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THE RIGHT TO REFUSE LIFE-SUSTAINING MEDICAL TREATMENT: NATIONAL TRENDS AND RECENT CHANGES IN MARYLAND LAW

KAREN E. GOLDMEIER*

INTRODUCTION

Although scientific advancements in recent years have enhanced the quality of health care for hopelessly and terminally ill patients, new treatment options also have presented patients, families, and health care providers with profound legal and ethical dilemmas. The scope of a guardian's authority to refuse life-sustaining treatment on behalf of an incompetent patient is one increasingly common question that ultimately must be answered independently in each of the fifty states. Because society is generally ill-prepared to handle the problems involved with making life and death decisions for others, courts have been forced into the role of arbiter.

The Maryland Court of Appeals entered into this debate in Mack v. Mack,1 a case in which the wife of a patient who had been in a persistent vegetative state2 (PVS) for eight years sought, against the wishes of other family members, to withdraw her husband’s medical treatment.3 The court ruled that an individual’s views regarding life-sustaining treatment cannot serve as grounds to supersede statutory priority for appointment as a guardian4 and that a guardian cannot

* B.S., Cornell University, 1987; J.D., University of Maryland School of Law, 1993. The author wishes to thank Professor Diane Hoffmann for her helpful suggestions in the preparation of this Comment.
1. 329 Md. 188, 618 A.2d 744 (1993).
2. The American Academy of Neurology has defined “persistent vegetative state” as “a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiologic sleep/wake cycles, but at no time is the patient aware of himself or his environment.” 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 1 (Apr. 21, 1988). The patient is incapable of voluntary action, and the few primitive reflexes that may be present are so basic that they require no brain regulation. Id. This condition is a result of “a functioning brain stem, [but] the total loss of cerebral cortical functioning.” Id. It is, however, not terminal, and the patient can remain in this condition for decades. Id.
4. Id. at 206, 618 A.2d at 753.
direct the withdrawal of life-sustaining treatment for a PVS patient absent clear and convincing evidence of that patient’s wishes.\(^5\) Because the Mack court was forced to make difficult determinations based on a small foundation of law, the court called for assistance from the legislature to help guide future decisions.\(^6\) A few months later, the General Assembly answered this request by passing the Health Care Decisions Act.\(^7\)

The speed with which the legislature moved to address the issues involved in Mack illustrates the impact and importance of the case. This Comment explores the issues the Mack case presented by drawing on the small body of controlling Maryland law that existed at the time the case originated, as well as the legal framework that had evolved in other jurisdictions. It also analyzes the Health Care Decisions Act in the context of this legal background. Part I of this Comment focuses on court concerns regarding guardianship determinations in Maryland prior to Mack. Part II describes the decisionmaking structure governing life-sustaining treatment issues that had evolved in other jurisdictions at the time of the Mack ruling. Part III summarizes the reasoning of the Mack court, and Part IV analyzes the court's conclusion. Finally, Part V explains Maryland’s recent Health Care Decisions Act and illustrates the influence the Mack decision had on this important piece of legislation.

I. THE GUARDIANSHIP DETERMINATION

When an incompetent patient is capable of being kept alive indefinitely through the use of scientific technology, interested parties are usually unanimous in their treatment decisions and courts are reluctant to intervene.\(^8\) In Mack, however, a family dispute forced the

\(^5\) Id. at 217-22, 618 A.2d at 758-61. The court also decided not to grant full faith and credit to a guardianship determination established by a Florida court. Id. at 198-203, 618 A.2d at 749-51.

\(^6\) Id. at 220, 618 A.2d at 760 (“Methods are available to the Legislature, but not to this Court, for determining what society currently accepts in regard to the administration of artificial sustenance to a patient in a persistent vegetative state.”).


\(^8\) See generally In re Jobes, 529 A.2d 434, 451 (N.J. 1987) (“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.”); see also American Bar Association, Standards Relating to Trial Courts § 2.73.5, at 122-23 (1992) (“Disputes regarding a decision to forgo, continue, or withdraw life-sustaining medical treatment . . . preferably should be resolved without court involvement.”); State Justice Institute, Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases 36-37 (2d ed. 1992) (recommending that trial courts decline to hear these cases unless parties cannot agree on the patient’s actual or probable wishes).
Court of Appeals to decide the appropriate course of medical treatment for an incompetent patient.\textsuperscript{9} Issues in \textit{Mack} included which family member should serve as guardian over the ward and whether a potential guardian's philosophy regarding medical care should play a role in the guardianship determination.\textsuperscript{10} Although Maryland law at the time provided no clear answers to these questions, the statute governing the appointment of guardians set forth a basic framework:

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

(1) A person . . . nominated by the disabled person . . . ;

(2) His spouse;

(3) His parents . . . .

. . . .

(c) Selection by court.—(1) Among persons with equal priority the court shall select the one best qualified of those willing to serve. For good cause, the court may pass over a person with priority and appoint a person with a lower priority.\textsuperscript{11}

Before \textit{Mack}, Maryland judges adhered to the statutory scheme of priority and rarely dismissed a guardian based on "good cause."\textsuperscript{12} When they did consider the good cause variable, they looked only to the personal character and competence of a guardian; substantive law, details of family disputes, and an individual's personal beliefs were conspicuously absent from the analysis.\textsuperscript{13}

A. \textit{Grounds for Superseding Statutory Priority}

Maryland judges focus on the personal character and competence of the guardian to assure that a guardianship appointment is in

\begin{itemize}
  \item \textsuperscript{9} \textit{See Mack}, 329 Md. at 194, 618 A.2d at 747.
  \item \textsuperscript{10} \textit{Id.} at 197-98, 618 A.2d at 749.
  \item \textsuperscript{11} \textit{MD. CODE ANN., EST. \& TRUSTS} § 13-707 (1991).
  \item \textsuperscript{12} Courts had little flexibility to appoint new guardians under the former Code. \textit{See id.} § 13-707(c). Delegate Ida Ruben noted the limits on judicial discretion when she introduced the Bill that was eventually codified as §§ 13-705 to -710 of the Estates and Trusts Article:
    \[\text{[The Bill] clearly spells out the authority and duties of a guardian of the person and enumerates the order in which prospective guardians are to be chosen . . . . Stringent guidelines are set for departmental and court procedures concerning protective guardianship . . . . The bases for emergency intervention before full proceedings can be held are also spelled out and limited.}\]
    \textit{Hearings on H.B. 381 Before the Dep't of Legislative Reference} (1977) (floor statement of Ida Ruben, delegate).
  \item \textsuperscript{13} \textit{See MD. CODE ANN., EST. \& TRUSTS} § 13-707 (1991); \textit{see infra} notes 14-22 and accompanying text.
\end{itemize}
the ward’s best interest. Only if a court finds that appointing a guardian based on the statutory scheme of priority is not in the ward’s best interest will it supersede the statute by appointing a guardian it considers better qualified. In adoption cases, for example, courts focus on the ability and interests of contesting parties to provide children with “love and affection and caring.” In Newkirk v. Newkirk, the Court of Special Appeals discarded statutory priority because it found that exceptional circumstances justified awarding custody of teenage children to a twenty-nine year old half-brother with whom they had been living and had developed an “excellent relationship.” Likewise, in In re Adoption No. 09598, the court held that inappropriate conduct by the natural parents made a grant of guardianship to foster parents in the children’s best interest.

In property disputes, courts similarly hesitate to uphold grants of guardianship to individuals who are not conscientious in fulfilling responsibilities. This principle was demonstrated in Law v. John Hanson Savings and Loan, Inc., in which, because evidence indicated that a guardian had issued improper deeds of trust, engaged in usury, and delayed fulfilling financial responsibilities, the court threatened to “act upon its own motion” and dismiss the original grant of guardianship for “good cause shown.”

Although no Maryland court prior to Mack had resolved a guardianship dispute in a medical treatment case, courts in other jurisdictions had confined their focus to the personal attributes of controverted guardians in this context as well. For example, in Barber v. Superior Court, the California Court of Appeals reasoned that [the patient’s] wife and children were the most obviously appropriate surrogates in this case. They were the people who

14. See supra text accompanying note 11 (outlining the statutory rankings of certain individuals in guardianship appointments).
17. Id. at 594, 535 A.2d at 950.
19. Id. at 519-25, 551 A.2d at 147-49.
21. Id. at 512-13, 618 A.2d at 1158.
22. Id. at 514, 440 A.2d at 1159.
23. See, e.g., In re Estate of Longeway, 549 N.E.2d 292, 300 (Ill. 1989) (warning that “greed may taint the judgment of the surrogate decisionmaker”); In re Peter, 529 A.2d 419, 429 (N.J. 1987) (emphasizing the importance of selecting a guardian who cares about the patient); In re Sylvester, 598 A.2d 76, 84 (Pa. 1991) (emphasizing the importance of the guardian’s trustworthiness in carrying out her responsibilities).
would be most affected by the decision and were in the best position to know [his] own feelings and desires. In addition, there was clear evidence that they were concerned for his comfort and welfare . . . .

