1993

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THE HEALTH CARE DECISIONS ACT OF 1993

John Carroll Byrnes†

On May 11, 1993, Maryland’s Governor, William Donald Schaefer, signed into law the Health Care Decision Act (HCDA), one of the most comprehensive health care decision laws in the nation. In doing so he set free a bird that some fear may be a predator at times, but that all of its many authors expect will be a dove of peace for individuals who while on a painful threshold of death, have not yet crossed it.  

† Judge of the Circuit Court for Baltimore City and chairman of the legislative drafting committee of the Conference of Circuit Judges committee formed to propose life support decision standards for judges in guardianship cases. Judge Byrnes served as an adjunct faculty member of the University of Baltimore School of Law from 1988-92, and as an adjunct faculty member of the University’s Yale Gordon College of Liberal Arts since 1990. He has also served as an adjunct faculty member of Loyola College since 1986.

The author expresses sincere appreciation to Jack Schwartz for his preview of this Article, his helpful editing and comments, and his assurance that its tone is “generous and even.” Very helpful reviews by Senators Walter M. Baker and John A. Pica, Delegate Stephen J. Braun, Hon. Rosalie S. Abrams, Dr. Louis C. Breschi and Dr. George A. Taler, and Howard L. Sollins, Esq. are greatly appreciated as well. Opinions expressed in this Article are those of the author.

1. Md. Code Ann., Health-Gen. §§ 5-601 to 618 (1994). This Act took effect on October 1, 1993. By 1992, every state had authorized some form of life-sustaining treatment decision making, although the source, scope, and circumstances of the authority varies. Alaska law, for example, did not permit agents to make life support decisions. Twenty-seven states had no law clearly permitting family-surgeon decisions in the absence of advance declarations. The District of Columbia and 20 states did have such laws; and three states, including Maryland, had either court or attorney general opinions recognizing surrogate decisions. Right-to-Die Case & Statutory Citations State-by-State Listing, Choice in Dying (Choice in Dying, formerly Concern for Dying and the Society for the Right to Die, 200 Varick St., New York, N.Y. 10014), Dec. 1990 (on file with author).

2. Death is defined in the Maryland Code as either the irreversible cessation of circulatory and respiratory functions, or the cessation of "all functions of the entire brain, including the brain stem." Md. Code Ann., Health-Gen. § 5-202 (1994).
My experience with this field of law began in 1986 with *In re Cole.* This case came to my courtroom in Baltimore City's Courthouse East almost exactly six years before the Governor's approval of the health care decision bill. I later described it:

On May 9, 1986, I was approached in the courthouse hallway by a well regarded young lawyer who was frequently court appointed in routine guardianship proceedings for the disabled. He mentioned a pending request for an order permitting withdrawal of a life support system. The hearing was scheduled in a few hours. I asked if research had been done. Apparently, this inquiry was unexpected because the pending requested order seemed indistinguishable from the nearly pro forma non-controversial guardianship proceedings that routinely appear on our civil "fast track" docket.

At the hearing several hours later, I was informed that the subject of the proceeding was comatose following a stroke 41 days earlier. This order was sought by her husband, a respected minister, with the support of all of their children, none of whom were present.

The husband was represented by another young attorney who candidly acknowledged that the matter was outside his professional experience. The attending physician testified that the patient's chances of recovery were between one in one thousand to one in one billion; and that there had been no formal hospital ethics committee review.

The husband testified that he was told that his wife, as she suffered the stroke, in the presence of several of their children, declared that she "didn't want to live like this," and this statement was consistent with comments made during previous family discussions on the plight of another member of her family. As noted, none of the children who actually heard this declaration were present to testify.

While persuaded that the bereaved husband was sincere and caring in his petition, I was perplexed that such a grave request was being made with such legal and medical casualness. To the apparent surprise and chagrin of the petitioner husband and counsel, I declined to sign the order. Six days later, the patient regained full consciousness and, rather quickly thereafter, virtually all her faculties.

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4. John Carroll Byrnes, *A "Macro" View of the Law of Life Support Withdrawal,* 3:3 *The Barrister* 9 (1990). The story of this case has been published. *Harry A. Cole & Martha M. Jablow, One in a Million* (1990). One of the children expressed strong disagreement with the requested order, but this apparent dissent was not made known to me at the hearing. *Id.* at 220.
I was intrigued by the rather simple approach taken in Cole, as compared to the case of Karen Ann Quinlan ten years earlier in New Jersey, where the issue was given much greater legal and medical attention. These two cases were similar, however, in the lack of clear governing law and procedural standards. Also present in both

6. Before the decision in Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993), Maryland had little common law on the subject of health care decision making. In addition to Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977), which adopted the informed consent doctrine (a physician must have the knowing consent of the patient in order to treat) in Maryland, there were only a handful of related decisions. See Wentzel v. Montgomery Gen. Hosp., 293 Md. 685, 703, 447 A.2d 1244, 1253 (1982), cert. denied, 459 U.S. 1147 (1983) (holding that the clear and convincing standard applies to proof of facts justifying sterilization of an incompetent ward at the request of his guardian); Levitsky v. Levitsky, 231 Md. 388, 190 A.2d 621 (1963) (holding that the religious beliefs of a mother, a Jehovah's Witness, could not overcome the state's interest in the welfare of her child, and blood transfusions were properly ordered); Craig v. State, 220 Md. 590, 155 A.2d 684 (1959) (recognizing a statutory duty of parents to provide reasonable medical treatment to minor children even when such treatment is antithetical to the religious beliefs of the parents); Mercy Hosp., v. Jackson, 62 Md. App. 409, 489 A.2d 1130 (1985), vacated, 306 Md. 556, 510 A.2d 562 (1986) (concluding that a circuit court judge properly declined to appoint for a competent, conscious, rational, adult hospital patient who required a Caesarean delivery, but refused on religious grounds to consent to a blood transfusion, putting only the mother, not the fetus, at risk); Snyder v. Holy Cross Hosp., 30 Md. App. 317, 327, 352 A.2d 334, 339, cert. denied, 276 Md. 750 (1976) (finding the state's interest in peace, health, and good order was sufficiently compelling to override the religious objections of the father, an Orthodox Jew, who did not want his son's body autopsied). After Cole, the appeal in In re Riddlemoser, 317 Md. 496, 564 A.2d 812 (1989), was dismissed as moot, but the Court of Appeals of Maryland commented, in dicta, that the "withdrawal of respiratory life-support or a gastric feeding tube is the termination of already existing medical treatment." Id. at 504 n.5, 564 A.2d at 816 n.5. Study has also been done at the Maryland Circuit Court level. See In re Sahm, No. 92-T-0043, Mar. 30, 1992, Cir. Ct. for Balt. Co. (J. Jacobson); In re Mack, No. 91-T-103, Mar. 10, 1992, Cir. Ct. for Balt. Co. (J. Fader). See generally John Carroll Byrnes, A "Macro" View of the Law of Life Support Withdrawal, 3:3 The Barrister 9 (1990); John Carroll Byrnes, Life Support Withdrawal: Law of Commiseration or Principle, 2:2 Md. J. Contemp. Legal Issues 333 (1991).

cases was an instinctive and sincere belief on the part of counsel and the parties that the relief sought was necessary and appropriate to the needs, wishes, and best interests of the afflicted patient.

