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Notes: Right to Die — Court Requires Clear and Convincing Evidence of Persistent Vegetative Patient's Intent to Terminate Life-Sustaining Procedures; Health Care Decisions Act of 1993 Casts New Light on Outcome. *Mack v. Mack*, 329 Md. 188, 618 A.2d 744 (1993)

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## NOTES

RIGHT TO DIE—COURT REQUIRES CLEAR AND CONVINCING EVIDENCE OF PERSISTENT VEGETATIVE PATIENT'S INTENT TO TERMINATE LIFE-SUSTAINING PROCEDURES; HEALTH CARE DECISIONS ACT OF 1993 CASTS NEW LIGHT ON OUTCOME. *Mack v. Mack*, 329 Md. 188, 618 A.2d 744 (1993).

For decades, the advocacy of groups supporting euthanasia, as well as the actions of those such as Dr. Kevorkian, have piqued the nation's awareness of the medical and ethical issues concerning the right to die. Due to the "constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it,"<sup>1</sup> the right to die has begun to make inroads in our laws. Legislatures across the nation have now addressed this issue and most states have laws protecting some version of the right to die.<sup>2</sup> Generally, the argument for the right to die is most persuasive in situations where a person is kept alive artificially against his will.<sup>3</sup>

Before the enactment of the Health Care Decisions Act of 1993<sup>4</sup> (HCDA), Maryland had two statutes governing who had the right to die, who could invoke this right, and under what circumstances. Maryland's Living Will Statute<sup>5</sup> enabled an individual to write a declaration directing the withholding of life-sustaining procedures in the event of a terminal illness. In lieu of such a declaration, Maryland's Guardian Statute<sup>6</sup> allowed an appointed guardian to determine

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1. *Mack v. Mack*, 329 Md. 188, 227, 618 A.2d 744, 764 (1993) (McAuliffe, J., dissenting) (quoting *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 292 (1990) (Scalia, J., concurring)).
  2. See *Cruzan v. Harmon*, 760 S.W.2d 408, 413 (Mo. 1988); see also John Carroll Byrnes, *The Health Care Decisions Act of 1993*, 23 U. BALT. L. REV. 1, 1 n.1 (1993).
  3. However, determining what that individual's wishes are or would be is susceptible to much debate. In the case of perpetually unconscious patients, this determination arguably necessitates the deployment of a "fiction." See *infra* Part III; see also Byrnes, *supra* note 2, at 6 n.17.
  4. MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1994 and Supp. 1994) (formerly cited as Health Care Decisions Act, Chapter 372, Laws of 1993).
  5. MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -614 (1991) (repealed and re-enacted in its current form by Section 1, ch. 372, Acts of Md. 1993).
  6. MD. CODE ANN., EST. & TRUSTS §§ 13-701 to -713 (1991) (amended to current form by Section 4, ch. 372, Acts of Md. 1993).

when to withhold a patient's medical procedures with court authorization.<sup>7</sup> The right to die controversy clearly did not abate with the passage of these laws. Instead, the battleground merely expanded to include the judicial forum.

Attention turned to the controversy in *Mack v. Mack*,<sup>8</sup> which culminated with Maryland's highest court writing three separate opinions interpreting and applying Maryland's Guardian Statute.<sup>9</sup> *Mack* involved the disputed guardianship of a persistently vegetative patient. One of the potential guardians sought to have life-sustaining procedures terminated, the other did not. In *Mack*, the Court of Appeals of Maryland held that there must be clear and convincing evidence of a patient's intent to refuse life-sustaining procedures, that this standard was not met by the facts of the case, and consequently, that sustenance could not be removed.<sup>10</sup>

While the decision in *Mack* established that a patient does have the right to refuse artificial sustenance, it also made clear that Maryland's laws were in need of revision.<sup>11</sup> *Mack* revealed certain inconsistencies in Maryland's law. For example, the Living Will Statute was narrower than the Guardian Statute in that it did not allow the withholding of artificial sustenance.<sup>12</sup> *Mack* required Maryland courts to demand clear and convincing evidence<sup>13</sup> of a persistently unconscious patient's prior intent to terminate life-sustaining procedures before authorizing a guardian's decision to withhold life support.<sup>14</sup> This new standard of proof arguably limits the utility of the Guardian Statute.

The decision in *Mack* soon caught the attention of the Maryland legislature. Ultimately, the enactment of the HCDA largely repealed and modified the statutes on which the decision in *Mack* was based.<sup>15</sup> Under the new Advance Directives Statute,<sup>16</sup> a surrogate may make decisions without court oversight unless another party petitions for an injunction.<sup>17</sup> Under the new Guardian Statute,<sup>18</sup> a court may

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7. One of the crucial issues in *Mack* proved to be defining what court authorization requires.

8. 329 Md. 188, 618 A.2d 744 (1993).

9. See *infra* notes 106-08 and accompanying text.

10. *Mack*, 329 Md. at 188, 618 A.2d at 744.

11. *Id.* at 198, 222, 618 A.2d at 749, 761.

12. See, e.g., *id.* at 213, 618 A.2d at 756; see generally *supra* notes 5-6.

13. Only four judges favored this standard, three judges would have adopted a more relaxed approach. *Mack v. Mack*, 329 Md. 198, 618 A.2d 744 (1993).

14. *Mack*, 329 Md. at 207, 618 A.2d at 754.

15. See generally MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1994 and Supp. 1994).

16. *Id.*

17. MD. CODE ANN., EST. & TRUSTS § 13-708(c)(2) (1993 and Supp. 1994); accord *Mack*, 329 Md. at 239-40, 618 A.2d 769-70 (Chasanow, J., concurring in part

prospectively authorize certain guardians to make decisions regarding a patient's treatment without further court intervention into the decision making process.<sup>19</sup> Further, even if court authorization is necessary, clear and convincing evidence of the patient's intent is only preferable, not necessary, and authorization may be based upon clear and convincing evidence of the patient's best interests.<sup>20</sup>

## I. THE RIGHT TO DIE

The terms "euthanasia" and "right to die" are often used in the same context. There are, however, some distinctions. As previously mentioned, the right to die generally attaches to situations where a person would be kept alive artificially, but for the fact that it is against the intent or best interests of that patient.<sup>21</sup> Euthanasia, on the other hand, is directed at ending life that is no longer beneficial, whether or not artificial means are used to prolong that life.<sup>22</sup> The action associated with the invocation of the right to die involves the removal of whatever artificial means are prolonging the life, and in some cases, arguably constitutes a passive form of euthanasia.<sup>23</sup> Passive euthanasia is less frequently sought by conscious patients as it may involve a relatively slow and painful death. In contrast, incurring death by an affirmative measure, such as poisoning, is known as active euthanasia, and can be invoked upon a conscious patient capable of consenting (termed assisted suicide), or upon perpetually unconscious subjects.<sup>24</sup> In Maryland,<sup>25</sup> as in most jurisdictions, euthanasia is prohibited.<sup>26</sup>

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and dissenting in part) (stating that "those closest to the patient, if unanimous, should be able to make the decision to terminate life support without judicial intervention").

18. MD. CODE ANN., EST. & TRUSTS §§ 13-701 to -713 (1993 and Supp. 1994).

19. This is true only where the court considers it appropriate, unless there is a dispute between members of the same class. *See infra* Part IV.

20. *See* MD. CODE ANN., EST & TRUSTS §§ 13-711 to -713 (1994 and Supp. 1994).

21. *See supra* note 3 and accompanying text.