The New Jersey Supreme Court echoed this sentiment in *In re Conroy* when it stated that "a determination [to withhold medical treatment from a mentally impaired individual] necessitates an inquiry into the guardian's knowledge of the patient and motivations or possible conflicts of interest."\(^2^{27}\)

### B. Limits on Guardians in Medical Decisionmaking

Even after appointing a guardian, Maryland courts in the past have retained authority to play an active role in health-care decision-making when life is at stake.\(^2^{28}\) When the *Mack* case arose, this policy was evidenced in section 13-708 of the Estates and Trusts Article, which provided that

where a medical procedure involves, or would involve, a substantial risk to the life of a disabled person, the court must authorize a guardian's consent or approval for:

1. The medical procedure;
2. Withholding the medical procedure; or

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25. *Id.* at 493 n.2.
27. *Id.* at 1241. Consistent with this reasoning, the court offered the following explanation in *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976), for its decision to defer to the decision of the guardian regarding the withdrawal of his daughter's life support system:

The character and general suitability of Joseph Quinlan as guardian for his daughter, in ordinary circumstances, could not be doubted. The record bespeaks the high degree of familial love which pervaded the home of Joseph Quinlan and reached out fully to embrace Karen, although she was living elsewhere at the time of her collapse. The proofs showed him to be deeply religious, imbued with a morality so sensitive that months of tortured indecision preceded his belated conclusion . . . to seek the termination of life-supportive measures sustaining Karen. A communicant of the Roman Catholic Church, as were other family members, he first sought solace in private prayer looking with confidence, as he says, to the Creator, first for the recovery of Karen and then, if that were not possible, for guidance with respect to the awesome decision confronting him.

*Id.* at 657.

28. This policy is not always followed in other states, which have laws requiring judicial intervention only if the interested parties clearly disagree. See *Drabick v. Drabick*, 45 Cal. Rptr. 840, 844-45 & n.7 (Cal. Ct. App.), *cert. denied*, 488 U.S. 958 (1988).
(3) Withdrawing the medical procedure that involves, or would involve, a substantial risk to the life of the disabled person.29

Moreover, the Court of Appeals made clear its position on the status and authority of guardians in *Kicherer v. Kicherer*,30 in which it explained that “[i]n 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.”31 Consistent with this rationale, the court has appointed guardians while simultaneously denying them the power to consent to an operation for an incompetent ward. For example, in *Wentzel v. Montgomery General Hospital*,32 the court appointed guardians for an incompetent thirteen-year-old female, but refused to allow them to authorize a proposed sterilization procedure.33

C. The Authority of a Guardian to Transfer an Incompetent Patient to a Health Care Facility in Another Jurisdiction

Before the Health Care Decisions Act, the power of Maryland courts to deny a guardian’s request to move an incompetent patient across state lines mirrored their power to veto a guardian’s health care decisions. Just as a guardian lacked the authority to make health care decisions for the ward independent of court supervision, the Estates and Trusts Article also required “court authorization for any change in abode.”34 Thus, guardians could not transfer patients without

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   (b) *Nonexclusive enumeration of permissible powers.*—the rights, duties, and powers which the court may order include, but are not limited to:

   . . . .

   (8) The power to give necessary consent or approval for:

   (i) Medical or other professional care, counsel, treatment, or service;

   (ii) Withholding medical or other professional care, counsel, treatment, or service; and

   (iii) Withdrawing medical or other professional care, counsel, treatment, or service.

   Id.

31. Id. at 118, 400 A.2d at 1100.
33. Id. at 690, 704-05, 447 A.2d at 1247, 1254.

   (a) In general.—The court may grant to a guardian of a person only those powers necessary to provide for the demonstrated need of the disabled person.

   (b) Nonexclusive enumeration of permissible powers.—Subject to subsection (a) of this section, the rights, duties, and powers which the court may order include, but are not limited to:
court approval, and courts had the apparent authority to rule on a proposed transfer outside the realm of an initial guardianship determination.\(^{35}\)

Before Mack, the Maryland patient transfer provision had never been litigated. In fact, the only reported case involving the right to move incompetent patients across state lines was In re Busalacchi;\(^{36}\) a 1991 Missouri Court of Appeals decision. In Busalacchi, the father of a severely brain-damaged twenty-year-old woman attempted to move his daughter to a health care facility in Minnesota.\(^{37}\) As in Mack, opposing parties alleged that he planned to take advantage of the other state's more lenient laws governing the right to discontinue life-sustaining treatment.\(^{38}\) The Busalacchi majority focused on the patient's right to determine her medical treatment and prohibited the transfer on the basis of the patient's best interest.\(^{39}\) In support of its decision, the court emphasized Missouri's policy of "erring on the side of life".\(^{40}\)

The issue that is before us is whether a guardian properly discharges his duties when he attempts to move his ward from the jurisdiction of the court for the ostensible reason of avoiding litigation in Missouri where the decision to remove the feeding tube from his ward may be subject to heightened legal scrutiny. . . . Specifically, we will not permit guardian [sic] to forum shop in an effort to control whether [the patient] lives or dies.\(^{41}\)

The dissent, however, focused on a different issue. Rather than pinning the determination of whether Mr. Busalacchi could transfer his daughter based on the patient's "best interest," the dissent pointed to the rights of a caring parent to guide his daughter's treatment:

"The ultimate question in this case comes down to whether state employed professionals shall be permitted to substitute their judgment for that of the parents. No sanction for that

\(^{35}\) The right to custody of the disabled person and to establish his place of abode within and without the State, provided there is court authorization for any change in abode . . . .

\(^{36}\) See id.


\(^{38}\) Id. at *1. She had been in this condition for three years. Id.

\(^{39}\) Id.

\(^{40}\) Id. at *4.

\(^{41}\) Id. at *5.
type of substitution is granted by the law, unless there is neglect on the part of the parents . . . .” I am unable to conclude that Mr. Busalacchi’s decision . . . is unreasonable or constitutes a “failure to supply the minimum quality of care which the community will tolerate.”

The dissent also stressed the guardian’s right to unrestricted travel throughout the United States and asserted that this right cannot be constrained because of the purpose of the travel. In the dissent’s analysis, the possibility of contradictory court rulings was irrelevant because when state laws differ, the constitutional right to travel permits citizens to take advantage of the more favorable law.

The difference between the approaches of the majority and the dissent in Busalacchi was the focus on whose individual rights were at issue. The majority placed exclusive emphasis on the best interest of the patient. Focusing on an incompetent patient’s best interest is an imperfect approach, however, because it necessarily implicates the personal values of the courtroom judge. On the other hand, while the rights of the guardian are easier to ascertain, focusing on them in a right-to-transfer determination may not adequately address the seriousness of the life or death decision before the court.

II. REMOVAL OF LIFE-SUSTAINING TREATMENT

A. The Law in Other Jurisdictions

During the years following the landmark decision In re Quinlan, courts confronted a growing number of issues stemming from an individual’s right to refuse life-sustaining treatment. Although the facts of these cases have differed, a predictable pattern of decisionmaking has emerged. First, courts recognize both a common law and constitutional right of competent individuals to refuse medical treatment.

42. Id. at *8 (Smith, J., dissenting) (quoting In re C.F.B., 497 S.W.2d 831, 837 (Mo. App. 1973)).
43. Id. at *9 (Smith, J., dissenting) (“A state cannot prevent its residents from travelling to another state to take advantage of the laws of that state.”) (citing Bigelow v. Virginia, 421 U.S. 809 (1975)).
44. Id.
46. See Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 269 (1990) (“[N]o 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.”) (citation omitted).
47. See, e.g., id. at 277-78 (“The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”); Gray v. Romeo, 697 F. Supp. 580, 585 (D.R.I. 1988) (finding that the
Second, although states have an interest in preserving life, an individual's right to refuse treatment can overpower this state interest. Finally, patients do not lose this powerful right should they become mentally incapacitated; rather, courts attempt to ascertain whether that patient's right to refuse medical treatment should be asserted on his or her behalf. The patient's preferences or best interests form the basis of the right to refuse medical treatment. The process of discerning these preferences or interests is carried out through the two tests described below.

1. Substituted Judgment Analysis.—Although living wills and durable powers of attorney are considered the most reliable sources for discerning an incompetent patient's choice regarding medical treatment, an authorized legal document is not always required. The Attorney General of Maryland, for example, has recognized that "to require a written expression in every case would be unrealistic" and has suggested that courts accept other evidence in the form of conversations with family, friends, and doctors to determine a patient's preference. The patient's previous words and acts, although seemingly

right to refuse life-sustaining treatment is "properly grounded in the liberties protected by the Fourteenth Amendment's due process clause"); Quinlan, 355 A.2d at 633 (recognizing the right to privacy as "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances" even if that decision might lead to death).

48. See, e.g., Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body.").

49. See McKay v. Bergstedt, 801 P.2d 617, 620 (Nev. 1990) (permitting a mentally competent quadriplegic to remove his respirator even though his condition was not terminal because he "despaired over the prospect of life without the attentive care, companionship and love of his devoted father" who was dying of cancer). The McKay court wrote:

[A]t some point in the life of a competent adult patient, the present or prospective quality of life may be so dismal that the right of the individual to refuse treatment or elect a discontinuance of artificial life support must prevail over the interest of the State in preserving life.

Id. at 624. See also Quinlan, 355 A.2d at 664 ("[T]he State's interest ... weakens ... as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."); note 90 and accompanying text.

50. See generally notes 51-93 and accompanying text.

51. See In re Browning, 568 So. 2d 4 (Fla. 1990) (finding that a written document expressing the patient's wishes was a significant factor supporting the removal of a feeding tube).

