 60 (Wis. 1992):

In 1891, the United States Supreme Court stated unequivocally that individuals have a right to self-determination: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific Ry. Co. v. Botsford,* 141 U.S. 250, 251, 11 S. Ct. 1000, 1001, 35 L.Ed. 734 (1891). Judge Cardozo expanded this notion to create the doctrine of informed consent: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital,* 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). The logical corollary of the doctrine of informed consent is the right not to consent—the right to refuse treatment. Numerous courts have grounded the right to refuse treatment in whole or in part on the common law right to self determination and informed consent. *See, e.g., Superintendent of Belchertown State Sch. v. Säkewitz,* 375 Mass. 728, 370 N.E.2d 417 (1977); *In re Storar,* 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, *cert. denied,* 454 U.S. 858, 102 S. Ct. 309, 70 L.Ed.2d 153 (1981); *In re Conroy,* 98 N.J.321, 486 A.2d 1209 (1985).

*Id.* at 65; *see also In re Browning,* 568 So. 2d 4 (Fla. 1990) (discussing the right of a surrogate to refuse life-sustaining treatment for an incompetent patient); *Brophy v. New England Sinai Hosp., Inc.,* 497 N.E.2d 626, 628-32 (Mass. 1986) (recognizing evidence of a patient's
Therefore, it is correct, at least as a basic common law right and most probably as a constitutional right as well, to state that a person who is now incapable of making a decision to accept or refuse treatment still has a right to have the law carry out the health care decision that he or she made while competent. The patient's right of autonomy is not absolute, however. "It is subject to 'at least four countervailing State interests: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.'"\(^6^0\) Nonetheless, although the state can require that proof of the patient's wishes be proved by clear and convincing evidence before it allows a surrogate to act for the patient in withdrawing or withholding life-supporting measures,\(^6^1\) the state's interests pale in comparison to the basic right of the individual to autonomy in medical care decisionmaking.\(^6^2\)

Overall, when the Health Care Decisions Act is read together with the broad pronouncements in Mack, it is clear that the patient's right to self-determination is paramount and that the courts generally should respect and enforce advance directives when acting in their role as settlers of disputes. Even in cases in which an attending medical practitioner may be reluctant to accept a medical directive document—for example, one that is technically flawed because it contains only one witness signature instead of two\(^6^3\)—a trial court would most

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\(^6^1\) See Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 271 (1990); Mack, 329 Md. at 215-16, 618 A.2d at 758.

\(^6^2\) In In re L.W., 482 N.W.2d 60 (Wis. 1992), the court addressed the preeminence of the patient's interests:

[T]his [state interest] weakens as the degree of bodily intrusion increases and the chance of recovery wanes. At a certain point, treatment serves only to prolong the dying process unnaturally, and at this point the patient's liberty interest in refusing treatment prevails. An unqualified state interest in preserving life irrespective of either a patient's express wishes or of the patient's best interests transforms human beings into unwilling prisoners of medical technology.

Id. at 74 (citations omitted). Similarly, in Thor v. Superior Court, 855 P.2d 375 (Cal. 1993), the California Supreme Court gave only minimal consideration to the state's interests: "It is anathetical to our scheme of ordered liberty and to our self respect for the autonomy of the individual for the State to make decisions regarding the individual's quality of life." Id. at 383, 385.

\(^6^3\) MD. CODE ANN., HEALTH-GEN. § 5-602(c)(1) (1994).
probably give it legal effect. Therefore, in practice, the Health Care Decisions Act should not limit a patient’s right of autonomy.

C. Some Other Issues

The Health Care Decisions Act of 1993 was enacted after much debate and thought and with awareness of other state legislative schemes and after the analysis of many appellate court decisions throughout the United States. Hopefully, the Act will fulfill its purpose of protecting patients by minimizing disputes over their treatment. Experience, however, dictates that disputes are inevitable. Below is a discussion of some, but certainly not all, of the potential areas of dispute that may arise under the Act.

1. Competency.—Competent individuals, of course, can make their own health care decisions. Actions are taken pursuant to an advance medical directive or through a surrogate decisionmaking process only when an individual is or has become incapable of making an informed decision. Therefore, it is inevitable that disputes will arise concerning the patient’s competence to make decisions. Questions of competence arise in several different contexts: whether the patient was competent when the advance directive was written, when the agent was appointed, or when the verbal directive was given; whether the patient is “incapable” today to make his or her own decision; and whether the advance directive or surrogate’s decision will control. Most judges will agree, however, that these questions are rarely that troublesome and are often rather routine.