22. Webster's Dictionary does not mention the life of the individual, only the death. It defines euthanasia as "the act or practice of painlessly putting to death persons suffering from incurable conditions or diseases." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 786 (1971).

23. This situation occurs specifically when the patient's life-sustaining procedures are terminated because it is found to be in his best interests, allowing a "good death." *Cf.* Byrnes, *supra* note 2, at 12.

24. *See generally* Nancy W. Dickey, *Euthanasia, A Concept Whose Time Has Come?*, 8 ISSUES L. & MED. 521 (1993); Eugenie Anne Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 UCLA L. REV. 1545, 1550-51 nn.21-27 (1993); Jim Persels, *Forcing the Issue of Physician-Assisted Suicide: Impact of the Kevorkian Case on the Euthanasia Debate*, 14 J. LEGAL MED. 93 (1993); C. Ann Potter, *Will the "Right to Die" Become a License to Kill?*

The right to die has developed from both common-law theories<sup>27</sup> and through protections found in the United States Constitution.<sup>28</sup> The well-rooted, common-law doctrine of informed consent focuses on a patient's right of self-determination and gives rise to the right to refuse treatment even if that refusal makes death imminent.<sup>29</sup> The United States Constitution's protection of liberty embodied in the Fourteenth Amendment<sup>30</sup> and numerous state constitutional protections have also been held to engender a right to refuse treatment under the aegis of individual freedom from action by the state.<sup>31</sup>

There are different situations in which it is argued that a patient has the right to die. In instances where a patient is terminally ill and is kept alive by medical procedures, the right to die is most sacrosanct.<sup>32</sup> If the patient is conscious and able to express his intent to refuse treatment, his right is most likely to be honored.<sup>33</sup> If, however, the patient is not terminally ill, or is not conscious and cannot express an intent to refuse treatment, the situation becomes complicated as various philosophical<sup>34</sup> and ethical<sup>35</sup> problems arise. Deciding whether a persistently vegetative patient's treatment may be terminated, and deciding who is to make that decision, are particularly troublesome issues.

If a patient is perpetually unconscious, any known rights of prior self-determination and inviolability must be upheld.<sup>36</sup> As long

*The Growth of Euthanasia in America*, 19 J. LEGIS. 31 (1993); David R. Schanker, *Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis*, 68 IND. L.J. 977 (1993).

25. MD. CODE ANN., HEALTH-GEN. § 5-611 (1993) (prohibiting euthanasia and mercy killing).
26. See Gifford, *supra* note 24, at 1545 n.4.
27. For a discussion of Maryland's doctrine, see *Sard v. Hardy*, 281 Md. 432, 438-39, 379 A.2d 1014, 1018-19 (1977).
28. See *Mack v. Mack*, 329 Md. 188, 210-11, 618 A.2d 744, 755-56 (1993) (citing *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 278, 287, 304-05, 331 (1990)).
29. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 270-71. *But cf. Mack*, 329 Md. at 210 n.7, 618 A.2d at 755 n.7.
30. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 278-79.
31. See *Mack*, 329 Md. at 210-11, 618 A.2d at 755 (citing numerous states that have found state and federal constitutional bases for the right to die).
32. See Byrnes, *supra* note 2, at 8.
33. The patient's conscious choice will likely be adhered to unless the patient is incompetent or another person's interest is involved. See *Mack*, 329 Md. at 210 & n.7, 618 A.2d at 755 & n.7.
34. The most salient philosophical issue is whether man can "play God." See, e.g., Byrnes, *supra* note 2, at 13.
35. Primarily affected is the set of ethics associated with the medical profession and its inhering duty to provide aid.
36. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior

as a patient is deemed legally alive, the law will not discard the patient's known interests, even if that patient will never regain consciousness.<sup>37</sup> The quandary is in determining how to carry out the patient's wishes and protect those rights. Because the patient is unconscious, there exists no present intent to be ascertained. Either the individual's intent must be implied to provide an intent with which a judgment may be effected, or someone must be appointed to exercise a surrogate judgment.

#### A. *The Focus of the Right to Die Determination*

One way to determine that such a patient would wish to refuse treatment is to assess the totality of the evidence of the patient's intent prior to incompetence.<sup>38</sup> The patient's intent can be best demonstrated by a written living will expressly indicating a desire to refuse or terminate treatment under certain circumstances in the event of an inability to convey such wishes at that time.<sup>39</sup> If a living will is not available, then any prior statements or other circumstantial evidence can be used to determine the true intent of the patient with regards to receiving or withholding medical procedures.<sup>40</sup> This approach is often labelled as "substituted" judgment because the court substitutes either the patient's past intent or a construction thereof in place of a present intent.<sup>41</sup> The problem with the substituted judgment approach is that in many cases it is difficult to find enough clear evidence of a patient's intent regarding continuation of procedures to satisfy the requisite standard of proof.<sup>42</sup>

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decisions." *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 278 (1990).

37. See, e.g., *In re Westchester County Medical Ctr. on Behalf of O'Connor*, 531 N.E.2d 607 (N.Y. 1988) (refusing to accept less than the patient's clearly expressed intent before permitting a surrogate to exercise the patient's right to refuse treatment).

38. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 272.

39. Under Maryland's former living will law, there were restrictions as to which procedures could be refused pursuant to this instrument. The statutory living will suggested use of the following language:

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of food and water, and the performance of any medical procedure that is necessary to provide comfort, care or alleviate pain.

MD. CODE ANN., HEALTH-GEN. § 5-602 (1991) (repealed 1993); cf. MD. CODE ANN., HEALTH-GEN. § 5-603 (1994 and Supp. 1994) ("Suggested Forms") (reprinted *infra* note 147).

40. *Mack v. Mack*, 329 Md. 188, 215, 618 A.2d 744, 758 (1993).

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

42. Further, in the subjective analysis, there is an inherent degree of fiction

Alternatively, medical decisions can be made for the patient by a "surrogate," such as a court appointed guardian.<sup>43</sup> Under this approach, the patient's personal intent may be expressed by the surrogate, who is presumed to best know what the patient would have wanted.<sup>44</sup> In lieu of knowledge of the patient's intent, the surrogate may base a decision on an assessment of the patient's subjective best interests.<sup>45</sup> The surrogate judgment approach is criticized because a surrogate has the power to disregard or neglect what the patient would have wanted, and instead base a decision on his own considerations.<sup>46</sup>

Another possible approach is to make an assessment of the patient's condition based upon more objective criteria to determine what is the patient's "best interests."<sup>47</sup> Under this approach, a court makes a judgment as to the patient's quality of life, based upon factors such as the cost of treatment and the impact upon the family.<sup>48</sup> The main criticism of this objective approach is that a court, rather than interested parties, determines whether a particular life is worth continuing.<sup>49</sup> This approach creates a slippery slope that inevitably leads to a broadening of the relevant considerations to include, and even predominate, the cost to society of maintaining lives of patients.

To varying degrees, a subjective analysis also incorporates certain objective factors, and vice versa. Regardless of which approach is chosen, the pertinent criteria and analyses overlap. What may be dispositive in one approach may initially seem irrelevant in another, yet such a factor may enter into the analysis indirectly anyway—one's best interest is largely evolved from subjective intent, and conversely, one usually intends to have done what is in one's best interest.

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regarding the patient's intent. Because the patient is unconscious, whatever intent is construed is inaccurate in that it lacks the impact that being in the situation would actually have had on the patient. Facing death may awaken the survival instinct in even the most cynical individual. On the other hand, experiencing the realities of an undignified existence can weaken even the most stubborn. Nevertheless, for a patient that is, by definition, incapable of forming intent, it can be argued that "no intent" is the most accurate approximation.