This experience made obvious the need for standards to protect life needlessly threatened by the benevolent or malevolent intentions of others. Also needed are appropriate means by which every person can express his or her own health care wishes in a legally convincing manner, as well as means for lawful involvement by family members in life-ending health care decisions. Ideally, these goals should be met without crossing the border into mercy killing and euthanasia, and without re-engagement of the pro-choice and anti-abortion antagonists and antagonisms.\(^7\)

While it is fair to say that these goals were addressed with the adoption of the HCDA, only experience with the law will determine whether these goals are met. It is my intention to present this new law by explanation of its essential purposes, history, detailed provisions, and public policy expectations.

I. THE NEED FOR A UNIFORM STANDARD OF HEALTH CARE DECISION MAKING

The typical health care decision has been made either directly by the patient and the physician, or if the patient was unable to intelligently communicate a decision, by family members and the physician. Other than in distinct informed consent situations, such as by a parent for a minor child, or in emergencies,\(^8\) it has not been

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7. The philosophical and political similarities between the issues of abortion and euthanasia are superbly presented by Ronald Dworkin. RONALD DWORKIN, LIFE'S DOMINION, AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM (1993). Professor Dworkin argues that all reasonable people both reject government control of a citizen's medical choices and respect life, whether their rationale derives from religious, cultural, or legal traditions, or from personal humanitarian ethics. He suggests that the political debate should center on finding the reasonable balance between personal freedom to control what happens to one's own body, and community protection of life qua life. Although this writer and others involved in the drafting of proposed health care decision legislation had neither a pro-life nor a pro-choice agenda, the abortion issue had a marginal influence on the final design of the Bill. For example, the legislative sponsors deleted language referring to the traditional state interest in the preservation of life in favor of less provocative language of the same import.

8. MD. CODE ANN., HEALTH-GEN. § 20-107 (1990) provides physician and surrogate authority for emergency health care decisions. The seminal Maryland informed consent decision, Sard, 281 Md. at 432, 379 A.2d at 1014, arguably was confined to circumstances where some significant invasion of the body was contemplated. "The fountainhead of the doctrine of informed consent is the patient's right to exercise control over his own body, at least when undergoing elective surgery, by deciding for himself whether or not to submit to the particular therapy." Id. at 439, 379 A.2d at 1019. It is notable that Sard was decided in 1977, see id., the year following Quinlan, see 355 A.2d at 647.
entirely clear who was authorized as a matter of law—as opposed to practice—to make what decisions and when. This was particularly true when the decision involved placement or removal of a life support mechanism from an incompetent patient. The 1976 New Jersey decision in *In re Quinlan*\(^9\) and the 1990 decision of the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*\(^10\) focused the decisional authority in the life support context more sharply on the patient.\(^11\) Both decisions gave an older common-law doctrine of informed consent greater reach,\(^12\) and *Cruzan* recognized every individual’s constitutional liberty interest in controlling his own health care.\(^13\) *Quinlan* and several influential state decisions also proposed a solution to the dilemma presented by the comatose or otherwise incompetent patient who could not express any decision.\(^14\) The solution was to permit substituted judgments by surrogate decision makers, such as close family members and friends.\(^15\) In

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11. See id. at 261; *Quinlan*, 355 A.2d at 647.
12. The recent Maryland life support decision in Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993), rested upon common law, not constitutional law. *Id.* at 210-12, 618 A.2d at 755-56.
13. Chief Justice Rehnquist wrote:

> The Fourteenth Amendment provides that no State shall “deprive any person of life, liberty, or property, without due process of law.” The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions . . . . But determining that a person has a “liberty interest” under the Due Process Clause does not end the inquiry; “whether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.”

*Cruzan*, 497 U.S. at 278-79.

Decisions such as Union Pacific Ry. v. Botsford, 141 U.S. 250 (1891), Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914), and in Maryland, Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977), established informed consent principles, but did not expressly anticipate the application of those principles to a comatose patient for whom the question was not whether to perform some surgical procedure for therapeutic purposes, but rather whether to not perform a procedure, or to remove some therapeutic or life-sustaining device from a patient incapable of giving informed consent.


15. The doctrine of substitute judgment originated more than 150 years ago as a means of administering the estate of an incompetent person. See Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977) (citing *Ex parte Whitbread in re Hinde*, a Lunatic, 35 Eng. Rep. 878 (1816)) (gift from the incompetent’s estate was given to another person to whom the incompetent owed no duty of support). Basically, this doctrine permits the court to substitute itself for the incompetent by “don[ning] his mental mantle” and acting as the
addition to the substituted judgment doctrine, many states, including Maryland, also enacted what came to be known as living will laws. These laws provided that a person could state in a formal document that when they were in a terminal condition and their death was imminent, they did not wish their “dying [to be] artificially prolonged” by life-sustaining procedures.

As this personal autonomy law evolved, it did so simultaneously with, and partially driven by, a growing public interest in avoiding what was perceived to be an undignified and unnecessarily prolonged dying process. The process was often accompanied, if not sometimes partially caused, by artificial means of life support that replaced inoperative vital bodily functions. As these artificial devices came...

17. In Maryland, this declaration would not apply if the patient were pregnant and required the administration of medicine, food and water, and care required for comfort and pain relief. Md. CODE ANN., HEALTH-GEN. § 5-605 (1994 & Supp. 1994). Such declarations are referred to as “advance directives.” Id. § 5-601(b). The incorporation into this law, 1985 Md. Laws 620, of the pregnancy exception and that law’s political gestation period of 12 years, Mack, 329 Md. at 212, 618 A.2d at 756, presaged the same conflict eight years later in the 1993 Session when, again, the politics of abortion mingled with that of broader health care autonomy. In the end, it was agreed that abortion rights will be determined by national law and Md. CODE ANN., HEALTH-GEN. § 20-103 (1990 & Supp. 1994), and therefore it was important to steer this ship away from those shoals.
18. These included various feeding tubes, respirators, and other resuscitative technology. For a full discussion of the various types of feeding tubes, see Mack, 329 Md. at 192-93 n.1, 618 A.2d at 746-47 n.1.