Furthermore, the Act provides some guidance for determining when the patient is incompetent. The Health Care Decisions Act defines the term “incapable of making an informed decision” as

64. Id. §§ 5-602(e), 5-606.
65. In Thomas L. Hafemeister et al., The Judicial Role in Life-Sustaining Medical Treatment Decisions, 7 Issues in Law & Med. 53 (1991) the authors point out that, from a summary of responses to inquiries from trial judges, three issues predominate in this area of court decisionmaking: (1) patient competency, (2) appointment of a surrogate decisionmaker, and (3) resolution of the ultimate issue of foregoing life sustaining medical treatment. Id. at 53-54. Similarly, the American Hospital Association asserted in its amicus curiae brief in the Cruzan case that, of the 1,300,000 people who die in American hospitals each year, 70% die after a decision is made to forego life-sustaining medical treatment. Id. at 63 n.19 (citing Amicus Curiae Brief of the American Hospital Association at 3, Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261 (1990)). According to the article, there were fewer than 100 published judicial opinions between 1970 and 1989 on the subject of the withdrawal or withholding of life-sustaining measures following patient incompetence. Id. The results of the survey were based on responses from 2357 then-current state trial judges who had held hearings in at least one case. Id.
the inability of an adult patient to make an informed decision about the provision, withholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision.\textsuperscript{66}

Incapacity also can take different forms. An individual may be sufficiently disabled as to be unable to manage his or her property or person generally, but still be able to make health care decisions. The Act requires that a physician certify that an individual is incapable of making health care decisions before the advance directive becomes effective.\textsuperscript{67}

It is important, moreover, to understand the difference between the statutory threshold of incapacity—as a condition precedent to surrogate health care decisionmaking—and the threshold of incapacity for appointing a guardian of the person. Judges and attorneys who deal with guardianship matters are aware that there are occasions when an individual is incapable of managing his or her property or person, but still sufficiently competent to make a will disposing of his or her property.\textsuperscript{68} Indeed, the threshold degree of “inability to function” that warrants the appointment of a guardian normally is lower than the threshold of inability for being declared “incapable of making an informed decision.”\textsuperscript{69} The latter, higher threshold must be

\textsuperscript{66} \textit{MD. CODE ANN., HEALTH-GEN.} § 5-601(o)(1) (1994).

\textsuperscript{67} Id. § 5-606 (containing the statutory provisions setting forth the requirements for medical certification of incapacity and the condition of a patient). The medical certification requirements may differ depending upon the condition of the patient and the type of treatment being contemplated. \textit{Id.}

\textsuperscript{68} For a guardianship to be established on the basis of physical or mental disability, the Estates and Trusts Article requires a showing that the patient is unable to “provide for his daily needs sufficiently to protect his health or safety.” \textit{MD. CODE ANN., EST. & TRUSTS} § 13-101(d)(2)(i) (1991). That Article sets forth separate grounds upon which a guardian of the person may be appointed:

A guardian of the person shall be appointed if the court determines from clear and convincing evidence that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including provisions for health care, food, clothing, or shelter, because of any mental disability, senility, other mental weakness, disease, habitual drunkenness, or addiction to drugs, and that no less restrictive form of intervention is available which is consistent with the person's welfare and safety.

\textit{Id.} § 13-705(b).

\textsuperscript{69} In Miller \textit{v.} Rhode Island Hosp., 625 A.2d 778 (R.I. 1993), the court stated that “the trial justice’s presumption that a patient must be legally incompetent or of unsound mind in order for a hospital to dispose of the informed-consent requirement is too broad.” \textit{Id.} at
reached before an advanced directive, appointment of a health care agent, or surrogate decisionmaking may become operative to govern health care decisionmaking.\textsuperscript{70} As a practical matter, courts are most careful to recognize that an individual's right of autonomy (in will-making, health care decisionmaking, and otherwise) very often exists even though he or she is a ward of the court.

2. \textit{The Surrogate Priority Position}.—Individuals eligible to act as surrogates for a patient are listed, in order of priority, in the Health Care Decisions Act:

The following individuals or groups, in the specified order of priority, may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent in accordance with this subtitle. Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable.