43. Of course, to the degree that this process is overseen by a court, it ceases to be true surrogacy because it is the court that makes the real substituted judgment.

44. *Mack*, 329 Md. at 214, 618 A.2d at 757.

45. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 272 (1990).

46. *See Mack*, 329 Md. at 214-15, 618 A.2d at 757 (the court emphasized that "the 'substituted judgment' label is a misnomer").

47. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 272.

48. The Maryland Guardian Statutes do not look to factors such as financial cost or impact on the family. *See MD. CODE ANN., HEALTH-GEN. § 5-605* (1994) (setting forth certain "standards" for the surrogate to consider).

49. *Mack*, 329 Md. at 218, 618 A.2d at 759.

*B. The Refusal of Artificial Sustenance*

Further complicating decisions to withhold treatment are the distinctions that are drawn between the types of aid that can be administered to or refused by the patient. Artificial treatments are seen as the most invasive to a person's sanctity and right to self-determination,<sup>50</sup> and therefore, have been the most susceptible to the right to refusal. In reality, however, there is a spectrum of treatments and a continuous gradation in the level of "artificiality" of those treatments.<sup>51</sup> At one end of the spectrum are invasive surgical procedures to combat illness or disease, while at the other end is the mere providing of food and water. Defying facile characterization are procedures such as providing nutrition and hydration through a nasogastric tube or a gastrostomy.<sup>52</sup>

In 1990, the United States Supreme Court addressed the issue of refusing medical aid, including artificial nutrition and hydration.<sup>53</sup> The decision in *Cruzan v. Director, Missouri Department of Health*<sup>54</sup> concluded that there is a constitutional right, based on the Liberty Clause of the Fourteenth Amendment, to refuse artificial nutrition and hydration.<sup>55</sup> Nancy Cruzan, the patient, was left in a persistent vegetative state following a car accident.<sup>56</sup> Medical experts testified at trial that she was not terminally ill, and could live for another thirty years.<sup>57</sup> Years after consenting to the implanting of a gastrostomy tube, Nancy's guardians sought its removal.<sup>58</sup> The controversy made its way to the Missouri Supreme Court, which found an absence of clear and convincing evidence of Nancy's wishes regarding what decision she would have made.<sup>59</sup> The court held, therefore, that given Missouri's strong interest in preserving life, sustenance could not be withdrawn.<sup>60</sup>

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50. Such measures have been regarded by some Christian faiths as unnatural, and thus, able to be refused. Undoubtedly this has greatly influenced the common law as well as statutory right to die provisions. See, e.g., Wendy Ann Kronmiller, Comment, *A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act*, 47 Md. L. REV. 1188, 1193-94 & nn.37-44 (1988).

51. *Id.*

52. This involves a surgical procedure to insert a line directly into the stomach. See generally Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17 (1983).

53. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

54. *Id.*

55. *Id.* at 278-81.

56. *Id.* at 265.

57. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988).

58. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 265. Lester and Joyce Cruzan, Nancy's parents, were her co-guardians.

59. *Cruzan v. Harmon*, 760 S.W.2d at 411. Nancy's parents testified that Nancy



Although the United States Supreme Court affirmed this decision, it recognized that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment"<sup>61</sup> and "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."<sup>62</sup> The Court also recognized the validity of a state's "unqualified interest in the preservation of human life,"<sup>63</sup> which may be manifested "through the imposition of heightened evidentiary requirements."<sup>64</sup> While the Court noted that the case did not turn on the existence of a protected liberty interest, a majority of the Justices clearly stated that the right exists, and that it similarly extends to artificial nutrition and hydration.<sup>65</sup>

### C. Standards of Evidence

Associated with the determination of which factors<sup>66</sup> should be the focus of the right to die analysis is the question of what evidentiary standard should be applied in assessing these factors.<sup>67</sup> *Cruzan* established that states may constitutionally require clear and convincing evidence of a patient's wishes in determining whether to

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had a "somewhat serious conversation with a housemate friend that if she were sick or injured she would not wish to continue her life unless she could live at least halfway normally." *Id.* at 433 (trial court judgment reprinted in dissenting opinion).

60. *Id.* at 424-25.

61. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 278.

62. *Id.* at 279. Interestingly, the court did not indicate that this right stems from a right to privacy, as some commentators had expected. See, e.g., Thomas W. Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103 (1990).

63. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 282.

64. *Id.* at 282.

The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.

*Id.* at 283.

65. *Id.* at 279.

66. See *supra* Part I.A.

67. Sometimes, however, the determination of which standard of proof is appro-

terminate life support.<sup>68</sup> Indeed, most state courts require that these life and death determinations be supported by clear and convincing evidence of the relevant facts.<sup>69</sup> The relevant facts may include the terminal or "end-stage" nature of the patient's condition, the patient's past expressions of intent or preferences, and the patient's overall condition and best interests.<sup>70</sup> However, evidence of prior expressions of the patient's intent is not always required.<sup>71</sup> Only two states require clear and convincing evidence of past expressed intent.<sup>72</sup>

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appropriate has been confused with the selection of factors to which the standard is to apply. This confusion leads to a choice between clear and convincing evidence of prior intent and a determination of the patient's best interests, presumably with a preponderance of the evidence standard. The majority opinion in *Mack* is an example of this dubious comparison.

68. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. at 282-84. *Cruzan* does not mandate that states use this standard of proof. *Id.* at 283; see, e.g., *In re Guardianship of Doe*, 583 N.E.2d 1263, 1271, 1272 n.19. (Mass.), cert. denied *sub nom.*, *Doe v. Gross*, 112 S. Ct. 1512 (1992) (Massachusetts uses a preponderance of the evidence standard accompanied by an extra measure of evidentiary protection provided by "specific findings of fact after 'a careful review of the evidence.'").

The states that have addressed this issue have defined the relevant considerations and evidentiary standards with both statutes and case law. An example of a fairly explicit statute is Maryland's new Health Care Decisions Act. See *infra* Part IV; see generally Byrnes, *supra* note 2.

69. *Mack v. Mack*, 329 Md. 188, 208, 618 A.2d 744, 754 (1993). *Cruzan v. Director, Missouri Dep't of Health*, upheld the constitutionality of this requirement, as long as it is supported by a valid state interest, such as the preservation of life. *Cruzan*, 497 U.S. at 280-84. Missouri's standard of proof, upheld in *Cruzan*, is more rigid, however, than that in most states. See *infra* note 72.
70. See *Mack*, 329 Md. at 215, 618 A.2d at 758.
71. *DeGrella v. Elston*, 858 S.W.2d 698, 706 (Ky. 1993).
72. *Id.*

In all but two states, Missouri and New York, even when the court has been unable to precisely determine the express wishes of the patient, it has allowed the patient's family, or the patient's guardian, to exercise substituted judgment as to what the patient would wish. . . . [Missouri and New York] require clear and convincing evidence that the incompetent person, while competent, expressed the desire that such treatment be refused in the circumstances presented.

- Id.* (citations omitted). Other states have developed their own set of criteria. See, e.g., *In re Moorhouse*, 593 A.2d 1256 (N.J. Super. Ct. App. Div. 1991).