One historian has written that “[n]inety percent of the medicine being practiced today did not exist in 1950,” John Steele Gordon, How America’s Health Care Fell Ill, AM. HERITAGE, May/June 1992, at 49, and that life expectancy in this country increased 44%, to 68.2 years, between 1900 and 1950, id. at 52. Approximately 1400 to 1800 physicians used a variety of resuscitative methods including bellows ventilation, barrel maneuvers, and mouth-to-mouth. Arlo S. Hermreck, The History of Cardiopulmonary Resuscitation, 156 AM. J. SURGERY at 430 (1988). The mouth-to-mouth method was discouraged because of the potential for oral disease transmission, but was given renewed credence by scientific studies in the 1950s. Id. at 431. In this same decade, iron lung machines were introduced for Poliomyelitis victims. Gordon L. Snider, Thirty Years of Mechanical Ventilation: Changing Implications, 143 ARCHIVES OF INTERNAL MED. at 745 (1983). In 1960, successful use of closed-chest cardiac massage and defibrillation led to portable defibrillators used in combination with
into sometimes indiscriminate use, many physicians agreed that aggressive treatment was often superfluous and burdensome to dying patients.\textsuperscript{19} The dilemma of physicians was poetically captured in a commentary by David Schiedermayer, M.D., discussing his elderly patient, Cardinal Jackson, whose medical problems included dementia, Alzheimer’s disease, colon cancer, pneumonia, and multiple urinary tract and other infections. Dr. Schiedermayer described the dilemma as follows:

When I lecture in the Ethics Class, the medical students ask me why I keep treating her. Why not just stop treating, they ask.

Why not? Six years of knowing her. A dozen life-threatening infections. Already a no-code, already no-ICU. That’s why not. I asked [her] daughter five times to stop tube feeding, shocked her each time, and she said definitely no each time. That’s why not.

A socioeconomic history of discrimination and mistreatment. A tradition of poor health care and nontreatment. The need to show her somehow we’re not abandoning her. That’s why not. Because her daughter’s a nurse, because her daughter loves her and thinks it’s best to keep doing things just as we are. That’s why not. And because I can’t stand to think of the fire dying in those green eyes.

closed-chest massage. Hermreck, \textit{supra}, at 434. In the 1960s, respirators, or positive pressure ventilators, came into use. Snider, \textit{supra}, at 746. The positive pressure ventilator requires either an endotracheal tube or a tracheostomy tube. \textit{Id.} In the late 1960s, intravenous nutrition came into wide use for patients who could not tolerate feedings by mouth or by gastrostomy tubes. MAURICE E. SHILS & VERNON R. YOUNG, MODERN NUTRITION IN HEALTH AND DISEASE 1023 (7th ed. 1988). Parenteral nutrition now includes fats, sugars, and protein through indwelling venous catheters. \textit{Id.} at 1026. In the 1970s, shock trauma and intensive care facilities were inaugurated using, among other life support methodologies, mechanical ventilators, renal dialysis, and parenteral nutrition. Snider, \textit{supra}, at 746.

But why not just let her die, they ask.

I try, but I really can't explain. It just doesn't make sense to them. Their parents probably have living wills. They just don't understand yet, but they will understand when they have a Cardinal of their own.

Dying, you want dying, I guess I should say to them. I know how to stop treatment and let dying happen. I have stood by the bedsides of plenty of patients. I have seen long, slow dying. I have witnessed the leaving, the parting, the closing.

So then, I should ask the students, so then are we children of the sun or of the earth? If the students will answer this question, then I will tell them why I don’t just let Cardinal Jackson die.

What is it that gives a person dignity? What is that inner grace that projects out toward the doctor, so that he, despite his intellect and education and training and skills, is taken aback? Whatever it is, Cardinal has it . . . . It manifests itself as inner ability, as a palpable sense of self. The dignified are above reproach. You can't take dignity away from the dignified. They wear it lightly.

The tragic ambiguity of the lives of Karen Ann Quinlan and Nancy Cruzan accentuated but did not fully define the breadth of these concerns. Left in the wake of this evolution in health care decision making were many unanswered questions: Where was the dividing line between the individual’s health care autonomy and the physician’s professional discretion? Who can be a “surrogate,” and what is the extent of their authority and by what standards should they decide? Can an advance directive anticipate medical syndromes other than imminent death such as the comatose condition and the final, or even early stages of serious, inevitably fatal diseases such as AIDS and Alzheimer’s Disease? Can an advance directive designate someone else to make some or all health care decisions, and if so, who can be designated, and when and to what extent can their authority be effective? How, if at all, was emergency medical

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treatment authority affected by the enhancement of patient control? By what standards should guardians, often complete strangers to the disabled ward, and their appointing judges make potentially life-ending decisions?22 Because so many health care decisions will be made on behalf of patients lacking the mental competence to decide for themselves, how will such vulnerable patients be protected from thoughtless and harmful decisions they would not make themselves?

The HCDA is intended to answer these questions.

II. THE HISTORY OF THE HCDA

The seed of the HCDA was hybrid. It included strains of the heightened public attitude regarding the importance of self control over the dying process,23 recognition of dramatic improvements in

22. 1990 Md. Laws 709, sponsored by Senator Julian L. Lapides amended the guardianship provisions of Md. CODE ANN., EST. & TRUSTS § 13-708(b), (c) (1991), to permit judges to authorize guardians to decide whether to terminate or withhold life support, but the law did not provide any standards for those decisions.

23. In 1991, the citizens of the State of Washington defeated Initiative 119, which would have legalized euthanasia—permitting a physician to kill terminally ill patients who ask to die. N.Y. TIMES, Nov. 7, 1991, at B16. The vote (99% of precincts) was 701,440 (54%) opposed and 606,039 (46%) in favor. Id. A similar proposal the following year in California, Initiative 161, was defeated although over 4.5 million voters supported it. Virginia Ellis & Paul Jacob, California Elections, L.A. TIMES, Nov. 5, 1992, at A3. A 1986 American Medical Association poll reported nearly three of four Americans, 73% of the 1,510 survey respondents, favored "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it." George P. Smith, All's Well that Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination, 22 U.C. DAVIS L. REV. 275, 367 n.656 (1989). Fifteen percent were opposed and 12% were unsure. Id. Seventy-five percent of those younger than 65 years and 64% of those older than 65 favored it. Id. Of 509 lawyers responding to a Gallup telephone poll for the ABA Journal, 56.8% stated that administering a lethal injection to a terminally ill patient who wants to die and has made clear this wish, should be legally recognized. Id. Approximately 89% opposed active euthanasia if the patient's consent is ambiguous. Id.