52. See Camp v. White, 510 So. 2d 166 (Ala. 1987) (holding that Alabama's Natural Death Act did not require physicians to obtain written consent from patients before withholding life sustaining procedures).


insignificant at the time, provide courts with evidence on which to determine what the patient's "choice" would be in light of her prognosis.\(^5\) The process of weighing this evidence is labeled the substituted judgment test.\(^6\)

Courts generally apply a stringent "clear and convincing" standard of proof in substituted-judgment cases involving the withdrawal or withholding of life-sustaining treatment.\(^7\) The actual strictness of the standard, however, varies with the facts of the case. When courts analyze the "clear and convincing" quality of a patient's previous expressions, they cannot consider individual statements, incidents, and other items of proof in a vacuum; rather, they analyze them within the context of the particular patient's life.\(^8\) Regardless of the specific label a court chooses for the standard of proof, a premium is uniformly placed on demonstrating responsibility in deciding life and death issues.\(^9\) As a practical matter, courts tend to focus on a number of factors that take on varying weights.

\(^5\) See Longeway, 549 N.E.2d at 300 ("[T]he court should not hesitate to admit any reliable and relevant evidence if it will aid in judging [the patient's] intent.").


\(^8\) \textit{See Drabick}, 245 Cal. Rptr. at 856 ("[A]n incompetent person's own prior informal statements [do not] compel either the continuance or cessation of treatment in a particular case . . . . In order to determine what weight to assign to [the patient's] prior statements, it is necessary to put this debate into context.").

\(^9\) \textit{See Doe}, 583 N.E.2d at 1271 (citation omitted). In \textit{Doe}, the Supreme Judicial Court of Massachusetts stated:

\begin{quote}
We are confident that judges, mindful of the serious consequences following entry of [their] orders, will enter such orders only after carefully considering the evidence and entering specific findings on each factor and then balancing the
\end{quote}
As the number of substituted judgment decisions increases nationwide, the elements of this test have begun to crystalize and clear trends have emerged. Although the precise definition of "substituted judgment" may vary slightly by jurisdiction, the primary characteristic of the test is that it is strictly subjective, respecting the patient's definition of well-being as well as her interest in self-determination.

The factors courts typically consider in a substituted judgment analysis generally fit into one of four categories. First, courts routinely consider statements made by a patient regarding life-sustaining medical treatment and the context in which they were made. Opportunities to make such statements frequently arise in the context of one's job or when one witnesses others who are dependent on life-sustaining technology. For example, in *McConnell v. Beverly Enterprises—Connecticut*, a registered nurse frequently noted before becoming incompetent that she disapproved of life-sustaining medical treatment. She also was adamant that her mother, when dying of cancer, not receive extraordinary care. These comments and actions led the Connecticut Supreme Court to conclude that the incompetent patient had clearly expressed an intent never to become dependent on life-sustaining treatment. Similarly, in *Brophy v. New England Sinai Hospital, Inc.*, the Massachusetts Supreme Judicial Court discontinued the various interests. What we require is careful work and reflection on the part of the judge . . . .

*Id.* (citation omitted). The judge in *Doe* demonstrated the extent of this care by refusing to issue an order until he visited the patient. *Id.* at 1270. Similarly, in *In re Visbeck*, 510 A.2d 125 (N.J. Super. Ct. Ch. Div. 1986), the judge visited the patient to provide "a more careful articulation of [his] fact finding and reasoning." *Id.* at 128.

60. *Compare Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977) (defining "substituted judgment" as the choice "which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person") with *Morgan v. Olds*, 417 N.W.2d 232 (Iowa Ct. App. 1987) ("The decision made should, after considering the patient's actual interests, preferences, present and future incompetency, be the decision that would have been made by the patient if competent.").

61. *See generally President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, Deciding to Forego Life-Sustaining Treatment 132-33 (1983) [hereinafter Deciding to Forego Life-Sustaining Treatment].*

62. 553 A.2d 596 (Conn. 1989).

63. *Id.* at 605.

64. *Id.*

65. *Id.*

life-sustaining treatment of a fireman and emergency medical technician who had made similar comments at work.67

Implicit in the evaluation of opportunities to express medical treatment preferences is the consideration of age. Courts are clear that a patient's young age, and corresponding lack of opportunity to clearly present one's preferences, does not affect her right to self-determination.68 If the remarks admitted into evidence were solemnly spoken and the speaker realized the consequences of her words, her expressed intent is honored.69

Second, a patient's attitude towards her own previous medical care is considered in the substituted judgment analysis. In In re A.C.,70 for example, the District of Columbia Court of Appeals remanded a lower court's decision to prohibit a cesarian section on a terminally ill pregnant woman because it had insufficiently considered the patient's previous medical choices.71 Recognizing that a patient's prior deci-

67. Id. at 631-32, 639-40. Approximately five years before his illness, Brophy received a medal for helping to rescue a man who received extensive burns in a truck fire and died a few months later. Id. at 632 n.22. He tossed the commendation in the trash and said, "I should have been five minutes later." Id. In discussing the accident with his brother, he said, "If I'm ever like that, just shoot me, pull the plug." Id.

68. See In re L.H.R., 321 S.E.2d 716, 722 (Ga. 1984) (holding that the right to refuse medical treatment "rises to the level of a constitutional right which is not lost because of the incompetence or youth of the patient"); In re Beth, 587 N.E.2d 1377 (Mass. 1992) (allowing the removal of life-sustaining treatment for infants under a substituted judgment analysis); cf. In re Doe, 583 N.E.2d 1263 (Mass.) (finding that a profoundly retarded woman in a persistent vegetative state would have chosen to have her life-support system removed), cert. denied, 112 S. Ct. 1512 (1992).

69. See, e.g., In re E.G., 549 N.E.2d 322, 326 (Ill. 1989) ("We see no reason why [the] right of dominion over one's own person should not extend to mature minors."); In re Swan, 569 A.2d 1202, 1203 (Me. 1990) (honoring a lower court's determination that the comments of a teen were spoken in a "serious and deliberate manner" and, therefore, must be considered valid evidence of a previous determination). The Maryland Attorney General has stated that the "clear and convincing" level of proof "can be satisfied through testimony that a mature person had thought about the issue . . . and had expressed his or her desires 'forcefully and without wavering' corroborated by testimony that the decision to forgo treatment reflected that person's values." 75 Op. Att'y Gen. 27, 44 (1990) (quoting McConnell v. Beverly Enters.—Conn., 553 A.2d 596, 604-05 (Conn. 1989)).

An issue arising in cases involving younger patients is that because there is generally less evidence regarding their intent, the few existing pieces of evidence may take on increased significance. See In re Gardner, 534 A.2d 947 (Me. 1987) (finding three clear and convincing statements by a 22-year-old man to be sufficient); Swann, 569 A.2d at 1205 (holding that because a teenage boy had clearly and convincingly expressed his opinion on two separate occasions, life-sustaining treatment could be withdrawn).

When the intent of an older patient is at issue, the court may require comparatively more evidence. See In re Conroy, 486 A.2d 1209 (N.J. 1985) (holding that because no friends or relatives could testify to the patient's feelings about life-sustaining medical treatment, the evidence was insufficient to support a grant to discontinue treatment).


71. See id.
sions regarding medical treatment may reveal related feelings about life-sustaining treatment, the court urged the lower court to attempt to find a "discernibly consistent pattern of conduct or of thought." 72

When no conclusive evidence exists to indicate a patient's preference, a third factor, the patient's general system of values, is considered in the substituted judgment analysis. 73 Courts often rely on the opinions of people close to the patient to discern these values. In In re Greenspan, 74 for example, a patient's daughter acknowledged that she never discussed life-support systems with her father, but asserted that he detested the idea of being incapacitated. 75 The patient's wife also acknowledged never having discussed life-sustaining treatment with her husband, but agreed that he "would never have wished to live without full control of his faculties or as a burden to others." 76 She further stated that he told her on numerous occasions that he would "rather be shot than reside in a nursing home." 77 Based on this testimony, the court vacated the lower court's denial of the petition to discontinue treatment. 78

Courts generally consider the tenets of a patient's religion and the patient's actual religiosity as a component of his or general system of values. In In re Eichner, 79 for example, an eighty-three-year-old former teacher and resident at a Catholic boarding school expressed agreement with the view that "Catholic principles permitted the termination of extraordinary life support systems when there is no reasonable hope for the patient's recovery." 80 In ruling that the patient's treatment could be discontinued when he entered a persistent vegetative state, 81 the court gave great weight to his agreement with these principles. The court in In re Jobes 82 also considered religion in a life-sustaining treatment case. 83 In this case, however, religion played a minimal role because the court found no probative evidence of the

72. Id. at 1250.
73. See generally In re Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989) (espousing consideration of the patient's values in a substituted judgment analysis).
74. 558 N.E.2d 1194 (Ill. 1990).
75. Id. at 1198.
76. Id. at 1197.
77. Id.
78. Id. at 1204. The court remanded the case and directed the lower court to apply the substituted judgment test. See id. at 1205.
80. Id. at 68.
81. Id. at 72.
82. 529 A.2d 434 (N.J. 1987).
83. Id. at 443.
patient's religiosity and her church did not express a position on the issue of medical decisionmaking.\textsuperscript{84}