The three tests established by the Court are as follows and apply to an elderly, formerly competent but presently incompetent nursing-home resident with severe and permanent mental and physical impairments and a life expectancy of one year or less. Under the "subjective" test, when it is clear that the patient would have refused the treatment under the circumstances involved, life-sustaining treatment may be withheld or withdrawn from the patient. The limited-objective test applies when the patient has not unequivocally expressed his desires before becoming incompetent. Here, life-sustaining treatment may be withheld or withdrawn from a patient when there is

*D. Statutes Governing the Right to Die*

Subsequent to the Supreme Court's decision in *Cruzan*, the right to die controversy continued to draw much attention in state legislatures and courts. Most states already had laws providing for living wills<sup>73</sup> and surrogate decision making,<sup>74</sup> but *Cruzan* provided direction to the dialogue in state legislatures. In Maryland, the area of law governing the right to die has seen constant legislation and amendment in the past few years. The two statutes that were applicable in *Mack v. Mack*, both now substantially repealed or modified, were known as the Living Will Statute and the Guardianship Statute.<sup>75</sup>

Maryland's Living Will Statute, formerly sections 5-601 through 5-614 of the Health-General Article of the Maryland Code, enacted in 1985, enabled anyone qualified to write a will to also write a declaration directing the withholding of life-sustaining procedures in the event of a terminal illness.<sup>76</sup> This law, explicitly precluded, however, application to declarations to withhold "food, water, or of such medication and medical procedures as are necessary to provide comfort, care and to alleviate pain."<sup>77</sup> At the same time, the law provided that it was "cumulative and may not be construed to impair

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some trustworthy evidence that the patient would have refused the treatment and the decision maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him and that the treatment would merely prolong the patient's suffering. Under the "pure-objective" test, applicable when there is no trustworthy evidence that the formerly competent patient would have declined the treatment, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life.

*Id.* at 1259 (citations omitted); see also *In re C.A.*, 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992), *cert. denied*, 610 N.E.2d 1264 (Ill. 1993). Further, some states will apply the best interests test in the case of patients who were never competent to express an intent. See *In re Rosebush*, 491 N.W.2d 633, 639 (Mich. Ct. App. 1992).

[A]s applied to immature minors and other never-competent patients, the substituted judgment standard is inappropriate because it cannot be ascertained what choice the patient would have made if competent. We therefore conclude that, where the patient has never been competent, the decision-making test that better guides the surrogate is the best interests standard.

*Id.* at 639-40 (citations omitted).

73. See generally JONATHAN J. RIKOUN, *HANDLING YOUR FIRST HEALTH CARE PROXY, LIVING WILL, AND DURABLE POWER OF ATTORNEY* (1992) (Practicing Law Institute). In 1992, 45 states had statutes that recognized some form of a living will. *Id.*

74. See generally GUIDELINES FOR STATE COURT DECISION MAKING IN AUTHORIZING OR WITHHOLDING LIFE SUSTAINING MEDICAL TREATMENT (1991).

75. See *Mack v. Mack*, 329 Md. 188, 212, 618 A.2d 744, 756 (1993).

76. MD. CODE ANN., HEALTH-GEN. § 5-602(a) (1990) (repealed 1993).

77. *Id.* § 5-605(1) (repealed 1993).

or supersede any legal right or responsibility that any person may have to effect the initiation, continuation, withholding, or withdrawal of life-sustaining procedures.’<sup>78</sup>

Opinions by Maryland’s Attorney General construed this statute to be self-executing only with regard to terminal illness and life-sustaining procedures other than food and water.<sup>79</sup> Those opinions also acknowledged a person’s constitutional right to refuse sustenance.<sup>80</sup> The Attorney General’s opinions indicated that a declarant could add language to a living will regarding the withholding of treatment under other conditions, including the withholding of artificially administered food and water.<sup>81</sup>

Maryland’s Living Will Statute<sup>82</sup> was only applicable where a patient had the foresight to write a living will; as a result, Maryland’s Guardianship Statute was pertinent to most cases.<sup>83</sup> This statute provided for the appointment of a guardian for certain patients,<sup>84</sup> and allowed guardians to determine whether to withhold or withdraw medical or other professional care, including counselling, treatment, or service.<sup>85</sup> However, the guardian’s decision was subject to court approval if the course of action chosen involved a substantial risk to the patient.<sup>86</sup>

Both laws were amended in 1990, and in contrast to the 1988 amendment to the Living Will Statute<sup>87</sup> that explicitly precluded

78. *Id.* § 5-610(1) (repealed 1993).

79. 73 Op. Md. Att’y Gen. 162, 180-83 (1988).

80. *Id.*; see *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 278 (1990).

81. Op. Md. Att’y Gen., No. 90-044 (Sept. 24, 1990) (unbound).

82. MD. CODE ANN., HEALTH GEN., §§ 5-601 to -614 (1990) (repealed 1993).

83. MD. CODE ANN., EST. & TRUSTS §§ 13-701 to -710 (1990) (repealed 1993).

84. *Id.* § 13-705(a). Former § 13-705(b) set forth the grounds required for appointment:

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

*Id.* § 13-705(b). Former § 13-707(a) accorded priorities of appointment to: “(1) a person, agency, or corporation nominated by the disabled person . . . ; (2) His spouse; and (3) His parents.” *Id.* § 13-707(a).

85. MD. CODE ANN., EST. & TRUSTS § 13-708(b)(8)(ii), (iii) (1991) (amended 1993).

86. Former § 13-708(c) provided:

[W]here a medical procedure involves, or would involve, a substantial risk to the life of a disabled person, the court must authorize a

termination of artificial sustenance, the 1990 amendment expressly allowed the guardian to approve the withholding of treatment, but was silent on the issue of sustenance.<sup>88</sup> Until *Mack*, however, no cases had construed whether the 1990 amendment meant that sustenance could be terminated by either a living will or court authorization.

## II. THE INSTANT CASE

Due to the ambiguity of the Guardianship Statute, it was not surprising that the Court of Appeals of Maryland granted certiorari in *Mack*.<sup>89</sup> Ronald Mack was born in 1962 and, in 1980, married his wife, Deanna.<sup>90</sup> In 1983, while stationed in California with the Army, Ronald was "involved in an automobile accident in which he suffered massive brain injuries."<sup>91</sup> He was thereafter in a persistent vegetative state, totally "incapable of cognitive activity."<sup>92</sup> Ronald's arms and legs were moderately spastic, and he was incontinent.<sup>93</sup> A tracheotomy was performed to remove secretions from his lungs, and he had to be fed through a gastrostomy tube.<sup>94</sup> Ronald, however, was not experiencing pain.<sup>95</sup>

In 1983, Ronald was moved from California to a hospital in Maryland in order to be near his family.<sup>96</sup> The next year, Deanna

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guardian's consent or approval for:

- (1) The medical procedure;
- (2) Withholding the medical procedure; or
- (3) Withdrawing the medical procedure that involves, or would involve, a substantial risk to the life of the disabled person.

MD. CODE ANN., EST. & TRUSTS § 13-708(c) (1990) (amended 1993).

87. MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -614 (1988) (amended 1990).

88. An opinion of the Maryland Attorney General noted:

As amended by this statute, MD. CODE ANN., EST. & TRUSTS § 13-708(b)(8) now expressly empowers a guardian to approve the 'withholding' or 'withdrawing' of 'medical or other professional care, counsel, treatment or service.' However, 'where a medical procedure involves, or would involve, a substantial risk to the life of disabled person,' the guardianship court must itself 'authorize a guardian's consent or approval for' a procedure, the withholding of a procedure, or the withdrawing of a procedure.

Op. Md. Att'y Gen., No. 90-044 (Sept. 24, 1990) (unbound).

89. *Mack v. Mack*, 329 Md. 188, 618 A.2d 744 (1993).

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

91. *Id.* at 192, 618 A.2d at 746.

92. *Id.* The circuit court found "no medically reasonable expectation of recovery."  
*Id.* at 192-93, 618 A.2d at 746-47.