Similar polls present the same popular opinion. For example, a national poll by the Boston Globe and the Harvard School of Public Health in 1991 showed that 64% of the respondents favored some form of legalized euthanasia. RONALD DWORKIN, LIFE'S DOMINION, AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 181 (1993). A 1994 random poll by Sidney Hollander found that nearly three out of four Marylanders polled favored assisted suicide. Frank P.L. Somerville, Poll Indicates Support for Assisted Suicide, THE SUN (Balt.), Feb. 21, 1994, at 1B. The problem is that such polls may reflect only what the respondents believe might be good public policy as applied to others. There is no reliable poll known to this author that asks the respondents what they would want done for themselves and extrapolation here may be unjustified. Maybe the most reliable poll of that nature is the rather modest actual usage of advance declarations.
life-sustaining and restorative medical technology, and the constitutional and common law informed consent principles enunciated in Quinlan and Cruzan.24

The roots of the HCDA are multiple. Perhaps the earliest legislative roots were established by the work of interested state legislators,25 all of whom sponsored bills in previous sessions of Maryland’s General Assembly to authorize advance directives such as the living will26 and durable power of attorney.27 1990 Maryland Laws 709, sponsored by Senator Lapides at the request of the Chief Judge of the Court of Appeals of Maryland, Robert C. Murphy, expressly authorized judges to permit guardians to consent to life support withdrawal and withholding, but provided no standards for such decisions. This left state circuit judges in the same quandary as before.28 To rectify this, Judge Hovey G.R. Johnson of the Circuit Court for Prince George’s County proposed to the Maryland Conference of Circuit Judges29 that a committee be formed to propose guidelines or standards for the implementation of this new guardianship authority. That committee was formed in late 199130 and it

24. See supra notes 11-13 and accompanying text.
27. S.B. 377, 1992 Sess. (Md. 1992). This Bill was proposed by Senators Hollinger and Boozer, but was not approved by the General Assembly. It would have authorized a person to execute a durable power of attorney for health care and to appoint an agent to make health care decisions. Id. It was criticized for its lack of precision and standards.

From 1988 through 1993 the Health Law Section of the Maryland State Bar Association, under the capable leadership of Robert J. Ryan, Jack C. Tranter, Robert G. Brewer, Jr., Howard L. Sollins, and N. Lark Schulze, strongly advocated both a durable power of attorney law and related changes in the Maryland Rules.

28. Many judges believed their equitable and plenary powers gave them such authority without specific legislation, particularly in light of such decisions as Quinlan and similar influential holdings in other states. Other judges believed that without some clear expression from the legislature, the Supreme Court, or the Court of Appeals of Maryland, they lacked that authority.

This was the view of Baltimore City Circuit Court Judge Thomas Ward in his decision that led to the appeal in In re Riddlemoser, 317 Md. 496, 564 A.2d 812 (1989). "At the conclusion of the hearing, Judge Ward declined to issue the [do not resuscitate] order. He stated that whether the relief sought by the guardians should be granted was 'not properly before this court,' thereby indicating his belief that he lacked the authority to issue the order." Id. at 501, 564 A.2d at 814-15. Subsequent legislative amendments at least clarified the basic authority of Maryland’s circuit judges.

29. This organization was established by Maryland Rule 1207 and consists of the eight Circuit Administrative Judges and additional representative judges elected from each circuit by the judges of that circuit.
30. Its members included, in addition to Judge Johnson as chair, Catherine Bouchard
appointed a smaller committee to actually draft those standards.\textsuperscript{31}

Another very influential part of this root system were two opinions of Attorney General J. Joseph Curran, Jr. The opinions recognized a constitutional and common-law right to patient self-determination as well as an expanded range of advance directives and, in limited circumstances, surrogate decision making beyond that already authorized for emergency treatment.\textsuperscript{32} These opinions provided important and needed guidance pending legislative action.

Roots were also growing within the local academic community, notably in the well regarded Law and Health Program at the University of Maryland School of Law.\textsuperscript{33} Academicians, ethicists, and physicians grappled with the real life and death problems presented by the growing conflict between the traditional healing role of the physician and the contemporary demands made upon them for what many regarded as excessive or useless treatment. Physicians were sometimes motivated both by the need to practice defensive medicine

\begin{footnotes}
\item[31] The drafting committee included this writer as chairman, Walter McQuie, Esq., of the Maryland Disability Law Center, and Dr. George A. Taler of the University of Maryland Hospital. It was later expanded to include Jack Schwartz, Chief Counsel, Opinions and Advice, Office of the Attorney General, who had drafted the two comprehensive opinions of the Attorney General on this subject, and health law practitioner Howard L. Sollins, Esq., who chaired the Health Law Section of the Maryland State Bar Association. It was hoped that Diane E. Hoffmann, Assistant Professor of Law at the University of Maryland School of Law, could also join this drafting group, but she could not, initially because of scheduling conflicts and later because of differences as to approach. She made excellent contributions to the work of the group in any event and ultimately became a chief drafter of an alternative bill, the Westminster proposal.


\item[33] This program is chaired by Professor of Law Karen H. Rothenberg and, among other activities, it uses an interdisciplinary approach to emerging medical, health policy, and law related issues. Assistant Professor of Law Diane E. Hoffmann serves on that faculty and was a chief drafter of the health care decision bill sponsored by Senator Hollinger.
\end{footnotes}
to forestall malpractice claims as well as to strictly adhere to the spirit, if not the letter, of the Hippocratic Oath. 34

The ethical-intellectual-medical interest in the problem was, of course, national and international in scope. A more subjective, patient-centered approach to the problems of the dying has been proposed. 35 The Hastings Center, The Right to Die Society (now

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34. The classic formulation of the Oath emphasizes that doctors should do no harm. In reaction to the dramatic changes in medical practice and perceptions of the good of patients, a significant number of medical schools have modified or abandoned the Oath, some in favor of this "Prayer of Maimonides," recommended by the World Medical Association in 1948:

Thy eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory, or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children. May I never see in the patient anything but a fellow creature in pain.