Courts also consider the actions and general conduct of formerly competent patients to discern their values. For example, a Delaware court considered a patient's membership on her state's Euthanasia Education Council indicative of her view of life-support systems,\textsuperscript{85} and a New York court recognized a patient's agreement with her sister that they would refrain from using medical treatment if either of them were ever hopelessly ill.\textsuperscript{86} In \textit{Gray v. Romero},\textsuperscript{87} a New York court described a patient's previous lifestyle in detail before allowing withdrawal of her treatment:

\begin{quote}
[The patient] was described by all as an active, vibrant and very happy woman. She jogged regularly, almost daily on a four mile route near her home by the ocean. She read avidly, both fiction and nonfiction, loved classical music, and continued to play the piano. She spent much of her time with her children, and she had a special love for her garden. She is described as somewhat shy, quite thoughtful and deep, and as very private. She was also described as a proud person who was meticulous about her appearance and how she presented to others. . . . [She] was a healthy and energetic woman who was rarely, if ever, ill.\textsuperscript{88}
\end{quote}

Based on this evidence, the court concluded that she would prefer to die rather than live without autonomy and independence.\textsuperscript{89}

Finally, a patient's prognosis weighs heavily into the substituted judgment equation. When a patient's illness is curable, the state's interest in preserving life is substantial; when the affliction is incurable, however, and much of the patient's "life" already has been drained, courts are much more willing to grant requests to discontinue treatment.\textsuperscript{90} In \textit{In re Peter},\textsuperscript{91} for example, the New Jersey Supreme Court

\begin{itemize}
\item\textsuperscript{84} Id. at 442-43.
\item\textsuperscript{85} \textit{In re Severns}, 425 A.2d 156, 158 (Del. Ch. 1980).
\item\textsuperscript{87} 697 F. Supp. 580 (D.R.I. 1988).
\item\textsuperscript{88} Id. at 582.
\item\textsuperscript{89} Id. at 587-88.
\item\textsuperscript{90} Courts justify this policy on the principle that a state's normally compelling interest in preserving life is weakened "as the degree of bodily intrusion increases and the chance of recovery wanes." \textit{In re L.W.}, 482 N.W.2d 60, 74 (Wis. 1992). The \textit{L.W.} court reasoned that "[a]t 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." \textit{Id.; see} Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (allowing a mentally astute quadriplegic to remove the nasogastric tube previously inserted into her body against her
focused on the "'prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of . . . biological vegetative existence.'" 92 Combining this analysis with a subjective analysis focusing on actual proof of the patient's preference, the court ordered the treatment to cease. 93

2. The Best Interest Test.—When insufficient evidence renders the application of a substituted judgment test impossible, courts are placed in the difficult position of deciding how to guard an individual's right to withdraw treatment without conclusively knowing whether that individual would choose to exercise this right. 94 In these situations, a number of courts have applied a best interest analysis, in which the surrogate decisionmaker considers the objective costs and benefits of treatment without considering the patient's personal views. The factors involved in the best interest test include:

[T]he patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for

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91. 529 A.2d 419 (N.J. 1987).
92. Id. at 424 (citing In re Quinlan, 355 A.2d 647, 669 (N.J.), cert. denied, 429 U.S. 922 (1976)).
93. Id. at 424-25.
94. See In re Storar, 420 N.E.2d 64 (N.Y.) (finding it unrealistic to attempt to determine whether a profoundly retarded, never-competent adult would want to continue life-prolonging treatment), cert. denied, 454 U.S. 858 (1981). At least one jurisdiction, however, has applied the substituted judgment doctrine to authorize the removal of treatment from persistent vegetative state patients who have never been competent. See In re Beth, 587 N.E.2d 1377 (Miss. 1992) (determining that an infant in a persistent vegetative state would choose, if competent, to have a "do not resuscitate" notice entered on her medical charts).
recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.95

As applied, the best interest test is little more than a stopping point on a subjective-objective decisionmaking continuum.96 At the subjective end are unequivocal expressions of individual preference, such as those provided by living wills and durable powers of attorney. In the middle of the continuum is the substituted judgment test, which involves a careful balancing of less concrete evidence of a patient's intent as well as his or her prognosis. At the objective end is the best interest test, in which the importance of prognosis escalates because evidence of individual preference is unavailable. Under this test, the fact that a patient is in a persistent vegetative state or is terminally ill sometimes has been sufficient to convince a court to discontinue treatment.97 The difficulty in applying this test lies in ensuring that the "best interest" border of the subjective-objective decisionmaking continuum does not operate to disregard the objective value of life.

B. Maryland Law

Before Mack and the Health Care Decisions Act, Maryland law was clear on only one point with respect to decisions involving medi-

95. In re Conroy, 486 A.2d 1209, 1231 (N.J. 1985); see also Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987) (en banc) (noting the importance of "the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination") (quoting DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, supra note 61, at 32); In re Grant, 747 P.2d 445, 457 (Wash. 1987) (en banc) (reciting the Conroy list); In re L.W., 482 N.W.2d 60, 72 (Wis. 1992) (same).


97. See Rasmussen, 741 P.2d at 689 (noting that the patient's best interest would be served by placing "do not resuscitate" orders on her hospital chart because "the medical probability that she would ever return to a cognitive sapient state, as distinguished from a chronic vegetative existence, was virtually non-existent"); In re H.R.R., 321 S.E.2d 716, 723 (Ga. 1984) ("Once the diagnosis is made that the infant [or adult] is terminally ill with no hope of recovery and in a chronic vegetative state with no reasonable possibility of attaining cognitive function, the state has no compelling interest in maintaining life."); In re Torres, 357 N.W.2d 332, 339 (Minn. 1984) ("[C]ontinued treatment beyond a minimal level will often not serve the interests of permanently unconscious patients optimally.") (quoting DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, supra note 61, at 181-83); In re Hamlin, 689 P.2d 1372, 1376 (Wash. 1984) (en banc) (holding that because the patient was in a persistent vegetative state, "the guardian could conclude that it was in Hamlin's best interest to terminate the life support systems"); see also In re Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (allowing parents of a hopelessly ill infant to discontinue treatment); In re Lawrence, 579 N.E.2d 32 (Ind. 1991) (permitting parents of an incompetent daughter in a persistent vegetative state to discontinue treatment).
cal treatment: a competent adult had a right to refuse medical care.98 Although the Code did not expressly guarantee this right, the principle of personal autonomy in medical decisionmaking was imbedded in legislative policy. For example, the Code permitted competent adults to rely on living wills and powers of attorney to establish instructions dictating whether and how life-sustaining treatment could be used should they become incompetent.99 These statutory provisions demonstrate that even before the passage of the Health Care Decisions Act, the legislature was dedicated to preserving patients' personal autonomy in medical decisionmaking.

III. MARYLAND'S CHALLENGE: MACK v. MACK

A. Background

The controversy in Mack arose after an automobile accident left Ronald Mack in a persistent vegetative state.100 The Circuit Court for Baltimore County appointed Ronald's wife, Deanna, his guardian.101 She served in that capacity for close to eight years before learning of the possibility of terminating his husband's treatment.102 By this time, Deanna had moved to Florida,103 where previous court decisions had permitted surrogates to discontinue their wards' life-sustaining treatment.104 Deanna considered moving her husband to Florida in order to terminate his medical treatment,105 but before she was able to do so, Ronald's father and sister submitted a complaint to the
United States District Court for the District of Maryland to enjoin Deanna from taking this course of action. The court issued a temporary injunction forbidding the hospital from discharging Ronald.

Ronald’s father then petitioned the Circuit Court of Baltimore County to obtain guardianship of his son. The court reexamined Deanna’s initial appointment and attempted to choose between the competing candidates for guardian by selecting the family member whose views most accurately reflected those of the previously competent patient. The circuit court weighed the facts and tried to ascertain what Ronald Mack’s preference regarding treatment would have been if he were competent. The Court noted:

Through his father and sister, who desire to hold onto his life, there is recollection of a Ronald who loved life, who would hold onto life, and who had thanked his father for attempting to keep his mother alive at a time she had experienced a cerebral hemorrhage, even though that probably would have meant that his mother would have survived only in a vegetative state. From Deanna Mack, there is recollection of an incident, when the couple visited Ronald’s infirm grandmother, that he commented he would not want to live if he could not do for himself. He had also expressed to Deanna his gratefulness that a friend had died and did not have to suffer, when that friend had been shot. There was testimony that Ronald hated hospitals, doctors, medicine, and confinement. Deanna points to his love of life and sports as an indication he would not want to live in his present unconscious and confined state.