93. *Id.* at 192, 618 A.2d at 746.

94. *Id.*

95. *Id.* at 193, 618 A.2d at 747.

96. *Id.* at 192, 618 A.2d at 747.

was appointed Ronald's guardian in Maryland and moved to Florida where she lived with another man for about five years.<sup>97</sup> Deanna then sought and obtained appointment as guardian by decree of a court in Florida, and was discharged under the Maryland appointment.<sup>98</sup> In 1991, Deanna expressed an interest in having Ronald's treatment terminated.<sup>99</sup> Soon thereafter, Ronald's father, Mr. Mack, filed an application with the United States District Court for the District of Maryland for a temporary restraining order preventing Deanna from moving Ronald to a hospital in Florida.<sup>100</sup> A preliminary injunction was entered and Mr. Mack then petitioned the Circuit Court for Baltimore County to have himself appointed as Ronald's guardian.<sup>101</sup> Deanna cross-petitioned for guardianship and requested termination of Ronald's sustenance.<sup>102</sup> The circuit court ruled that the Florida court lacked jurisdiction to appoint Ronald's guardian and instead appointed a temporary guardian pending trial.<sup>103</sup>

At trial, the circuit court resolved the issue of guardianship and the termination of sustenance. The court appointed Mr. Mack as Ronald's guardian,<sup>104</sup> and found that there was no clear and convincing evidence of Ronald's intent to have sustenance terminated. The court held, therefore, that sustenance could not be withdrawn at the request of the guardian.<sup>105</sup>

On appeal, the majority of the Court of Appeals of Maryland agreed that the Florida court's appointment of a guardian was invalid.<sup>106</sup> The court also vacated the appointment of Mr. Mack as Ronald's guardian, finding that the appointment had been based on erroneous criteria.<sup>107</sup> The majority upheld the lower court's denial of the request to withhold life support.<sup>108</sup> Nonetheless, the majority

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97. *Id.* at 193, 618 A.2d at 747.

98. *Id.* at 193-94, 618 A.2d at 747.

99. *Id.* at 194, 618 A.2d at 747.

100. *Id.*

101. *Id.*

102. *Id.* at 195, 618 A.2d at 748.

103. *Id.* at 194-95, 618 A.2d at 747. The circuit court appointed Edward J. Gilliss, Ronald's counsel, as a temporary guardian. *Id.* at 195, 618 A.2d at 747.

104. Despite Deanna's higher priority under former § 13-707(a), she was not appointed as guardian. The appointment was based primarily on Deanna's desire not to continue the administration of food and water, which the court found to be in contravention of the objectives of Maryland law. *Id.* at 196, 618 A.2d at 748.

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

106. *Id.* at 200, 618 A.2d at 750.

107. The circuit court based the determination of guardianship on the fact that Deanna intended to withdraw Ronald's life support, ostensibly in contravention of the objectives of Maryland law. *Id.* at 196, 618 A.2d at 748; *see supra* note 104.

108. Five judges refused to withhold life support. Judge Chasanow agreed with the

accepted a basis for the right to die that would aid in interpreting the statutory provisions at issue. This basis was supported by the common-law rights of informed consent<sup>109</sup> and self-determination.<sup>110</sup> A determination as to whether the right to die is based on the Constitution or on the common law was irrelevant to the court's decision.<sup>111</sup> The court cited other jurisdictions that similarly found no need to address the constitutional issue.<sup>112</sup> The court noted, however, that "all of the [the Supreme Court] Justices, save Justice Scalia, flatly stated or strongly implied that a liberty interest under the fourteenth amendment guarantees a protected right to refuse life sustaining hydration and nutrition."<sup>113</sup>

The court of appeals' holding that artificial sustenance could be refused or removed relied heavily on the Attorney General's opinion that "there is no difference, as a matter of law, between artificially administered sustenance and other forms of life sustaining treatment."<sup>114</sup> The court distinguished the Guardian Statute from the Living Will Statute, which precluded the refusal of food and water.<sup>115</sup> In light of the authorities, the court remarked that "absent a statutory exclusion" in former section 13-708, sustenance could be withheld or withdrawn under the Guardian Statute.<sup>116</sup>

Stating that "[t]he statute does not, however, supply the standards or guidelines for a court's exercise of the power to grant or withhold authorization,"<sup>117</sup> the court recognized a common-law right to die analysis applicable to the procedural guidelines in former section 13-708.<sup>118</sup> The court then focused on establishing the proper guidelines and standards to be applied in right to die cases.<sup>119</sup>

The Court of Appeals of Maryland held that because the right to die was one of self-determination, a rule of "substituted judgment" must apply, wherein the guardian or court supplies an incompetent patient's past intent regarding the withdrawal or withholding

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result, but dissented with respect to the standard employed by the other four judges. *Mack*, 329 Md. at 233, 618 A.2d at 766-67. Judge McAuliffe and Chief Judge Murphy dissented. *Id.* at 222, 618 A.2d at 761.

109. *Id.* at 210, 618 A.2d at 755.

110. *Id.* at 214-15, 618 A.2d at 757-58.

111. *Id.* at 211, 618 A.2d at 756.

112. *Id.*

113. *Id.*

114. *Id.* at 213, 618 A.2d at 757 (quoting 73 Op. Md. Att'y Gen. 179, 181 (1988)).

115. "[T]he unqualified language used by the General Assembly in the 1990 amendment of [Estates & Trusts] § 13-708(b)(8) and (c) stands in stark contrast [to that of the living will statute]." *Id.* at 214, 618 A.2d at 757.

116. *Id.*

117. *Id.* at 212, 618 A.2d at 756.

118. *Id.* at 215, 618 A.2d at 758.

119. *Id.* at 215-17, 618 A.2d at 757-59.

of life support.<sup>120</sup> The court further determined that such substituted judgment must be based upon clear and convincing evidence of the patient's past intent.<sup>121</sup> The court applied this high standard of proof because it was utilized by the "overwhelming majority" of states.<sup>122</sup> Applying that standard to the facts, the court affirmed the lower court's denial of authorization to withhold life support procedures.<sup>123</sup>

Finally, the court rejected the proposed best interests standard, irrespective of the pertinent standard of proof. The court elaborated on the problems inherent in the best interests test,<sup>124</sup> maintaining that the legislature did not intend for that standard to apply.<sup>125</sup>

The dissent, however, took issue with the clear and convincing standard as applied by the majority in the authorization of a guardian's request to terminate life support.<sup>126</sup> First, the dissent argued that the substituted judgment approach "comes into play when the ward has made no prior statements bearing on the issue" of intent.<sup>127</sup> Second, the dissent argued that the court's analysis of the patient's intent was unnecessarily "limited to . . . the intent the ward may have formed when competent,"<sup>128</sup> to the exclusion of other factors that should be taken into consideration in the absence of explicit expressions of intent.

### III. ALTERNATIVE APPROACHES

The court could have held that construing former section 13-708 in *para materia* with former section 5-605 precluded the possibility of removal of artificial nutrition and hydration.<sup>129</sup> The court recog-

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

121. *Id.* at 207-09, 618 A.2d at 753-55. The court likened the request to withdraw or withhold life support to a request for punitive damages in a tort case, and a request for sterilization of an incompetent ward, both of which have been held subject to the clear and convincing evidence standard. *Id.* at 208, 618 A.2d at 754.

122. *Id.* at 208-09, 618 A.2d at 754-55. Curiously, the court cited New Jersey and Illinois as two of the jurisdictions that require "clear and convincing evidence that the ward's decision would have been to forego life support." *Id.* Clearly, that is incorrect. *See supra* note 72.