Hippocratic Oath, AM. MED. NEWS (1971).

35. The Hemlock Society, the name derived from an ancient means of suicide, has also attracted interest. It defines itself as a society supporting active voluntary euthanasia for the terminally ill and has attracted some notoriety for its self-deliverance suggestions. DEREK HUMPHRY, LET ME DIE BEFORE I WAKE (1981). In California, suicide workshops are conducted for the public. CBS EVENING NEWS: Suicide Workshops (CBS television broadcast, Mar. 3, 1993). A new organization, Compassion in Dying, advocates humane death by suicide with the assistance of medical volunteers. N.Y. TIMES, June 13, 1993, at 32. A strong proponent of physician-assisted suicide is Dr. Jack Kevorkian of Michigan who on August 4, 1993, assisted his 17th patient in "a merciful suicide," explaining, "I will always do so when a patient needs it, because I'm a physician." THE SUN (Balt.), Aug. 5, 1993, at 8A. His patient, suffering from Lou Gehrig's disease, a degenerative nerve disorder, died after inhaling carbon monoxide. Id.; see also Nancy Gibbs, Rx for Death, TIME, May 31, 1993, at 34.

Attorney General Curran has issued a formal opinion that assisted suicide is probably a common-law crime in Maryland and that any uncertainty should be resolved by a statute that clearly prohibits it. 78 Op. ATT'y Gen. MD. No. 93-036 (Sept. 8, 1993). A bill introduced in the 1994 session of the General Assembly prohibiting assisted suicide was not enacted. S.B. 343, 1994 Sess. (Md. 1994). There is a reasonable basis for limited disagreement with the Attorney General's opinion if one concludes that the General Assembly preempted the health care decision field by enacting the HCDA with its explicit language that "[n]othing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." MD. Code Ann., HEALTH-GEN. § 5-611(c) (1994). Once a person becomes a patient within the umbrage of health care decision making, a decision not expressly permitted by the HCDA, e.g., the provision of excessive medication with the knowledge that the patient wishes it suicidally and not for symptom relief, has no lawful sanction. Assisted suicide in a medical treatment context is likely to be as violative of the HCDA as would be a surrogate decision made in bad faith, or a hospital's decision to ignore a clear advance directive in order to maintain room occupancy. Additionally, the Attorney
known as Choice In Dying), and the American Society of Law, Medicine, and Ethics are among those asking not only what the traditional medical response is to a given affliction, but also whether that response is what the patient wants—or if that is not known, whether it is in the patient’s best interest. In other words, if either by patient wish or by the acceptable judgment of someone else, preferably a close family member or friend, the routine medical response would unduly prolong the dying process and outweigh the presumed benefit, that medical response should be withheld or withdrawn. 

Although the developing academic and ethical consensus was that it is not always appropriate to maximize the techno-medical response to every severely distressed patient, there remains serious ethical and political uncertainty about the extent to which the authority for these decisions should be placed in the hands of persons other than the patient. This is especially true when there is no evidence of the patient’s wishes, and the decision rests upon someone else’s perception of the patient’s best interest.


37. Judge Rodowsky, writing for the majority in Mack, stated the concern this way:

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

Mack v. Mack, 329 Md. 188, 218, 618 A.2d 744, 759 (1993). The court then stated that “‘[t]he problem with the best-interests test is that it lets another make a determination of a patient’s quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse treatment stands.’” Id. (quoting In re Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989)). An example of the difficulty here may be seen in this excerpt from the amicus brief of the Attorney General in Mack: “The only existence [Mr. Mack] has is as the ‘subject of bodily intrusions that . . . [from an observer’s point of view] are humiliating and undignified.’” Mack, 329 Md. at 217, 618 A.2d at 759 (citing Rep. Br. App. at 6). In other words, there is danger in shifting the perspective from the patient to an observer of the patient.
In 1948, Dr. Leo Alexander, who had studied German Nazi medical practices for the post-World War II Nuremberg war crimes tribunals, published an early warning that a public policy of permitting someone other than the patient to decide that the patient deserves a good death is inevitably a form of euthanasia. He was concerned that American medical practice was on the threshold of subtly accepting an early, pre-Holocaust, Nazi medical principle of *lebensunwerten leben*—life unworthy of life. There was also some


39. The term euthanasia has two references. The first, active euthanasia, involves action intended to give a person a good death. ALAN MEISEL, *THE RIGHT TO DIE* 62-63 (1989). The second, passive euthanasia, involves action intended to allow a person a good death. *Id.* at 63-64. The HCDA expressly excludes euthanasia from its reach. MD. CODE ANN., HEALTH-GEN § 5-611(C) (1994). It is arguable that, despite the express language of the HCDA, permitting a decision to not act to sustain life or to act by removal of life support is at least passive euthanasia. The conflict can be resolved by focusing on the purposes of the HCDA. Nowhere in the legislation did the General Assembly express a desire to facilitate good deaths. Rather, the sole focus is on permitting a citizen to control his or her own medical course and stating how that might be done when the patient is incapable of personally deciding, all within the context of the state's life-respecting ethic. Obviously, there is a hint of sophistry here because the intent of a humanitarian decision maker to afford the patient a good death will frequently, even if impermissibly from a literalist's point of view, creep into the process. Nevertheless, the distinction is important in order to keep the attention of the decision maker where it belongs—on the patient's preferences as they might be honored pursuant to this law. Further, a personal request of a patient for an action or inaction that a reasonable person would understand to be a request for euthanasia or assisted suicide will, at the very least, bump up against the euthanasia wall, if it cannot reasonably be seen as intended only "to permit the natural process of dying." MEISEL, *supra*, at 62-63.

40. The Nazis applied this at first to the mentally ill; and it is worth noting that dementia may be considered a form of mental illness and is also a prominent characteristic of Alzheimer's Disease. The concern many have is that if the HCDA permits dementia to be a reference point for life support decisions, why not paranoia or schizophrenia? Holocaust references are overblown in a history of the HCDA because the development of the law, in contrast to that of
concern that recognizing absolute autonomy on the part of a patient, who might be in an undiagnosed transitory despondency or nonclinical depression, may permit medical suicide and confer a corollary right to insist upon the active collaboration of the medical professions in a desire to die. These concerns also became part of the HCDA root system.