(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 the requirements of [the following paragraph] of this subsection.\textsuperscript{71}

Disputes may arise from this statutory prioritization when a person who would be appointed as surrogate under the Act holds a position that is at odds with the wishes or best interests of the patient or with another potential surrogate of equal priority.\textsuperscript{72} It is unclear whether

\textsuperscript{785} The court also observed that "the capacity to make medical decisions need not be synonymous with one's sanity or legal capacity." \textit{Id.} The mental capacity to make a decision is to be evaluated "according to particular circumstances involved rather than [being derived] from a general presumption." \textit{Id.} (citations omitted). The question of a patient's competence to consent to a medical procedure is thus one of fact. \textit{Id.}

\textsuperscript{70} \textsc{Md. Code Ann., Health-Gen.} § 5-606 (1994).

\textsuperscript{71} \textit{Id.} § 5-605(a)(2) (1994). At the lowest level of priority, the "friend or other relative," there is an additional requirement that the potential surrogate present an affidavit to the attending physician attesting to his or her qualifications to serve as a surrogate. The affidavit must set forth specific facts and circumstances demonstrating, \textit{inter alia}, that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activities, health, and personal beliefs. \textit{Id.} § 5-605(a)(3).

\textsuperscript{72} \textit{Id.} § 5-605(b) (addressing the problem of conflicts between persons with equal decisionmaking authority).
courts have discretion to change the statutory priority in selecting a surrogate. The statute, however, should not be interpreted to allow a surrogate to make a decision that is contrary to the wishes of the patient or that is against the patient’s best interest merely because that surrogate has a higher priority under the Act than another individual.

The answer to this question of surrogate priority probably lies in the *Mack* decision. In the guardianship context of the Estates and Trusts Article, the Maryland Court of Appeals stated in *Mack* that the order of preference in the appointment of a guardian is always subject to the court’s overriding concern for the best interest of the ward and that the decision of whom to appoint must ultimately lie in the discretion of the trial judge. Moreover, the Health Care Decisions Act provides, above everything else, that a decision is to be made first on the basis of “the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient’s best interest.”

Future litigation concerning the prioritization of surrogates under the Health Care Decisions Act probably will result in a holding similar to that reached in *Mack*. That is, while the statutory priorities must not be lightly overlooked, they may be adjusted, in the discretion of the court, when necessary to assure that the patient’s wishes and best interest are given legal effect.

3. The Best Interest Test.—In the 1993 Act, the Maryland legislature decided to allow a surrogate to act according to a “best interest” test, under which the “best interest” of the patient is to be determined upon consideration of factors enumerated in the statute. The statutory list of criteria is crucial to resolving disputes in this area, especially in light of the Court of Appeals’ decision to shun a judicial definition of the “best interest” test.

73. 329 Md. 188, 618 A.2d 744 (1993).
74. Id. at 203, 618 A.2d at 752 (citations omitted). In *Mack*, the Court of Appeals remanded the case to the trial court for a determination of whether the wife of the disabled person, who had a higher statutory priority under the Estates and Trusts Article than the disabled person’s father, was properly bypassed in favor of the father. Id. at 206, 618 A.2d at 753.
76. Id.
77. See supra notes 47-49 and accompanying text. The factors listed in the Health-General Article are similar to the factors described in the Estates and Trusts Article concerning guardianship matters. See supra note 21 (suggesting a comparison between Md. Code Ann., Health-Gen. § 601(e) (1994) and Md. Code Ann., Est. & Trusts § 13-711(b) (Supp. 1993)).
78. Mack v. Mack, 329 Md. 188, 222, 618 A.2d 744, 761 (1993) (stating that a definition of the best interest test was best left to the legislature). Two judges dissented, however, stating that the articulation of a best interest test was an appropriate step for the court to
The statute leaves certain questions unanswered, however. Noticeably missing from the legislature's list of "best interest" factors are considerations of the financial impact of a contemplated treatment program and the burden it could impose on society's limited resources. These considerations are important. With our society's resource limitations, remedial measures such as rationing of health care already are being discussed. If health care rationing were to occur by statute, it could lead to a situation in which courts give interpretations, frame quality of life structures, and set standards that may be in conflict with the ethical views of the medical profession. It may be wise to consider factors such as financial impact in determining the patient's best interest.