Applying a “clear and convincing” standard of proof, the trial court found these facts to be an insufficient basis on which to determine the patient’s preferred course of treatment. “‘If anything,’” the court wrote, “‘the evidence produces a stalemate.’” In apparent recognition of this “stalemate,” it refused to apply a best interest test and granted the petition for guardianship of Ronald Mack’s father. According to the court, the father’s intention to continue

106. Id.
107. Id.
108. Id.
109. See id. at 194-95, 618 A.2d at 747-48.
110. Id. at 195-96, 618 A.2d at 748 (quoting In re Mack, No. 91-T-103, slip op. at 62 (Cir. Ct. for Baltimore County Mar. 10, 1992 (mem.)).
111. Id. at 196, 618 A.2d at 748.
112. Id. (quoting Mack, No. 91-T-103, slip op. at 63).
113. Id.
treatment would "carry into effect the applicable law of Maryland," which the court interpreted as requiring a disabled life to be continued through the administration of food and water.114 Deanna appealed to the Court of Appeals, which bypassed the intermediate appellate court and granted certiorari.115

B. The Guardianship Determination

The Court of Appeals vacated and remanded the lower court's decision to appoint Ronald Mack's father as guardian, but affirmed the decision to continue Ronald Mack's life-sustaining treatment.116 Writing for the majority, Judge Rodowsky first rejected the circuit court's merging of the issues of guardianship and medical care.117 He reasoned that the guardianship statute's requirement that a guardian obtain court approval before transferring an incompetent patient across state lines118 or ordering the withdrawal of life-sustaining treatment indicated that the guardianship issue should be decided separately from the medical issue.119 The court then decided that, because Deanna recognized the need for additional court approval before she could order the withdrawal of Ronald's life-sustaining treatment, her views neither automatically disqualified her from a guardianship appointment120 nor constituted good cause to overrule her statutory priority to be appointed guardian.121

The court did not, however, automatically grant guardianship to Deanna. Acknowledging that the "statutory preference in the appointment of a guardian . . . is always subject to the overriding concern of the best interest of the ward,"122 the court remanded the case for a full consideration of Deanna's fitness to be guardian.123 In particular, Judge Rodowsky asserted that the circuit court failed to consider issues such as whether Deanna could fulfill her guardianship duties and the extent to which the geographical proximity of Ronald Mack's father tipped the best interest scale in his favor.124

114. Id. (quoting Mack, No. 91-T-103, slip op. at 1).
115. Id.
116. Id. at 197-98, 618 A.2d at 749.
117. Id. at 204, 618 A.2d at 752.
118. Id. at 206 n.6, 618 A.2d 753 n.6 (citing MD. CODE ANN., EST. & TRUSTS § 13-708(b)(2) (1991)).
119. Id. at 205, 618 A.2d at 753 (citing MD. CODE ANN., EST. & TRUSTS § 13-708(c) (1991)).
120. Id. at 205, 618 A.2d at 753.
121. See id. at 204, 618 A.2d at 752.
122. Id. at 205, 618 A.2d at 753.
123. Id. at 206, 618 A.2d at 753.
124. Id. at 204, 618 A.2d at 753.
also noted that although a guardian’s views “are not per se disqualifying from appointment as guardian . . . the court may consider them as a factor in an overall determination.”

Judge Chasanow dissented from the majority’s guardianship determination. First, he asserted that the trial judge’s decision should not have been disturbed unless it was “clearly erroneous” or “an abuse of discretion.” He then distinguished Deanna’s “views” about her husband’s treatment from her “intent” and “apparent ability” to act on her views by removing the gastronomy tube. Because he maintained that her intent and apparent ability to remove the treatment was an appropriate consideration in the lower court’s good cause analysis, he would have upheld the lower court’s decision to grant guardianship to Ronald Mack’s father. Finally, Judge Chasanow argued that additional factors relating to Deanna’s fitness to be guardian, such as “whether [she] could or would fulfill the duties of guardianship,” did not need to be addressed because, as a matter of law, they could only favor Ronald’s father.

C. The Right to Refuse Treatment

After resolving the issue of guardianship, the court turned to Ronald Mack’s right to refuse medical care. Following the traditional pattern established by courts deciding similar cases, the majority first recognized the right of competent adults to refuse medical treatment. It then emphasized that an authorized guardian may exercise this right on behalf of an incompetent patient, but indicated that no legal standards or guidelines governed the determination of this issue.

Thus, the court created its own version of a substituted judgment test, holding that the crucial question was “whether Ronald, while competent, sufficiently had evidenced his views, one way or the other, to enable the court to determine, by clear and convincing evidence, what [his] decision would be under the present circumstances.” Before applying its test, however, the court carefully voiced its reservations:

125. Id. at 206, 618 A.2d at 753.
126. Id. at 229-30, 618 A.2d at 765 (Chasanow, J., concurring and dissenting).
127. See id. at 233, 618 A.2d at 767 (Chasanow, J., concurring and dissenting).
128. Id.
129. Id. at 233-34, 618 A.2d at 767 (Chasanow, J., concurring and dissenting).
130. Mack, 329 Md. at 210-11, 618 A.2d at 755.
131. Id. at 212, 618 A.2d at 756.
132. Id. at 215, 618 A.2d at 758.
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. 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.\textsuperscript{133}

Applying this standard to the facts of \textit{Mack}, the court first found that Ronald had never explicitly made his views or preferences known by executing a living will or durable power of attorney or by taking any other definitive action.\textsuperscript{134} The court then turned to evidence of Ronald's lifestyle, religion, general system of values, and reactions to previous medical treatment.\textsuperscript{135} Finding this evidence to be "conflicting," the court concluded that it did not satisfy the "clear and convincing" threshold of proof and upheld the circuit court's decision.\textsuperscript{136}

After rejecting Deanna's request under a substituted judgment analysis, the majority considered and rejected an application of the best interest test.\textsuperscript{137} The court reasoned that because Ronald's intent was unknown, a conclusion that it was in his best interest to die would be based entirely on his physical condition.\textsuperscript{138} Such a holding, the court continued, would set a precedent for withholding artificially administered sustenance from every patient in a persistent vegetative state who had never expressed views explicit enough to satisfy the clear and convincing standard of proof.\textsuperscript{139} The court warned that this "unworthy" life standard could thereafter expand until it encompassed the lives of the handicapped, the retarded, and others, in a "logical progression" reminiscent of Nazi Germany.\textsuperscript{140}

In justifying its refusal to apply a best interest test, the court pointed to its perception that public consensus had not yet crystallized enough to definitively answer questions regarding the quality of life of

\textsuperscript{133} \textit{Id.} at 214-15, 618 A.2d at 757.
\textsuperscript{134} \textit{Id.} at 215, 618 A.2d at 757.
\textsuperscript{135} \textit{Id.} at 217, 618 A.2d at 758. The court wrote: "The 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." \textit{Id.} at 215, 618 A.2d at 758. "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." \textit{Id.} (quoting Stephen A. Newman, \textit{Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician, and the State}, 5 N.Y.L. SCH. HUM. RTS. ANNUAL 35, 47 (1985)).
\textsuperscript{136} \textit{Id.} at 198, 618 A.2d at 749.
\textsuperscript{137} \textit{Id.} at 217-22, 618 A.2d at 759-61.
\textsuperscript{138} \textit{Id.} at 218, 618 A.2d at 759.
\textsuperscript{139} \textit{Id.} at 221, 618 A.2d at 761.
\textsuperscript{140} \textit{Id.} at 221 n.11, 618 A.2d at 761 n.11.
patients in a persistent vegetative state.\textsuperscript{141} As the court explained, "[w]here 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."\textsuperscript{142} Thus, the court not only refrained from applying any test that would require a "quality of life" judgment,\textsuperscript{143} but also indicated its intention to continue to do so until it received clear guidance from the legislature.\textsuperscript{144}

In his dissent, Judge McAuliffe agreed with the majority that the term "substituted judgment" was a misnomer.\textsuperscript{145} The true question, he reasoned, is "what the ward would wish done under the present circumstances."\textsuperscript{146} Judge McAuliffe considered numerous factors in answering this question, including Ronald's previous reactions to the medical care of others, his values, and his attitude toward health care professionals and institutions.\textsuperscript{147} The strongest influence on Judge McAuliffe's determination, however, was Ronald's prognosis.\textsuperscript{148} The patient, McAuliffe argued, was not "alive" in the traditional sense; he was permanently unconscious, incapable of thought or feeling, and unable to perform any basic functions independently—including eating and breathing.\textsuperscript{149} Because there was no reasonable hope of a cure or remission during Ronald's lifetime, McAuliffe posited that "most reasonable persons would elect to terminate this existence."\textsuperscript{150} He

\begin{itemize}
\item \textsuperscript{141} Id. at 219-20, 618 A.2d at 760.
\item \textsuperscript{142} Id. at 219, 618 A.2d at 759-60.
\item \textsuperscript{143} See id. at 219-20, 618 A.2d 760.
\item \textsuperscript{144} Id. at 222, 619 A.2d at 761 ("Unless and until current public policy, as we perceive it, is changed by the General Assembly, sustaining Ronald and other persons like him, whose desires concerning the withdrawal of artificial sustenance cannot clearly be determined, is a price paid for the benefit of living in a society that highly values human life.").
\item \textsuperscript{145} Id. at 224, 618 A.2d at 762 (McAuliffe, J., dissenting) ("Semantics may be a part of the problem here. 'Substituted judgment' is not a particularly apt term . . . .").
\item \textsuperscript{146} Id.
\item \textsuperscript{147} Id. at 225, 618 A.2d at 763 (McAuliffe, J., dissenting). Judge McAuliffe created his own substituted judgement standard:

\begin{quote}
If Ronald Mack, complete with his personality, predilections, philosophies, beliefs, and values were given competency for a day, and fully informed concerning what had transpired, the condition and environment to which he would shortly and permanently return, the beliefs and desires of his family members, and the prognosis in his case, what decision would he make concerning the discontinuance of artificially administered nutrition and hydration?
\end{quote}
\textit{Id.} at 225-26, 618 A.2d at 763 (McAuliffe, J., dissenting).
\item \textsuperscript{148} Id. at 227, 618 A.2d at 763-64 (McAuliffe, J., dissenting).
\item \textsuperscript{149} Id. at 226, 618 A.2d at 763 (McAuliffe, J., dissenting). Ronald had a tracheostomy to permit suctioning of lung secretions and a surgically implanted gastronomy tube for nutrients. \textit{Id.}
\item \textsuperscript{150} Id. at 227, 618 A.2d at 763-64 (McAuliffe, J., dissenting).
\end{itemize}
concluded that absent evidence indicating that Ronald would prefer to maintain any semblance of life, "it is not only permissible, but indeed necessary, to attribute to the ward the inclination or desire of an ordinary, prudent person under the same circumstances . . . and to give that factor the heavy weight it deserves . . . ."\(^{151}\)

Judge Chasanow concurred with the majority's decision to maintain treatment, but agreed with Judge McAuliffe's sentiment on the patient's physical condition. He wrote that "it is doubtful that society 'highly values' life in a persistent vegetative state."\(^{152}\) In addition, he stated that "'[s]ince [the Quinlan case], public opinion polls have revealed an impressive shift of opinion in just one generation from a majority opposed to "pulling the plug" on permanently comatose patients to a large majority—sometimes nearing 90%—in favor of such measures.'"\(^{153}\) He also noted that this view dominates current writings on medical ethics.\(^{154}\) In light of this evidence, Judge Chasanow asserted that judicial intervention should be unnecessary when health care providers and people close to the patient unanimously agree to terminate treatment.\(^{155}\) Only when family members and health care providers differ in opinion, he urged, must treatment be continued absent clear evidence of the patient's previous views to the contrary.\(^{156}\)

\(^{151}\) Id. at 228, 618 A.2d at 764 (McAuliffe, J., dissenting).