Another root consisted of the strong desire on the part of powerful constituent organizations, such as the American Association of Retired Persons (AARP), for flexible advance directive forms to which the elderly, in particular, could have easy access. The existing living will statutory form was considered inadequate by the AARP and many others because its utility was restricted to those who had executed it in advance, with a degree of formality similar to the traditional last will and testament, and whose death from a terminal illness was imminent. It was reasonably argued that by enacting the living will law in 1985 the General Assembly stated the outer boundaries of advance directives in Maryland, and that those boundaries did not encompass: oral advance directives; surrogate decisions; appointments of agents to make health care decisions; or the possibility of a more comprehensive advance directive that anticipated Germany in the 1930s, was very patient-centered and it now requires health care decisions which give scrupulous attention to the wishes, values, and medical circumstances of the patient. Also, our state interests have a common denominator of life protection, whereas the state's interests during the Nazi era were presumably advanced by applying the leben unwerten leben medical-political ethic.

41. This organization was actively and effectively represented throughout the drafting process by Gerard F.B. Miller and the late Martin Milrod. They sought to minimize restrictions on decision making and the publication of a model form declaration, among other objectives. At the national level, AARP joined the ACLU in the latter's opposition to a Michigan anti-Kevorkian law. Physician assisted suicides have been tolerated in the Netherlands for two decades and recently have been given legal approbation so long as there is patient consent. "Yet a 1991 study found that in one year more than 1,000 Dutch patients who were not capable of giving consent died at their doctors' hands." Nancy Gibbs, Rx for Death, TIME, May 31, 1993, at 35, 38. For the results of a comprehensive study of this Dutch medical practice, see Paul J. Van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 338 THE LANCET 669 (1991). This study reported that "[l]ife termination by administering legal drugs without an explicit and persistent request from the patient . . . happens in about 0.8% of all deaths," but that in a majority of these cases the decision had been discussed "in a previous phase" of the illness. Id.

other medical conditions, including the persistent vegetative or comatose state and conditions of severe deterioration that fall short of terminal illness and imminent death. Additionally, the living will law required the provision of food and water and precluded its implementation if the patient was pregnant.\footnote{Law of July 1, 1985, Ch. 620, § 5-605(2), 1985 Md. Laws 2944, 2950 (repealed 1993). There is a more conservative perspective, quite different from that represented by the HCDA, of which the reader should be aware. According to this perspective, it is arguable that the traditional living will is all that is required if the concern is that people, when terminally ill, will be kept lingering on the threshold of death at a point in time when it is only the machines that sustain them. If a patient executes one in advance or upon admission to a chronic care facility, he would receive normal nourishment to avoid the discomfort of dehydration and starvation as well as pain medication to minimize whatever pain is associated with his illness. However, no extraordinary intervention, such as resuscitation to interrupt the normal dying process, would be permitted. The very different dilemma of the patient in a persistent vegetative state could be resolved by legislation that addressed it forthrightly and exclusively. The "end-stage condition" would be addressed by patients exercising their common-law informed consent rights and simply informing the physician of their wishes in advance of the end-stage phase. This is particularly apt for those afflicted with diseases such as Alzheimer's and AIDS which are marked by progressive and predictable deterioration. Sadly, they often have significant advance warning of what is to come. Family decision making, where there are caring families, would continue, de facto in collaboration with physicians. In the absence of caring family members, guardianship is available. According to this conservative view, it will eventually become normal for patients to advise their health care providers about which medical procedures should be used in various circumstances based on their medical prognosis; thereby making health care agents unnecessary. In other words, if it is the public intent to honor patient self-determination, this more limited public policy is all that would be required, not the HCDA.}

In an effort to nurture these roots and to consider whether a responsible plant could be brought to full flower with a minimum of philosophically acrimonious weeding and pruning, three interested individuals representing different perspectives met in the winter of 1991-92 on an ad hoc basis to fashion a balanced statement of principles that might guide future growth in this area of the law in Maryland.\footnote{This trio consisted of Jack Schwartz, Chief Counsel for Opinions and Advice, Office of the Attorney General; Diane E. Hoffmann, Assistant Professor of Law, University of Maryland School of Law; a respected health law scholar; and this writer.} Several informal meetings of this group brought substantial consensus on various principles that persisted throughout the subsequent drafting process. First, individual decision making would be strengthened, including the authority of family-surrogate decision making. Second, the persistent vegetative state would be included as a condition that might justify consideration of discontinuing life sustaining treatment. Third, the state interests would not be independent standards but would be implicit in particular protective provisions, including appropriate definitions of critical concepts.
Finally, the standards for agent, surrogate, and guardian decisions would be consistent throughout the law. The standards would require that the first consideration be what the patient wanted, and if that was unknown, the best interest of the patient could be considered. These discussions ultimately provided a basis for a bill filed in the waning days of the 1992 session of the General Assembly. 45 A revised version of this Bill was later endorsed by the Conference of Circuit Judges Committee for its drafting committee (hereafter Conference Committee) as a working document. 46 This draft was then the focus of many Conference Committee drafting meetings throughout 1992.

In order to solicit the views of interested individuals and organizations on a direct basis, the Conference Committee supported a public meeting to be convened by the Attorney General and the Law and Health Program of the University of Maryland School of Law on November 18, 1992. That large meeting, held at Westminster Hall in Baltimore, was successful in exposing deficiencies in the draft then in circulation. 47 A deficiency from one perspective was that it severely compromised the role of the state interests in legislation that had as its purpose shifting medical decision responsibility in many instances to agents, guardians, and family members, not all of whom would be completely dependable in giving the welfare and wishes of the patient first priority. From another perspective came the criticism that there was too much restriction on decision making, which in some aspects might adversely affect women in particular. 48 Rather


46. Although the principal task of the Conference Committee was to develop standards for guardianships, in the 1992 session there was some disagreement over a durable power of attorney bill, S.B. 377, 1992 Sess. (Md. 1992), sought by state bar leaders and sponsored by Senator Paula C. Hollinger and Senator F. Vernon Boozer because it, like the guardianship amendments enacted in the 1990 Session, lacked standards. An alternative durable power bill was sponsored by Senator Michael J. Collins. This conflict and the judges' related interest in guardianship standards prompted the chairman of the Senate Judicial Proceedings Committee, Senator Walter M. Baker, to agree with this writer that a comprehensive approach to health care decision making was needed. The Conference of Circuit Judges Committee thereafter enlarged its scope and began work on a comprehensive approach that would include individual, agent, surrogate, and guardian decisions.