Moreover, there are other statutes that may affect and complicate the determination of a patient's best interest. For example, in In re Baby K., a disagreement arose between parents concerning whether medical treatment should be continued for an encephalic infant. Attorneys argued that withholding the ventilator from the child would violate the Emergency Medical Treatment and Active Labor Act, the

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79. In Mack, the court recognized, but did not act on, these concerns:

The best interest, i.e., reasonable person, standard that [the patient's spouse] seeks enlarges the concept of best interest beyond the needs of the ward to include consideration of the emotional and financial impact on, and desires of, [the patient's] family and of the burden on the limited resources of society. But we are by no means confident that there exists on this quality-of-life question the degree of societal consensus that this Court ordinarily requires before announcing a change in the common law.

Id. at 219-20, 618 A.2d at 760.


Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Child Abuse Act, as amended in 1984, and the Virginia Medical Malpractice Act. The *Baby K.* court ruled that withdrawal of the ventilator would violate the Emergency Medical Treatment and Active Labor Act, the Rehabilitation Act, and the Americans with Disabilities Act. The court declined to express an opinion on the other two statutes. Consequently, in some situations, the "best interest" of a patient may have less to do with the legislature's enumerated factors in health care decisionmaking than with other extralegal or extrajudicial factors, or even with other applicable federal or state statutes.

4. **Medically Ineffective Treatment.**—By providing that a physician is not required to prescribe or render medical treatment that is ethically inappropriate, the Health Care Decisions Act of 1993 addresses an area of frequent ethical controversy: "medically ineffective" treatment. The Act defines "medically ineffective treatment" as treatment or procedures "that, to a reasonable degree of medical certainty, . . . will not: (1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." This part of the Act does not provide *carte blanche* authorization for the physician to proceed on his or her own or to force medical treatment to be provided, withheld, or withdrawn. Although physicians have professional responsibilities to themselves and to their profession—and are not required to render ethically inappropriate treatment—they are subjected to some limitations.

First, the Act states:

[A] patient's attending physician may withhold or withdraw as medically ineffective a treatment that under generally ac-

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88. *Id.*
89. Id. § 5-611(i). The controversial nature of "medically futile" treatment has often been addressed. See, e.g., Allen J. Bennett, *When Is Medical Treatment "Futile"?*, 9 ISSUES IN L. & MED. 35 (1993) (discussing statutory parameters and limitations, examples of some futility issues, definitions of futility, and physician, patient, and societal concerns); Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 16, 35 (1992) (stating that, if the clinician believes that an incompetent patient is "being harmed seriously by futile care that is demanded by a surrogate, the clinician has a duty to try to get the surrogate's decision overridden. It is not the clinician's duty to override [the surrogate's decision] on his or her own . . . .").
cepted medical practices is life-sustaining in nature only if the patient's attending physician and a second physician certify in writing that the treatment is medically ineffective and the attending physician informs the patient or the patient's agent or surrogate of the physician's decision.\textsuperscript{92}

Second, when a physician determines that a patient's wishes or best interests run counter to what the physician feels is appropriate—for example, when the physician concludes that the contemplated treatment is medically futile—the physician cannot simply abandon the patient. There is no requirement that the physician continue to treat that patient, but the Health Care Decisions Act mandates that the physician give notice of his or her intent not to comply with the patient's wishes.\textsuperscript{93} The physician must assist in the transfer of the patient to another health care provider and must maintain the patient's life until the transfer is made.\textsuperscript{94} Third, the Act prohibits the physician from involvement in mercy killing or euthanasia.\textsuperscript{95} Thus, both in the area of medically ineffective treatment determinations and in the realm of physician ethics, the Act provides some guidance but still presents the possibility of dispute.

5. Health Care Provider Court Action.—The Health Care Decisions Act gives a health care provider the right, and in some cases the responsibility, to take action when he or she believes that a surrogate is acting in a manner that is "inconsistent with generally accepted standards of patient care."\textsuperscript{96} In such a case, if the patient is in a hospital or related institution, the health care provider "shall" petition the patient care advisory committee for advice concerning the withholding or withdrawal of the life-sustaining procedure.\textsuperscript{97} If the patient is not hospitalized, the health care provider "shall" seek a court injunction or other relief relating to the life-sustaining procedure.\textsuperscript{98}

The legislature sought to encourage maximum health care provider action by using the word "shall" to describe the physician's legal responsibilities in this area, but the legislature also imposed some limitations on this avenue of action. First, the Act directs a reviewing

\textsuperscript{92} Id. § 5-611(a)(2)(i). The following section adds, "If the patient is being treated in the emergency department of a hospital and only one physician is available the certification of a second physician is not required." Id. § 5-611(a)(2)(ii).