123. *Mack*, 329 Md. at 217, 618 A.2d at 759. "[The trial court's] fact findings are not clearly erroneous. This is a case in which we do not know what decision, if any, the patient had made or would make." *Id.*

124. One such problem includes the theoretical fallacy in attributing any interests whatsoever to someone who is permanently unconscious. *Id.* at 220, 618 A.2d at 760 (citing 73 Op. Md. Att'y Gen. 162, 189-90 (1988); *In re Peter*, 529 A.2d 419, 425 (N.J. 1987)). Another problem is the slippery slope potential of the best interests test. *Id.* at 221-22 n.11, 618 A.2d at 761 n.11; *see also supra* text accompanying notes 47-49.

125. *Mack*, 329 Md. at 217-22, 618 A.2d at 759-61.

126. *Id.* at 223-29, 618 A.2d at 762-65 (McAuliffe, J., dissenting).

127. *Id.* at 223, 618 A.2d at 762.

128. *Id.* at 228, 618 A.2d at 764.

129. It should also be noted, on the other hand, that the court could have merely



nized the implications of *Cruzan*, however, and avoided basing its decision on a rule that would prove constitutionally challengeable.

More confounding was the court's assertion that the Guardian Statute did not actually rely on the guardian's judgment in this paramount determination, but instead used the court's assessment of the patient's judgment.<sup>130</sup> Even accepting the proposition that the legislature intended the court, rather than the guardian, to make such determinations,<sup>131</sup> the court's statement that the patient is entrusted to the court holds only partially true under the rule in *Mack*.<sup>132</sup> Only if the guardian invokes the court's oversight, by opting for the withholding or withdrawal of sustenance as opposed to initiation or continuation,<sup>133</sup> is clear and convincing evidence of an incompetent

allowed Florida to appoint Deanna as guardian. Sufficient contacts, however, is a well established requisite to the exercise of jurisdiction over the person. Such contacts were lacking in this case, as Ronald resided in Maryland. It may be argued that this rule could be surreptitiously avoided by merely attaining guardianship in Maryland and then moving the ward to another state to obtain the benefit of its laws. Although this too required court authorization, the guardian could be disingenuous as to his intent. MD. CODE ANN., EST. & TRUSTS § 13-708(b), (c) (1991) (amended 1993) ("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 the classification of abode. . . .").

130. *Mack*, 329 Md. at 212, 618 A.2d at 756. "Ronald, as a ward of the court, is entitled to plenary protection of the court." *Id.*

131. Indeed, a recent poll indicated that there is a clear consensus in America that the family should make the decision, rather than the court.

An overwhelming 88 percent of Americans say the family should decide whether to end artificial life support when an individual is in a coma without hope of recovery and has left no instructions on personal wishes. Only 8 percent said doctors should make the decision; 1 percent said the courts should decide, and no one selected the state.

*Id.* at 248, 618 A.2d at 774 (Chasanow, J., concurring in part and dissenting in part) (quoting M. Coyle, *How Americans View High Court*, NAT'L L.J., Feb. 26, 1990, at 36).

132. The court later admitted this inconsistency in its opinion:

From the standpoint of initiating a request to withdraw life-sustaining treatment, the judgment of the guardian or applicant for guardianship is truly substituted for that of the ward. But, from the standpoint of whether the treatment is to be withdrawn, the "substituted judgment" label is a misnomer. The judgment of the guardian is not accepted by the court in lieu of the judgment of the ward. Rather, because the right is one of self-determination, the inquiry focuses on whether the ward had determined, or would determine, that treatment should be withdrawn under the circumstances of the case.

*Id.* at 214-15, 618 A.2d at 757. The clear implication is that the right to self-determination is not involved unless treatment is sought to be withdrawn.

133. Initiation would tend to occur well before a court could take action to authorize, and continuation would ordinarily require no authorization. See *infra* note 162 and accompanying text.

patient's intent required. To the contrary, the patient's intent could be ignored at the option of the guardian by not involving the court at all. As a result, the patient's intent would be carefully evaluated only under certain circumstances. If the guardian allowed treatment to continue against the patient's intent, the court would not be involved.<sup>134</sup> Thus, the *Mack* court reduced the role of the guardian to an arbitrary invoker of judicial determinations as to the patient's treatment.

The plain language of former section 13-708 provided that the court need only "authorize" the guardian's decision to withhold or withdraw sustenance.<sup>135</sup> If the legislature intended a full-blown evidentiary determination, it would have so indicated. The term "authorize" is defined as: "To empower; to give a right or authority to act. To endow with authority or effecting legal power, warrant, or right . . . . To permit a thing to be done in the *future* . . . ."<sup>136</sup> The court provided no cogent reason as to how the term "authorize" translated into a disenfranchising supervision of the guardian's decisions. Indeed, in the case of an incompetent patient on life support, the provisions for the appointment of a guardian are meaningless because the court must make the ultimate decision anyway. More logically indicated by the word "authorize" would have been a determination by the court that the guardian has no improper motives in making a decision, and has a sufficient relationship to the patient to have developed a decision based on clear and convincing evidence, as is the case in other jurisdictions.<sup>137</sup>

Moreover, requiring clear and convincing evidence of a patient's prior intent was not implicit in the statute.<sup>138</sup> In fact, the test employed by the court unnecessarily focused upon the existence of evidence that is not likely to be present in many cases. The result is that anyone who left behind little memorable evidence of an opinion on the subject of a dignified death would have their case resolved

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134. *Mack*, 329 Md. at 214-15, 618 A.2d at 757.

135. *Id.*

136. BLACK'S LAW DICTIONARY (5th ed. 1979) (emphasis added) (citation omitted).

137. *See, e.g., In re Rosebush*, 491 N.W.2d 633 (Mich. Ct. App. 1992).

We therefore hold that, in general, judicial involvement in the decision to withhold or withdraw life-sustaining treatment on behalf of a minor or other incompetent patient need occur only when the parties directly concerned disagree about treatment, or other appropriate reasons are established for the court's involvement.

*Id.* at 639; *see also In re of Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989) (although a decision must be based on clear and convincing evidence, the surrogate makes the decision in an informal forum).

138. *See generally*, MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1991) (repealed 1993); MD. CODE ANN., EST. & TRUSTS §§ 13-701 to -713 (1991) (amended 1993).

the same way, despite their actual intent. It is arbitrary to ignore the hopelessness and severity of the condition and its effect upon the patient's family; indeed, it is illogical to regard these factors as irrelevant to the patient's putative intent. Certainly, the primary indicia should be any prior expressed intent of the patient, but a reasonable approach would also admit evidence of the current situation itself. It may be argued that by recognizing this, the objective best interests test is approximated in a case with sparse subjective indicia. That does not make the subjective test flawed, however, it merely points out its fictitious aspect—when the patient is perpetually unconscious, subjective intent is non-existent.<sup>139</sup>

The court was correct in intimating that lawmaking is best left to the legislature;<sup>140</sup> nonetheless, by taking affirmative measures instituting a "pro-life" bias, the court did effect a change in the law.<sup>141</sup> With its decision in *Mack*, the Court of Appeals of Maryland put the ball squarely in the legislature's court.<sup>142</sup> The legislature responded quickly, enacting the Health Care Decisions Act of 1993 which became effective as of October 1, 1993.