47. Hereafter, the thinking and drafting proposals of several of the participants in that meeting (including S.B. 664, 1993 Sess. (Md. 1993), the 1993 legislation sponsored by Senator Hollinger and co-sponsored by Senators Boozer and Boergers will be referred to as the work of the "Westminster Committee." There is no intent to suggest that this Committee represented a single viewpoint of the Westminster meeting attendees.

48. This was in part a response to the earlier referenced state interest in the
than limit decision making because of the possibility of abuse of vulnerable patients, some Westminster attendees\(^49\) argued that there should be a presumption of trustworthiness.\(^50\) There was also criticism that the language of that draft lacked sufficient clarity to be user friendly. There was strong interest in a law that could be read and easily understood by nonlawyers and included a broad advance directive form in addition to, or instead of, the living will. Finally, there was criticism of the process of the Conference Committee.\(^51\)

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49. There was, as of yet, no Westminster Committee.

50. At the Westminster meeting, Professor Rothenberg included among her criticisms of the draft of the Conference Committee that the "proposal also ignores reality ... individuals do not live in isolation, but within complex and caring relationships." The Conference Committee consisted of a judge experienced in guardianships, an assistant attorney general thoroughly familiar with the implications of health care law, an active health care law practitioner, a family medicine practitioner, and an attorney with a particular interest in the disabled. Additionally, others were consulted on this point and there was no disagreement that the reality is that unfortunately many individuals do not enjoy such relationships. Nurses voiced their concern to the Conference Committee about the dangers of concentrating excessive authority in family surrogates or agents and counting on informed, reliable advance directives at the moment of decision. How to offer adequate protection in the other cases without unduly restraining personal, agent, guardian, and family decision making caused continuing disagreement among the various drafting groups. In the end, the General Assembly opted for the protectionist school supported by the Conference Committee.

51. This criticism was fueled somewhat by the perception that the Conference Committee was closed to certain viewpoints and had only males as members. In response, it can be said that the drafting committee did not expect to be all male and went to great lengths to solicit and include a feminist perspective. Ultimately, the Committee was closed to the idea of absolute autonomy and
The Westminster criticism was fair and not all unexpected. It had always been anticipated that there would be some interested commentators who would see the presence of a restraint on choice in dying as a limitation on personal autonomy politically akin to restraints on abortion. Furthermore, there were those who felt such a restraint was contrary to the ideals of contemporary health care decision making and the Constitution.\textsuperscript{52} The Conference Committee drafters were devoted to balance however, perhaps anticipating the eloquent discussion of this philosophical conflict by Professor Ronald Dworkin:\textsuperscript{53}

It is obviously important to think about who should make life-or-death decisions, with what safeguards and formal requirements, and whether and how the decisions, once made, should be reviewed by others. But it is also important

unrestrained decision making by persons other than the patient. The Committee was also closed to the idea of excluding any opinion solely because it had a religious source as well as the notion that any single philosophy should prevail. The Conference Committee, in more than a dozen meetings in 1992 and 1993, including meetings exclusively for critics, considered hundreds of ideas and amendments. That an idea did not receive the support of the Committee did not mean the Committee was closed to it. As with any detailed drafting project, in order to avoid a horse becoming a camel, it is inevitable that the writing reverts to a precious few, as the Westminster Committee itself learned. The Conference Committee outreach to so many consultants, the public meeting at Westminster Hall, the continuous and amicable negotiations with the Westminster Committee, and the lengthy Senate and House of Delegates hearings accorded full and productive vent to every viewpoint. The balanced approach of the Conference Committee was fully vindicated by the decisions of the General Assembly that eventually adopted the substantive recommendations of the Conference Committee Bill in the format of the Westminster Committee Bill, adding from the latter bill "end-stage" and the emergency medical technician language, all as modified by the House subcommittee, under the able leadership of Delegate Stephen J. Braun.

\textsuperscript{52} As noted in \textit{Mack}, several state appellate and federal district courts had recognized a constitutional right of privacy as applicable to personal health care decisions during the 14 years between \textit{Quinlan} and \textit{Cruzan}. See \textit{Mack v. Mack}, 329 Md. 188, 210-11, 618 A.2d 744, 755. Had that view prevailed, this argument would have significantly greater value. However, the Supreme Court in \textit{Cruzan} recognized only the lesser constitutional liberty interest in health care autonomy and thus gave some latitude to the states to enact laws that reasonably control the exercise of this right: "[W]e think that a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." \textit{Cruzan v. Director, Missouri Dep't of Health}, 497 U.S. 261, 282.

to think about an even more fundamental matter: which decision is the right one to make, no matter who makes it. 54

Much of the Westminster criticism found its mark, and the Conference Committee thereafter produced a significantly changed draft. 55 But the legislative clock was ticking; the General Assembly was to convene shortly. It was generally agreed that everyone should continue to cooperate and resolve differences so as to avoid the risk inherent in presenting a volatile concept to the General Assembly that lacked consensus. Consensus did continue regarding the primary issues and the basic decisional formula recommended by the Conference Committee. 56

54. Id. at 182. Professor Dworkin, also writes:

That paramount question is sometimes thought to lie in the exclusive province of religion. But it must also be asked by people who are not religious, or by those whose religion gives no answer they believe suited to the contemporary world. It is also a political question, moreover. We cannot think intelligently about the legal and political issues—about who should make what choices, what constitutions should permit, and what nations and states should do—unless we have a better shared understanding, not necessarily about the meaning of death but at least what kind of question we are asking. How should we think about when and how to die?

Id.

55. Jack Schwartz was the principal and very skilled author of all of the Conference Committee drafts. Schwartz and the Conference Committee believed that the one objective everyone shared—to keep health care decisions in the family and out of the court—was best attained through precise language that anticipated interpretation problems. For example, the Conference Committee draft differentiated the roles and standards of health care agents, family members, physicians, and guardians, and preserved the living will, but also authorized a more general advance directive and stated limitations and standards for various kinds of decisions with some precision. This approach necessarily caused a lengthy and, to a layperson perhaps, ostensibly obtuse text. The subsequent November 1992 Conference Committee draft was improved in general clarity; it responded to the criticism that the tone of the earlier draft was one of health care decision restriction rather than liberation. The earlier drafts were focused on life support denial, but the focus had since widened to include all health care decisions. Accordingly the tone was altered to give greater emphasis to the freedom of individual choice. However, the careful delineation of roles and standards, the continuation of the living will, and the expression of the state interests remained.