\textsuperscript{93} Id. § 5-613(a)(1)(i).

\textsuperscript{94} Id. § 5-613(a)(2), (3).

\textsuperscript{95} Id. § 5-611(c).

\textsuperscript{96} Id. § 5-612.

\textsuperscript{97} Id. § 5-612(a)(i).

\textsuperscript{98} Id. § 5-612(a)(ii).
court to follow the provisions of the guardianship laws in reviewing surrogate decisionmaking according to the "substituted judgment" or "best interest" standard.\textsuperscript{99} Second, the Health Care Decisions Act permits a court to enjoin the health care provider's action "upon finding by a preponderance of the evidence that the action is not lawfully authorized by this subtitle or by other State or federal law."\textsuperscript{100}

Overall, this section of the Act should not generate much court involvement. Most people will do the "right" thing most of the time. Even so, the legislature has given the patient an important safeguard by allowing the physician to bring a health care provider court action in a proper case. Moreover, with strong pronouncements in the Act and in \textit{Mack v. Mack}\textsuperscript{101} that an individual's interest in autonomy will prevail over the interests of the state and the personal opinions of others,\textsuperscript{102} physicians probably will reserve their input for those situations in which it most properly should be given.

6. \textit{The Competence of Minors}.—The Health Care Decisions Act addresses the capacity of minors to make reasoned choices regarding the provision, withholding, or withdrawal of medical treatment. The Act defines a competent individual as "a person who is at least 18 years of age or who under § 20-102(a) of this article has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision."\textsuperscript{103} This view of minors' competency is consistent with other pronouncements of the law.

\textsuperscript{99} Section 5-612(a)(2) of the Health-General Article refers to sections 13-711 to 13-713 of the Estates and Trusts Article, which define "best interest," "life-sustaining procedure," and "substituted judgment," and discuss the applicability of the "best interest" standard when a substituted judgment is impossible).

\textsuperscript{100} MD. CODE ANN., HEALTH-GEN. § 5-612(b) (1994). Moreover, the Act provides an expedited procedure for this type of action. \textit{Id.} § 5-612(c).

\textsuperscript{101} 329 Md. 188, 618 A.2d 744 (1993).

\textsuperscript{102} See supra notes 59-62 and accompanying text.

\textsuperscript{103} MD. CODE ANN., HEALTH-GEN. § 5-601(f) (1994). The Health-General Article provides, in § 20-102(a), that minors may give informed consent under the following circumstances:

(a) \textit{Minor who is married or parent}.—A minor has the same capacity as an adult to consent to medical treatment if the minor:

(1) Is married; or

(2) Is the parent of a child.

(b) \textit{Emergency treatment}.—A minor has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.

\textit{Id.} § 20-102(a).
The Act, however, does not go far enough in recognizing that some minors have sufficient capacity to make health care decisions. The Supreme Court recognized in Planned Parenthood of Central Missouri v. Danforth\(^\text{104}\) that minors must be permitted to bypass parental consent requirements in order to obtain abortions independently if a court finds that a minor is capable of mature decisionmaking.\(^\text{105}\) Similarly, some minors have sufficient capacity to make decisions regarding life and death, including whether to provide, withhold, or withdraw life-sustaining measures. Respect for a minor's decision is most important when the responsible adult fails to act in the best interests of the child.\(^\text{106}\) In sum, the Act's failure to recognize that some minors' have the capacity for mature decisionmaking in health care matters will raise problems that the courts will be called upon to resolve.

7. Suicide.—Although physician-assisted suicide is at the forefront of public attention with the activities of Dr. Jack Kevorkian in Michigan, the Health Care Decisions Act makes it clear that suicide, euthanasia, and mercy killing are not authorized.\(^\text{107}\) The Act states: "Nothing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."\(^\text{108}\) The Act does not affirmatively state that suicide and mercy killing are illegal or criminal, but the Attorney General of Maryland has interpreted this section of the Act as expressly prohibiting active euthanasia or assisted suicide.\(^\text{109}\)

8. Clear and Convincing Evidence.—The Health Care Decisions Act reflects a broadening of individual rights of autonomy in medical decisionmaking, but the state retains interests in this area as well. Thus, the state may constitutionally require that proof of the "critical facts" in cases involving the withholding or withdrawal of life-sus-

\(^{104}\) 428 U.S. 51 (1976).