\(^{152}\) Id. at 236, 618 A.2d at 768 (Chasanow, J., concurring and dissenting).

\(^{153}\) Id. at 236-37, 618 A.2d at 768 (Chasanow, J., concurring and dissenting) (quoting Sanford H. Kadish, Letting Patients Die: Legal and Moral Reflections, 80 CAL. L. REV. 857, 860 (1992)).

\(^{154}\) Judge Chasanow wrote:

[T]he textbook, Clinical Ethics, has been used for the mandatory course in medical ethics at the University of Maryland School of Medicine for the last four years. In discussing when it is "ethically permissible" to discontinue respiratory support, that textbook states: "(1) . . . [T]he state of an irreversible loss of human cognitive and communicative function implies that a 'person' no longer exists in any significant sense of the term . . . . (2) As a result, no goals of medicine other than support of organic life are being or will be accomplished. We do not believe this goal, in and of itself, is an independent and overriding goal of medicine. (3) [The benefit of keeping the patient alive is questionable] when the patient now, and never will, be able to appreciate what is being done for him or her. (4) No preferences of the patient are expressed or known. The conjunction of these four factors justifies, in our judgment, a decision not to continue medical intervention . . . ."

\(^{155}\) Id. at 237, 618 A.2d at 769 (Chasanow, J., concurring and dissenting) (quoting ALBERT R. JONSEN ET AL., CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE 106-07 (2d ed. 1986)).

\(^{156}\) Id. at 241, 618 A.2d 770-71 (Chasanow, J., concurring and dissenting).
Acknowledging the family dispute before the court, Judge Chasanow then turned to the task of discerning Ronald's intent. He eschewed the "substituted judgment" and "best interest" labels in favor of the more encompassing term "surrogate judgment." He concluded that the key in this analysis is whether "the surrogate decision maker believe[s], and ha[s] an adequate basis for believing, that this patient, if suddenly and miraculously given the ability to express a preference, would choose to terminate life support." This decision allowed relatives of infants and individuals who had never been competent to discontinue treatment if they firmly believed the patient would make that decision if competent.

An overriding theme of Judge Chasanow's surrogate judgment analysis was the great discretion given to individuals close to the patient in setting the course of treatment. He emphasized the inherent problems in constructing an incompetent patient's likely decision and submitted that the lesser of all evils requires strong reliance on the opinions of those "who best knew the patient." He afforded the opinions of these individuals considerable force, to the extent that they alone could satisfy the "clear and convincing" standard of proof required in determining an incompetent patient's intent.

Judge Chasanow recognized that situations may continue to arise in which family members offer conflicting opinions. In these instances, he conceded that "[m]easuring contrasting opinions against the objective criteria of the best interests test may aid the court in resolving the conflict." He refused, however, to presume that patients in a persistent vegetative state would choose, as suggested by the majority opinion, to continue life-sustaining medical treatment absent

157. Id. at 242-48, 618 A.2d at 771-74 (Chasanow, J., concurring and dissenting).
158. Id. at 245, 618 A.2d at 773 (Chasanow, J., concurring and dissenting) (emphasis added).
159. See id. at 245, 618 A.2d at 772-73 (Chasanow, J., concurring and dissenting).
160. Id. at 247, 618 A.2d at 774 (Chasanow, J., concurring and dissenting) ("If a decision is to be made, then the patient's probable decision can best be determined by those closest to the patient rather than by a legislature or a judge.").
161. Id. at 243, 618 A.2d at 772 (Chasanow, J., concurring and dissenting).
162. Id. at 242, 618 A.2d at 771 (Chasanow, J., concurring and dissenting). Judge Chasanow set forth the types of evidence that should be considered in determining an incompetent patient's intent, ranked in the following order of priority: (1) legal documents; (2) relevant statements made by the patient; (3) opinions of people close to the patient; and (4) "the patient's attitude towards medical treatment, ethical, religious, and moral views, life goals, etc." Id. Of these categories, only the first three types of evidence would meet the "clear and convincing" standard of proof; evidence in the fourth category would be admitted only to provide additional support. Id.
163. Id. at 246 n.3, 618 A.2d at 773 n.3 (Chasanow, J., concurring and dissenting).
164. Id.
clear evidence to the contrary.\textsuperscript{165} He therefore concluded that "[the circuit court] was correct in ruling that Ronald's gastrostomy tube should not be removed because (1) Ronald had never clearly evidenced his views on the subject \textit{and} (2) the two family members closest to him differed in their sincere beliefs as to what Ronald would have wanted."\textsuperscript{166}

\section*{IV. Analysis of the \textit{Mack} Decision}

Although the right to refuse life-sustaining medical treatment is an inherently personal concern, state courts have been forced to create formal legal structures to guide the decisionmaking process. Despite the significant progress courts have made in this area, cases continue to arise and increase in number and complexity. \textit{Mack}, for example, combined the issues of guardianship, interstate patient transfers, family disputes, and medical treatment for patients in a persistent vegetative state. The disagreement among the judges on the \textit{Mack} court illustrates the difficulty in answering the questions posed in such cases.

\subsection*{A. Separating the Determination of Guardianship from the Treatment Issue}

The small foundation of Maryland law guiding the \textit{Mack} court on the guardianship issue dictated that opinions of contesting family members regarding medical treatment were inappropriate to consider in an initial guardianship determination. Former section 13-708(c) of the Estates and Trusts Article, which required that a previously appointed guardian obtain court approval to withhold or withdraw life-sustaining treatment, however, gave the courts authority to address the treatment issue after a guardian had been appointed.\textsuperscript{167} As the majority noted, because Deanna Mack acknowledged that she needed additional court approval to discontinue Ronald's treatment, her views were consistent with the governing Maryland statutory scheme.\textsuperscript{168} The judicial supervision requirement also rendered Judge Chasanow's fears over Deanna's "intent and apparent ability" to withdraw the treatment unfounded.\textsuperscript{169} Although Deanna may have had the intent to discontinue her husband's treatment, Maryland statutory

\begin{itemize}
\item 165. \textit{See id.} at 251, 618 A.2d at 775 (Chasanow, J., concurring and dissenting).
\item 166. \textit{Id.} at 769.
\item 167. \textit{Md. Code Ann., Est. \\ & Trusts} § 13-708(c) (1991) (amended 1992); \textit{see supra} text accompanying note 29 (quoting § 13-708(c)).
\item 168. \textit{Mack}, 929 Md. at 205-06, 618 A.2d at 753.
\item 169. \textit{See supra} notes 127-128 and accompanying text.
\end{itemize}
law did not authorize her to take this course of action independently, either within the state or by moving Ronald to Florida. In reality, therefore, she had no “apparent ability” to withdraw treatment. Thus, the Court of Appeals wisely determined that Deanna’s views on medical treatment alone did not constitute good cause to disregard her statutory priority to become guardian, and it took the appropriate action by vacating the circuit court’s guardianship determination.

In his dissent, Judge Chasanow emphasized Mr. Mack’s geographic proximity to the patient, his regular visits, and Deanna Mack’s living and having a third child with another man. However, none of these facts were analyzed, and the last two were not even mentioned, in the circuit court opinion, which instead “center[ed] on the conflict over whether artificial hydration and nourishment should be withdrawn.” Judge Chasanow did not address Deanna’s efforts to care for her husband both before and after his accident or the fact that Mr. Mack could not explain numerous entries in his son’s medical record that cast doubt on his claim that he visited his son frequently. With respect to Deanna’s actions, evidence adduced at trial showed that she visited her husband four to five times per week during his first year of hospitalization. She continued to visit her husband several times a year after she moved to Florida, often bringing their children. Moreover, she never divorced her husband, even though this course of action would have been financially advantageous to her. Thus, Judge Chasanow’s claim that the facts clearly and unambiguously compelled as a matter of law the selection of the patient’s father as guardian is easily controvertible.