#### IV. THE IMPACT OF THE HCDA

The preamble of the HCDA states:

Whereas, the State is constitutionally permitted to enact reasonable safeguards to assure that health care decisions made by others or on behalf of an incapacitated patient are in keeping with the wishes of the patient or are in the *best interests* of the patient . . . .<sup>143</sup>

##### A. *Advance Directives and Surrogate Decisions*

Section 5-602 of Maryland's Health-General Article allows a competent individual to make a written or oral advance directive to guide health care decisions in the event of incompetency.<sup>144</sup> Unlike the former Living Will Statute, the current provisions allow for the

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139. The test employed by the court depends on the fiction that the patient's past indications correspond to what he would want to do now. The court was unwilling to admit that a patient in a persistent vegetative state cannot have intent, although it may be constructed for him. There is no reason why the construction chosen in *Mack* would better vindicate the patient's rights than a broader or more objective assessment of his best interests. For a critical analysis of the variety of judgments employing this fiction, see Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1 (1990).

140. *Mack*, 329 Md. at 198, 222, 618 A.2d at 749, 761.

141. *Id.* at 222, 618 A.2d at 760-61.

142. The court held that the "'best interest' standard for withdrawal of life support involves a quality-of-life judgment which . . . should be made only under guidelines established by the General Assembly." *Id.* at 198, 618 A.2d at 749.

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

144. *Id.* § 5-602 (1994 and Supp. 1994).

refusal of nutrition and hydration.<sup>145</sup> Two model forms are suggested in section 5-603.<sup>146</sup> Form I is a Living Will. It provides a range of options concerning possible courses of treatment and suggests that the individual tailor these options to different circumstances.<sup>147</sup> Form II is comprised of two optional parts, the first directing the appointment of a health care agent to make decisions on behalf of the

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145. *Id.* § 5-601(m)(2) (1994) (stating that "a life sustaining procedure includes artificially administering hydration and nutrition").

146. *Id.* § 5-603 (1994 and Supp. 1994).

147.

Form I  
Living Will  
(Optional Form)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial those statements you wish to be included in the document and cross through those statements which do not apply.)

a. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery—

\_\_\_I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

\_\_\_I direct that, even in a terminal condition, I be given all available medical treatment in accordance with accepted health care standards.

b. If I am in a persistent vegetative state, that is if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery within a medically appropriate period—

\_\_\_I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take in food by mouth, I wish to receive nutrition and hydration artificially.

\_\_\_I direct that I be given all available medical treatment in accordance with accepted health care standards.

c. If I am pregnant my agent shall follow these specific instructions: \_\_\_\_\_

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By signing below, I indicate that I am emotionally and mentally competent to make this living will and that I understand its purpose and effect. . . .

individual in the event of incompetency.<sup>148</sup> The second part details

148.

Form II  
Advance Directive  
Part A  
Appointment of Health Care Agent  
(Optional Form)

(Cross through if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, cross through any items in the form that you do not want to apply.)

(1) I, \_\_\_\_\_, residing at \_\_\_\_\_

appoint the following individual as my agent to make health care decisions for me

\_\_\_\_\_  
(Full Name, Address, and Telephone Number)

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity

\_\_\_\_\_  
(Full Name, Address, and Telephone Number)

(2) My agent has full power and authority to make health care decisions for me, including the power to:

a. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;

b. Employ and discharge my health care providers;

c. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

d. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

(3) The authority of my agent is subject to the following provisions and limitations:

(4) My agent's authority becomes operative (initial the option that applies):

\_\_\_ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; or

\_\_\_ When this document is signed.

(5) My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

(6) My agent shall not be liable for the costs of care based solely on

in advance the specific health care instructions for that appointed agent to follow in such an event.<sup>149</sup>

this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect. . . .

MD. CODE ANN, HEALTH-GEN. § 5-603 (Supp. 1994).

149.

Part B  
Advance Medical Directive  
Health Care Instructions  
(Optional Form)

(Cross through if you do not want to complete this portion of the form. If you do want to complete this portion of the form, initial those statements you want to be included in the document and cross through those statements that do not apply.)

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial all those that apply.)

(1) If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery—

\_\_\_I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(2) If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery—

\_\_\_I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(3) If I have an end-stage condition, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective—

\_\_\_I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

\_\_\_I direct that no matter what my condition, medication not be given to me to relieve pain and suffering, if it would shorten my remaining life.

\_\_\_I direct that no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.

(4) If I am pregnant, my decision concerning life-sustaining

Section 5-605 further allows a surrogate to make decisions regarding an incompetent patient's medical care, even if a health care agent was not nominated by the patient.<sup>150</sup> The surrogate is selected from an enumerated class<sup>151</sup> of the highest rank available.<sup>152</sup> "Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient<sup>153</sup> or, if the wishes of the patient are unknown or unclear, on the patient's best interest."<sup>154</sup> The factors to be considered by the surrogate in these determinations are explicitly listed.<sup>155</sup> A health care provider may petition the court to prevent the withholding or with-

procedures shall be modified as follows:

(5) I direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care)

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document. . . .

MD. CODE ANN., HEALTH-GEN. § 5-603 (Supp. 1994).

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

151. Those classes are: "(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 [sibling]; or (vi) A [qualified] friend or other relative of the patient. . . ." MD. CODE ANN., HEALTH-GEN. § 5-605(a) (1994).

152. Section 5-605(a)(1) provides that the surrogate is unavailable when:

(i) After reasonable inquiry, a health care provider is unaware of the existence of a surrogate decision maker;

(ii) After reasonable inquiry, a health care provider cannot ascertain the whereabouts of the surrogate decision maker;

(iii) A surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider;

(iv) A surrogate decision maker is incapacitated; or

(v) A surrogate decision maker is unwilling to make decisions concerning the health of the individual.

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

153. The factors to be considered are: (1) the "current diagnosis and prognosis with and without treatment at issue"; (2) "expressed preferences regarding the . . . treatment at issue or of similar treatments"; (3) "relevant religious and moral beliefs and personal values"; (4) behaviors and attitudes regarding medical treatment; (5) "reactions to . . . similar treatment for another individual"; and (6) "expressed concerns about the effect on the family or intimate friends." MD. CODE ANN., HEALTH-GEN. § 5-605(c)(2) (1994).

154. The considerations relevant to the patient's best interests are: (1) the effects of treatment on the disabled person; (2) the pain involved in withholding or withdrawing treatment; (3) the degree of insult to the patient's dignity caused by treatment or its withdrawal; (4) the effect of treatment on life expectancy; (5) the effect of treatment on the prognosis; (6) the risks and benefits of the treatment or its withdrawal; and (7) the religious beliefs and basic values of

drawal of a life-sustaining procedure if he believes such an instruction to be inconsistent with generally accepted standards of patient care.<sup>156</sup> Others may petition the court to enjoin a request for withholding or withdrawal if such a request is not authorized by law.<sup>157</sup>

*B. A Guardian's Decision Making*

The HCDA also significantly modified Title 13 of the Estates & Trusts Article. Section 13-707 now provides that the designated health care agent, as defined by title 5 of the Health-General Article, is second in priority in the appointment of a guardian.<sup>158</sup> Section 13-708(c)(2) was added, providing that "the court may, upon such conditions as the court considers appropriate,<sup>159</sup> authorize a guardian to make a decision regarding medical procedures that involve a substantial risk to life *without further court authorization*," if the disabled person executed an advance directive allowing a guardian to make decisions, or if the guardian is a spouse, parent, adult child, or adult sibling of the disabled person.<sup>160</sup> In all other cases, "the court must authorize a guardian's consent or approval" for withdrawing or withholding medical procedures that would involve a substantial risk to the patient's life.<sup>161</sup> Court authorizations are to be based upon clear and convincing evidence of what the patient would

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the patient. MD. CODE ANN., HEALTH-GEN. § 5-605(c)(1) (1994). Neither the financial burden nor the impact upon the patient's family or loved ones are included among these factors.