\(^{105}\) Id. at 74-75. In that case, the Supreme Court held invalid a blanket parental consent requirement for unmarried women under 18 years of age.


\(^{108}\) Id.

taining medical treatment be made by clear and convincing evidence.110

Maryland's Court of Appeals has expressly rejected a lesser standard of proof for these cases.111 Similarly, a 1990 opinion of Maryland's Attorney General112 presented a well-reasoned statement concerning the nature of "clear and convincing" evidence:

The Court of Appeals has characterized the clear and convincing evidence test in comparative terms: more than a preponderance of the evidence and less than evidence beyond a reasonable doubt. Berkey v. Delia, 287 Md. 302, 319-20, 413 A.2d 170 (1980). More descriptively, Maryland Civil Pattern Jury Instruction 1:8(b) (2d ed. 1984) states that "[t]o be clear and convincing, evidence should be 'clear' in the sense that it is certain, plain to the understanding, and unambiguous and 'convincing' in the sense that it is so reasonable and persuasive as to cause you to believe it."

Applied to the question of substituted judgment when a decision about life-sustaining treatment must be made, this standard calls for a careful assessment of the quality of the evidence. "The probative value of prior statements will vary, depending on the age and maturity of the incompetent patient, the context of the statements, and the connection of the statements to the debilitating event." In re Grant, 109 Wash. 2d 945, 747 P.2d 445, 457 (1987).

The clear and convincing evidence standard seeks to assure that a decision will not be made if "'the evidence is loose, equivocal or contradictory' . . . ." In re Storar and

110. See supra notes 61-62 and accompanying text.
111. Mack v. Mack, 329 Md. 188, 208, 618 A.2d 744, 754 (1993). The court wrote:

Deanna [Mack, the wife of Ronald, the disabled] vigorously argues that the playing field should not, in all cases, be tilted in favor of "life" and against "death," recognizing that "[t]his grim dichotomy seems to leave little room for debate on the issue." Appellant's Brief at 35. Deanna argues that the "issue is whether [Ronald] will have a vegetative existence for the next three or four decades helplessly dependent on others, without any pleasure. . . . Thus, the quality of his very existence is at stake." Id. at 36. Deanna "submits that this grim, degrading result cannot be one that public policy, however defined, can be deemed to favor," so that "this court should not enhance it by adopting an unusual standard of proof."

Deanna's argument, in essence, would have the standard of proof vary, based on the quality of life of the patient. Whether a court, in the absence of legislative guidelines, should undertake to evaluate the quality of the ward's life is a question which we answer, in the negative . . . .

Id. at 209, 618 A.2d at 755. The overwhelming majority of appellate cases around the country have reached the same conclusion. See id. at 208, 209, 618 A.2d at 754-55 (listing such cases).
Eichner, 52 N.Y.2d 363, 379, 420 N.E.2d 64, 72 (1981). As the New Jersey Supreme Court wrote, "an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances." In re Conroy, 98 N.J. 321, 486 A.2d 1209, 1230 (1985).

On the other hand, the clear and convincing evidence standard can be satisfied through testimony that a mature person had thought about the issue of life-sustaining treatment and had expressed his or her desires "forcefully and without wavering," corroborated by testimony that the decision to forego treatment reflected that person’s values.113

Thus, all authorities agree that the clear and convincing standard of proof is applicable to cases arising under the Health Care Decisions Act of 1993.

Conclusion

The Health Care Decisions Act of 1993 has answered many questions and has given much-needed direction regarding the patient’s right of autonomy in health care decisionmaking. All individuals, including wards of the court, may make binding advance medical directives, appoint agents to carry out their wishes, and have family and friends act in accord with those wishes—or, alternatively, in accord with their best interest. Although the law makes clear that it is biased in favor of life, it also states that, above all else, the autonomy of the individual is to be preserved. Future choices in medical care will be influenced by advances in medical science and possibly by health care rationing. It, therefore, was important for both the Maryland legislature and the Maryland Court of Appeals to provide clear guidelines concerning when to provide, withhold, or withdraw life-sustaining medical procedures. Although disputes will inevitably arise, the Health Care Decisions Act of 1993 and the Court of Appeals’s decision in Mack v. Mack will help keep life and death medical decisions out of the courtrooms and will allow more of these decisions to remain with the individual patient and his family and friends, where they belong.

113. Id. at 43-44.