Finally, the Mack majority also emphasized that case law required that a best interest test be applied in every guardianship determination. On first impression, this requirement may appear to conflict

171. Mack, 329 Md. at 197-98, 618 A.2d at 749.
172. See id. at 204, 618 A.2d at 752.
173. Id. at 234-35, 618 A.2d at 767 (Chasanow, J., concurring and dissenting).
174. In re Mack, No. 91-T-103, slip op. at 9 (Cir. Ct. for Baltimore County Mar. 10, 1992) (mem.).
176. Id.
177. Id.
178. Id.
179. Mack, 329 Md. at 203, 618 A.2d at 752.
with the court’s opinion as a whole: because the court refused to conduct a best interest analysis in its determination of whether to allow the withdrawal of Ronald’s life-sustaining treatment, it would seem inconsistent to mandate a best interest analysis as part of the guardianship decision. As the court explained, however, guardianship determinations are made independently from decisions regarding life-sustaining treatment.\textsuperscript{180} Thus, the guardianship best interest test does not necessarily impact medical treatment decisions. The factors listed by the majority to be considered with respect to the guardianship appointment—whether Deanna would or could fulfill her guardianship duties, and the relevance of Mr. Mack’s geographic proximity—are consistent with the type of factors traditionally considered in guardianship determinations; they are focused on the guardian’s personal character and ability to carry out the required duties.\textsuperscript{181} A consideration of the ward’s prognosis, the crux of a medical treatment best interest test, was noticeably absent from the factors the majority mentioned as a part of the Maryland “best interest” test.\textsuperscript{182} Thus, although the two analyses share a common name, the Mack decision demonstrated that they are fundamentally different and do not necessarily impact one another.

B. The Decision Concerning Life-Sustaining Treatment

In Mack, the members of the court expressed reservations over labeling the test it applied as a “substituted judgment” test.\textsuperscript{183} A brief review of state case law proves these reservations to be well-founded.\textsuperscript{184} The objective of the test is not simply to allow the guardian to substitute his or her judgment for that of the ward; rather, numerous factors must be weighed to discern what the patient would have wanted under the circumstances. This test is not perfect as sometimes these elements are lacking, or as Mack demonstrates, two people who apparently knew the patient well can establish conflicting patient preferences from similar sets of factors.

The “best interest” label is even more problematic. There is no objective truth to guide the determination of an incompetent patient’s best interest because every individual holds a unique personal

\textsuperscript{180}. See supra notes 117-119 and accompanying text.
\textsuperscript{181}. See Mack, 329 Md. at 204, 618 A.2d at 752.
\textsuperscript{182}. See id.
\textsuperscript{183}. See supra notes 133, 145 and accompanying text.
\textsuperscript{184}. See supra note 60 and accompanying text.
opinion as to the value of life. Because the best interest test does not emphasize the personal sentiments of the ward, attempts to define precisely a ward’s best interest are reduced to an application of the decisionmaker’s values and opinions. The question then becomes who should be the decisionmaker. As the Mack decision demonstrated, this question is not always easily answered.

The statutes governing the Mack decision were insufficient to assist the court in resolving these difficulties. For example, Maryland law did not expressly permit or forbid analysis of a guardian’s decision to terminate a ward’s life-sustaining treatment under the best interest test. Nevertheless, the fact that a guardian could not withdraw life-sustaining treatment without judicial approval implied such a limitation. Under the law at the time of the decision, a validly appointed guardian lacked the authority to carry out, without judicial approval, what she deemed to be in her ward’s best interest if that meant terminating treatment. She could, however, elect to continue treatment without judicial approval. Thus, Maryland law granted guardians the authority to make only one choice independent of court supervision—a legal structure that could not grant a person who, theoreti-

185. Massachusetts implicitly recognized the inevitable differences of opinion that exist on the personal issue of life-sustaining treatment in Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986). In Brophy, the court honored a patient’s choice to terminate treatment but did not force the hospital, which objected on ethical grounds, to take steps to withdraw treatment. Id. at 639. Instead, the court ordered the hospital to assist the guardian in transferring the ward to a suitable facility. Id.

186. As Professor Tribe has explained,

The problem with any “objective” or “best interest” standard is that there is no consensus in our society about how the value of a life is affected by the loss of higher brain function, severe physical deterioration, or extreme pain. A best interest approach for making a treatment decision imposes highly contested societal values paternalistically on the individual.

LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11, at 1369 (2d ed. 1988) (emphasis in original) (citation omitted). For example, at least one court has based its best interest test on the underlying assumption that the best interest of a patient requires medical providers to maintain whatever semblance of life is possible, even if part of the brain has been removed. See In re Busalacchi, 1991 WL 26851, at *5 (Mo. Ct. App. 1991). At the other extreme, a court that consistently values a patient’s right to refuse medical treatment above all else could ultimately be forced to legalize suicide. See TRIBE, supra, § 15-11, at 1366-67 (reasoning that if the patient’s right to refuse medical treatment were always to prevail, regardless of the prognosis, that standard would lead to the judicial approval of suicide).


189. See id.

190. See id.
cally, knew the patient best the power to protect that patient’s autonomy in every situation.

Moreover, the Mack court feared that if it were to conduct a best interest test and conclude that Ronald’s best interest dictated that his treatment be stopped, its decision would lead to the automatic withholding of artificially administered sustenance from all persons in a persistent vegetative state who had not clearly and convincingly noted a preference to the contrary. As decided, however, the Mack case, if not for the legislature’s immediate action, would have had the opposite effect. The court’s decision ultimately established that, when faced with uncertainty as to patients’ wishes, courts should mandate that all patients in a persistent vegetative state be maintained in this condition indefinitely.

While the state’s concern over protecting its interest in human life is both understandable and commendable, the standard created in Mack no longer mirrors reality. As Judges Chasanow and McAuliffe pointed out, most people today would not wish to live in a vegetative state. In honor of the premium placed on patient autonomy, it is this sentiment against continuing treatment that normally should prevail in cases involving PVS patients. Thus, although the Mack decision comported with the confines of state statutory law, it did not reflect the preferences of the public it was designed to protect.

V. THE HEALTH CARE DECISIONS ACT OF 1993

Three days after the Court of Appeals filed the Mack opinion, several members of the Maryland legislature introduced the Health Care Decisions Act of 1993. This law, which went into effect October 1, 1993, represents Maryland’s attempt to provide a legal structure to synthesize many of the complex issues posed in Mack. The Act created a mechanism to identify the appropriate decisionmaker, which can be an agent designated by the patient, a guardian, a family member, or a friend, and provides standards to guide that individual’s decisions.

The Act also addresses the weaknesses in Maryland’s statutory law that became apparent in Mack. A primary goal in setting the course of

191. See supra notes 138-140 and accompanying text.
192. See supra notes 150-154 and accompanying text.
195. Id. § 5-605(c); see infra note 217 and accompanying text (quoting the section).
making medical treatment decisions for incompetent patients is to ensure that the choices made mirror those the individuals receiving care would make.\textsuperscript{196} \textit{Mack} demonstrated that Maryland law granted guardians, presumptively competent decisionmakers in positions to know the would-be choices of their wards, little autonomy to make choices regarding life-sustaining treatment on their behalf. One of the dangers of enlarging the scope of a guardian’s discretion, however, was the possibility that incompetent wards will be left with little protection in situations where protection may be needed. Thus, the drafters of the new bill faced the challenge of granting guardians greater freedom from court supervision, while simultaneously guarding the state’s interest in protecting the lives of its citizens.

\textit{Mack} also magnified the need to establish conclusively a standard to guide the implementation of what has been called the substituted judgment test, and to decide how—or whether—to implement a best interest test in Maryland.\textsuperscript{197} In crafting these tests, the bill’s drafters again faced the delicate task of balancing patient autonomy against the necessity of safeguarding the value of human life.

\textbf{A. The Appointment and Powers of Guardians}

The Health Care Decisions Act authorizes surrogate decisionmaking for incompetent individuals who did not appoint an agent when they were capable of doing so.\textsuperscript{198} Like its predecessor,\textsuperscript{199} the Act provides a hierarchy of individuals who have decisionmaking authority:

(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

\begin{flushleft}
\textsuperscript{196} See \textit{Mack}, 329 Md. at 207, 618 A.2d at 753 (holding that a guardian must prove her judgment matches her ward’s).
\textsuperscript{197} See id. at 219, 618 A.2d at 760-61 (stating the court’s refusal to apply a best interest test).
\textsuperscript{198} Md. Code Ann., Health-Gen. § 5-605(a)(2) (1994) (setting forth the list of individuals who may make a health care decision for an incompetent patient “who has not appointed a health care agent in accordance with th[e] subtitle”).
\textsuperscript{199} The former law was § 20-107(d) of the Health-General Article. This section established an ordered list of individuals who could consent to “furnishing medical or dental care and treatment to a disabled individual” who had not executed a durable power of attorney for medical care and for whom there was no “judicially appointed guardian, conservator, committee, or trustee who ha[d] the authority to consent to medical care.” Md. Code Ann., Health-Gen. § 20-107(d) (1990) (repealed 1993).
\end{flushleft}
(vi) a friend or other relative of the patient who meets the requirements of paragraph (3) of this subsection.\textsuperscript{200}

To fully understand the revised Health Article, it must be read in conjunction with corresponding changes made in the sections of the Estates and Trusts Article addressing the powers of guardians. The Attorney General has interpreted section 5-605(A)(2)(i) of the Health-General Article to mean that the individual with the highest priority, a previously appointed guardian, is the individual "to whom the court has given power to consent to medical care under [section] 13-708(b)(8) of the Estates and Trusts Article."\textsuperscript{201} Thus, only if a guardian has not been given the power to consent to health care matters pursuant to section 13-708(b), may another surrogate make medical determinations on behalf of the patient.\textsuperscript{202}

To comprehend the full scope of the authority that may be granted to a guardian with respect to health care decisionmaking, one

\textsuperscript{200} MD. CODE ANN., HEALTH-GEN. § 5-605(a)(2) (1994). This section provides additional safeguards when a designated decision maker is not a guardian or a member of the patient's immediate family:

A friend or other relative may make decisions about health care for a patient under paragraph (2) of this subsection if the person:

(i) is a competent individual; and

(ii) presents an affidavit to the 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.