155. MD. CODE ANN., HEALTH-GEN. § 5-605(c)(2) (1994). Two physicians must certify the incapacity of the patient, *id.* § 5-606(a), and two physicians must also certify that the patient is in a terminal condition, or has an end-stage condition, *id.* § 5-606(b).

156. *Id.* § 5-612(a).

157. *Id.* § 5-612(b).

158. MD. CODE ANN., EST. & TRUSTS § 13-707(a)(2) (Supp. 1994). The highest priority remains an entity previously nominated by the patient to be a guardian. *Id.* § 13-707(a)(1) (1993 and Supp. 1994).

159. This appears to leave the court with the discretion to ascertain whether the surrogate has ulterior motives, or to determine whether there is any other reason his judgment would not be trustworthy.

160. MD. CODE ANN., EST. & TRUSTS § 13-708(c)(2) (Supp. 1994) (emphasis added). Section 13-708(c)(1) was also modified to clarify that court authorization of the decision may not be necessary: "[E]xcept as provided in [§ 13-708(c)(2)], . . . the court must authorize the guardian's consent or approval." *Id.* § 13-708(c)(1) (emphasis added). Although it could be interpreted that § 13-708(c)(3) requires the court to authorize, by engaging in its own analysis of the patient's wishes or best interests (following § 13-711 through § 13-713), all requests to withhold or withdraw life-sustaining procedures, such an interpretation would render the addition of subsection (c)(2) and the modification of subsection (c)(1) meaningless and of no effect. Thus, subsection (c)(3) appears to invoke the court's oversight of the actual decision only when the exception in (c)(2) does not apply.

161. MD. CODE ANN., EST. & TRUSTS § 13-708(c)(1) (1993).



do if competent;<sup>162</sup> however, if this substituted judgment cannot be made, authorization may be based upon clear and convincing evidence of what is in the patient's best interests.<sup>163</sup>

C. *Application to Mack v. Mack*

The HCDA bolstered individuals' ability to rely on others to appropriately act on their behalf in the event that they are unable to do so, thereby assuring a greater degree of prospective autonomy. Clearly, this has an impact on the potential future disposition of the *Mack* case.<sup>164</sup> Under the new law, Deanna Mack could proceed either under title 5 or 13 to make decisions regarding Ronald's treatment. Although Ronald never made an advance directive or appointed a health care agent, Deanna would be entitled to make surrogate decisions regarding his health care. Clearly, Deanna, as Ronald's wife, would have priority over Ronald's father in the decision making process.<sup>165</sup> Section 5-605(2) provides priority for the patient's guardian; if there is no guardian appointed, the second choice is the patient's spouse, the third choice is an adult child, and the fourth choice is a parent.<sup>166</sup>

Deanna would be required to act upon Ronald's wishes, considering such factors as his expressions, beliefs, and attitudes regarding the treatment and other relevant issues.<sup>167</sup> If she found that his wishes were unclear, she could then base her decision upon a broader assessment of Ronald's best interests.<sup>168</sup> Although the evidence regarding Ronald's wishes was found to be ambiguous,<sup>169</sup> the decision would still be Deanna's to make. At the least, she could base a decision to terminate procedures upon her intimate knowledge of

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162. *Id.* § 13-712(b) (Supp. 1994). The factors to be considered by the court in the substituted judgment are listed in § 13-711(d) and are essentially the same as those described in § 5-605(c)(2) for consideration of a decision by a surrogate. *Id.* § 13-711(d) (1993); *see also supra* note 153.

163. MD. CODE ANN., EST. & TRUSTS § 13-713(a) (Supp. 1994). The considerations relevant to the patient's best interests are the same as those outlined in § 5-605(c)(2). *See supra* note 154; MD. CODE ANN., EST. & TRUSTS § 13-711(b) (Supp. 1994).

164. Section 5-616 provides that the subtitle is "cumulative with existing law on the right to consent or refuse to consent to medical treatment and do[es] not impair any existing rights." MD. CODE ANN., HEALTH-GEN. § 5-616(a) (1994).

165. *See supra* note 151.

166. There would thus be no dispute among members of a class with equal priority because Deanna would be the only member of that class, and Ronald's father would have lower priority under the statute. *See* MD. CODE ANN., HEALTH-GEN. § 5-605(b)(1) (1994).

167. *See supra* notes 153, 154.

168. *See supra* note 154.

169. *Mack v. Mack*, 329 Md. 188, 217, 618 A.2d 744, 758-59 (1993).

Ronald and his best interests. Only upon petition by a concerned party to enjoin the termination would a court become involved in assessing whether the provisions of the law authorized that termination, that is, whether the patient's wishes or best interests dictated that course of action.<sup>170</sup> Ronald's father could make such a petition. However, given the new guidelines, Ronald's situation, and Deanna's knowledge of Ronald, it would be difficult to justify denying her request.

Alternatively, Deanna could invoke the revised Guardian Statute and make a decision regarding continuation of Ronald's treatment. Because Deanna is Ronald's spouse, she would come under the exception to court authorization in section 13-708(c)(2).<sup>171</sup> Thus, Deanna would be authorized in advance to make a decision regarding medical procedures that could involve a substantial risk to Ronald's life, without further court authorization.<sup>172</sup> Unless Deanna's motives for having Ronald's treatment terminated were questionable, there would appear to be no reason why a court should find such prospective authorization inappropriate.

## V. CONCLUSION

Ostensibly to avoid "legislating" in a controversial area,<sup>173</sup> the Court of Appeals of Maryland, in *Mack v. Mack*,<sup>174</sup> adopted an approach that deceptively allayed the court's fears of interfering with the patient's rights by ignoring those rights if the patient never clearly expressed the intent to choose a dignified end to his life. The court did provide, however, needed impetus and illustration for the legislature in its fashioning of the HCDA. The legislature made it clear that requiring courts to authorize every decision to withhold or withdraw life-sustaining procedures was unnecessarily disenfranchising to those who could best make such decisions. Thus, only when there is a dispute, when the decision maker is not sufficiently close to the patient, or when that decision maker's motives or reliability are questionable, does the court intervene and impose its own judgment.

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170. See MD. CODE ANN., HEALTH-GEN. § 5-612(b) (1994).

171. MD. CODE ANN., EST. & TRUSTS § 13-708(c)(2) (Supp. 1994).

172. *Id.*

173. The court seemed to indicate that it might have affected such a change had there been a clear societal consensus: "[W]e are by no means confident that there exists on this quality-of-life question the degree of societal consensus that this Court ordinarily requires before announcing a change in the common law." *Mack*, 329 Md. at 219-20, 618 A.2d at 760. *But see* Coyle, *supra* note 131.

174. 329 Md. 188, 217 A.2d 744 (1993).

Moreover, the legislature found the requirement of clear and convincing evidence of past intent of the patient to refuse treatments to be unnecessarily restrictive. Under the new Advance Directive Statute, no mention is made of clear and convincing evidence. Under the revised Guardian Statute, when court authorization is necessary, clear and convincing evidence of the patient's intent is preferred but not necessary, and the court may base its decision on the patient's best interests.

The HCDA responded to the complex challenge and debate underlying the laws that *Mack* interpreted. As a result, Maryland has taken a position of leadership in a crucial area, providing thorough, reasonable guidelines to focus on and protect its patients' wishes and best interests in life and death matters.

*Thomas J. Brindisi*