\textsuperscript{201} Id. § 5-605(a)(3).

must look beyond section 13-708(b) of the Estates and Trusts Article and consider section 13-708(c), which was amended by the Health Care Decisions Act and now provides in pertinent part:

(c) Medical Procedures.—(1) Notwithstanding the powers conferred to a guardian under subsection (b)(8) of this section, and except as provided in paragraph (2) of this subsection, where a medical procedure involves, or would involve, a substantial risk to the life of a disabled person, the court must authorize a guardian’s consent or approval for:

(i) The medical procedure;

(ii) Withholding the medical procedure; or

(iii) Withdrawing the medical procedure that involves, or would involve, a substantial risk to the life of the disabled person.

(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 ... that authorizes the guardian to consent to the provision, withholding or withdrawal 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 disabled person’s spouse, adult child, parent, or adult brother or sister.203

Before the passage of the Health Care Decisions Act, the Attorney General interpreted section 13-708(c), which did not include subsection (2) in its original form,204 as granting a guardian the opportunity to consent to life-threatening medical treatment only if the court approved.205 No provision explicitly granted guardians the authority to deny life-sustaining medical treatment, nor did the legislature provide any avenues for a guardian to act independently of court supervision when the issue of life sustaining treatment arose.206 Thus, the 1993 amendment significantly increased the autonomy of guardians and the importance of their role.

Read in its entirety, the revised Estates and Trusts Article indicates that the courts retain authority over supplying or denying life-sustaining medical treatment to a ward, but if either of the two situa-

204. See supra note 29 and accompanying text.
206. See supra note 29 and accompanying text.
tions described in section 13-708(c)(2) occur, the court may choose to relinquish much of its power.207 The legislature has therefore crafted a legal structure whereby "[t]he administration of guardianship affairs remains subject to judicial control by the equity court that appointed the guardian,"208 while also providing a mechanism that makes it possible to grant a degree of autonomy to the guardian. When a guardian obtains the authority to act independently of court supervision, she must nonetheless operate within the confines of the Health-General and Estates and Trusts Articles, which set standards for surrogate decisionmakers.209

The new law also provides a means for resolving disputes among parties of equal priority.210 If the patient is in a hospital or related institution when such a dispute arises, the health care provider or surrogate decisionmaker must refer the dispute to the institution's patient care advisory committee.211 If the patient is not in one of the enumerated places, a physician may not withhold or withdraw life-sustaining procedures unless all of the surrogates with equal claim to decisionmaking authority unanimously agree to do so.212 The new law does not provide a mechanism whereby parties who do not have statutory priority may attempt to influence the course of the patient's treatment.213

210. The bill is also sensitive to the personal values of health care providers, allowing them to transfer patients when they are morally opposed to a patient's wishes. See Md. Code Ann., Health-Gen. § 5-611 (1994).
211. See id. § 5-605(b)(1).
212. See id. § 5-605(b)(2).
213. See id. § 5-605(a)(2) ("Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable.").
B. Life-Sustaining Medical Treatment

In response to the need for guidelines to cover what Judge Chasanow referred to as "surrogate judgments," the Health Care Decisions Act addresses the "quintessentially legislative" question of when discontinuing life-sustaining medical treatment may be appropriate. First, the surrogate must apply a subjective "substituted judgment" test to discern the personal preferences of the patient. This test includes the by-now familiar elements a surrogate must consider when making decisions on behalf of a patient. They are: (1) diagnosis/prognosis; (2) previously expressed preferences regarding the medical treatment at issue or other treatment generally; (3) religion, values, and moral beliefs; (4) past behavior or other manifestations of attitude toward the procedure at issue or health care decisions generally; (5) reactions to life-sustaining medical treatment of others; and (6) expressed concerns over the treatment's psychological effect on family and friends.

If the wishes of a patient are unknown or unclear, the surrogate decisionmaker may base her decision regarding life-sustaining treatment on the patient’s best interest. The best interest test includes a consideration of the following factors:

215. Id. at 222, 618 A.2d at 761.
   (c) Standards for surrogates.—(1) Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient’s best interest.
   (2) In determining the wishes of the patient, a surrogate shall consider the patient’s:
      (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.
   Id.

(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 patient receiving treatment, to the extent these may assist the decisionmaker in determining best interest.\(^{219}\)

When a guardian does not have authority to make health care decisions for a ward pursuant to section 13-708(b) of the Estates and Trusts Article, she must apply to the court to withhold or withdraw life-sustaining treatment.\(^{220}\) In this situation, the court, using the substituted judgment factors, must find “clear and convincing” evidence of the patient’s intent before allowing a guardian to act.\(^{221}\) If no such evidence is found, the court may resort to a best interest test.\(^{222}\) The “best interest” of a patient in this context is defined as the point at which the benefits to the individual resulting from the treatment outweigh its burdens and is virtually identical to the best interest test discussed above and set forth in section 5-601(e) of the Health-General Article.\(^{223}\)

For the most part, there is nothing surprising about Maryland’s new substituted judgment or best interest tests. They are essentially a formalization of the various factors that have been considered in

\(^{219}\) Id. § 5-601(e).

\(^{220}\) Md. Code Ann., Est. & Trusts § 13-708(b), (c)(3) (1993) (establishing that a guardian without authority to make decisions regarding life-sustaining treatment must obtain court authorization to make such decisions).

\(^{221}\) See id. § 13-712(b).

\(^{222}\) See supra note 219 and accompanying text.
other jurisdictions in cases involving the issue of life-sustaining treatment.\textsuperscript{224}

The Health Care Decisions Act also includes numerous safeguards to protect against the gradual devaluation of human life feared by the \textit{Mack} majority. First, the Act expressly prohibits mercy killing and euthanasia.\textsuperscript{225} Second, surrogate decisions involving life-sustaining treatment may 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."\textsuperscript{226} Third, a surrogate may withhold or withdraw life-sustaining treatment in three situations only:\textsuperscript{227} when the patient is terminally ill,\textsuperscript{228} in a persistent vegetative state,\textsuperscript{229} or is suffering from an "end-stage" condition.\textsuperscript{230} In addition, some type of physician certification is required in all of these circumstances prior to providing, withholding, or withdrawing medical treatment.\textsuperscript{231} Fi-


\textsuperscript{225} See Md. CODE ANN., HEALTH-GEN. § 5-611(c) (1994). The law also strictly prohibits surrogates from authorizing sterilization and treatment for mental disorders. See id. § 5-605(d).

\textsuperscript{226} Id. § 5-605(c)(3).


\textsuperscript{228} A "terminal" condition is an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery. Md. CODE ANN., HEALTH-GEN. § 5-601(q) (1994).

\textsuperscript{229} "Persistent vegetative state" is defined as a condition caused by injury, disease, or illness:

(1) In which a patient has suffered a loss of consciousness, exhibiting no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response; and

(2) From which, after the passage of a medically appropriate period of time, it can be determined, to a reasonable degree of medical certainty, that there can be no recovery.

\textit{Id.} § 5-601(o).

\textsuperscript{230} "End-stage condition" is defined as 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.

\textit{Id.} § 5-601(i).

\textsuperscript{231} Section 5-606 provides:

(a) \textit{Certification of incapacity}.—(1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification,
nally, a medical provider also may petition a hospital’s patient care advisory committee or file a petition in court if she believes that “an instruction to withhold or withdraw a life-sustaining procedure from the patient is inconsistent with generally accepted standards of patient care.”

**CONCLUSION**

In *Mack*, the Baltimore County Circuit Court granted guardianship of a young adult male in a persistent vegetative state to his father, dismissing the original grant made to his spouse. The court justified its decision by finding that his wife’s desire to discontinue medical treatment was contrary to Maryland law and, therefore, sufficient to overrule her statutory priority. In actuality, however, Maryland law on this issue had yet to be created. Within days of the Court of Appeals’s responses to the lower court, in which it remanded the case on the issue of the wife’s guardianship but denied her request to end her husband’s life support absent a clear and convincing indication of his intent, the Maryland General Assembly addressed the need for legal structure in this relatively new area of the law. The resulting Health Care Decisions Act removed the authority for making certain medical decisions from the courts, clarified guardianship appoint-

shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.

(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician is not required under paragraph (1) of this subsection.

(b) Certification of condition.—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.

Id. § 5-606.

232. *See id.* § 5-612(a). A patient’s spouse, parent, adult child, grandchild, brother, sister, friend or other relative qualified as a surrogate under § 5-605 may also petition the court to enjoin, withdraw, or withhold treatment. *See id.* § 5-612(b). The court may do so upon a finding by a preponderance of the evidence that the action is not authorized by law. *Id.*

233. *Mack*, 329 Md. at 196, 618 A.2d at 748.

234. *Id.; see supra* notes 112-114 and accompanying text.

235. *Mack*, 329 Md. at 197-98, 618 A.2d at 749; *see supra* note 116 and accompanying text.
ment standards, and formalized the elements of substituted judgment and best interest determinations. It was an appropriate and timely response to the issues introduced in *Mack* and other state court decisions. The Health Care Decisions Act of 1993 will provide the necessary guidance to steer Maryland courts in the life-sustaining treatment cases that inevitably will arise in the future.