56. As noted, the primary issues for which there was consensus included: individual autonomy, surrogate-family decisions, advance directives that permitted appointment of health care agents and wide health care choices, and finally, guardianship, health care agent, and surrogate standards that required decisions to reflect what the patient either said he or she wanted under the circumstances or the substituted judgment of the surrogate, agent, or guardian of what the patient would want in light of previous statements and other evidence, or as a last resort, a determination of the patient's best interest.
Nevertheless, differences persisted and as the start of the legislative session became imminent an alternative draft was developed by an ad hoc committee of several participants in the Westminster conference (hereafter Westminster Committee) for introduction by Senator Paula Hollinger. This alternative draft was intended to present to the legislature the remaining differences on important secondary issues. Although the Conference Committee preferred another method of presenting those differences, Senator Hollinger’s

57. This Bill was modeled on the Virginia Natural Death Act, Va. Code Ann., §§ 2981 et seq. (1991 & Supp. 1993), which was seen as simpler in format and structure and generally less restrictive as compared to the Conference Committee Bill. It was drawn by an ad hoc committee coordinated by Assistant Professor of Law Diane Hoffmann with the assistance of various individuals, including: Leslie Fried, Joan O’Sullivan, and Eileen Franch of The Legal Aid Bureau, Gerald Miller and Martin Milrod of the Maryland Chapter of AARP, David Davis of the Maryland Chapter of Emergency Medical Physicians, and Baltimore County Circuit Court Judge John F. Fader, II. This drafting group conferred with some of the same consultants as the Conference Committee, but apparently did not include those with whom they disagreed, such as the Maryland Catholic Conference. The consequence of this was that the original Westminster Bill was considered seriously imbalanced on these secondary issues and perhaps only ostensibly “user friendly” in that its comparative brevity and apparent simplicity necessarily produced some ambiguity and a greater likelihood of litigation. See 78 Op. Att’y Gen. Md. No. 93-019 (June 1, 1993); see also Howard L. Sollins, MICPEL, Legal Issues Arising from the Maryland Health Care Decision Act Chapter 372 of the Laws of Maryland, 1993, June 18, 1993. The Conference Committee Bill, S.B. 676, 1993 Sess. (Md. 1993), was sponsored by Senator Pica, chair of the related subcommittee of the Judicial Proceedings Committee. Its companion in the House of Delegates, H.B. 1243, 1993 Sess. (Md. 1993), was sponsored by Delegate Sheila E. Hixson, a long time advocate of change in this area of the law. Both of these principal Conference Committee Bill sponsors deleted from the drafts, before formal introduction, the following recommendations of the Conference Committee: (1) codification of the state interests as a “Statement of Legislative Policy;” (2) the phrase “preservation of life” in the preamble; (3) mandated separate decision making for removal of tubes for food and fluids; (4) exclusion of comatose patients from a “best interest” decision to terminate life support; (5) limitation on agent and surrogate decisions concerning a pregnant patient; and (6) a controversial provision that would have required a court to consider any adverse effect on a minor dependent should a sole provider parent wish to forego life sustaining treatment that would be medically useful. This last proposal was perceived as an undue burden on women. In fact, it was, at least from that perspective anyway, a lessening of a potential burden on women in the context of existing law. In any event, the existing common and statutory law strongly empower the state to protect children from a parental decision which might prove harmful to them. See Md. Code Ann., Fam. Law §§ 5-502, 5-702, 5-1002 (1991); see also Wentzel v. Montgomery Gen. Hosp., 293 Md. 685, 699-702, 447 A.2d 1244, 1251-53 (1982), cert. denied, 459 U.S. 1147 (1983). It was deleted for this reason and because of the high unlikelihood that the suggested provision would ever need implementation.
Bill, and later its approximate companion Bill by Delegate Teitelbaum, (hereafter the Westminster Committee Bill) served the purpose well. Through the weeks between the Westminster meeting and the actual introduction of the Bills, and thereafter, discussions continued to resolve tertiary differences and the two approaches became more similar. Both the Conference Committee Bill and the Westminster Committee Bill agreed on the following primary legislative objectives: (1) recognize individual health care control, or "autonomy"; (2) permit family or close friend surrogate decisions by substituted judgment; (3) allow decisions to be made on a best interest basis if the individual was not able to make the decision and a substituted judgment was not possible; (4) authorize advance directives which give wide discretion to citizens to anticipate future therapy choices including the provision of artificially supplied nutrients and fluids and those that might accompany the persistent vegetative state; and (5) permit the appointment of a health care agent who could make whatever decisions the principal wished.

The sixth objective, providing judicial standards in guardianship cases, was met fully in the Conference Committee Bill, and uncertainly in the Westminster Committee Bill. A seventh common primary objective was to assure some degree of protection to vulnerable patients whose lives might be seen by the less scrupulous as leben-sunwerten leben. Because there was no serious disagreement with these primary recommendations of the Conference Committee, both Bills contained similar recommendations. Despite the similarities, significant differences remained concerning important secondary issues. First, and perhaps foremost, the

60. As the Conference Committee chairman, I had earlier decided that as the legislative session drew closer, leadership of its effort would be assumed by Jack Schwartz. He did a superior job in continuing the dialogue, achieving agreements and, assisted by Conference Committee staff counsel Alan Deanehan, Esq., and in close collaboration with representatives of the Westminster Committee, including Professor Hoffmann and Leslie Fried, Esq., shepherding the blended legislation through both houses. I remained, however, in daily contact with legislative activity and decisions.
62. There can be endless debate about what is primary and what is secondary. The
Westminster proposal vested virtually unguarded authority in surrogates to make life ending decisions without clear standards. The term "best interest" was only loosely defined. This was particularly important because good faith decision makers would be immunized. Additionally, the inclusion by the Westminster Committee of what came to be termed the "end-stage condition," a medical status which is somewhere short of imminent death, during which surrogates might order the cessation of life-sustaining therapies was another difference. Without standards, there was a clear danger of life-ending decisions being made for economic reasons or upon the surrogate's only mandate of *Cruzan* was to recognize patient self-determination. See *Cruzan* v. Director, Missouri Dep't of Health, 497 U.S. 261, 278-87 (1990). Writing on that nearly blank slate, the primary decisions concerned the extent to which others would be allowed to decide for the patient. Once those decisions are made they lead to secondary questions of degree and limits, and to tertiary questions about procedures and formalities. From another less structural perspective, decisions such as the recognition of end-stage are primary. See Md. Code Ann., Health-Gen. § 5-601(i) (1994 & Supp. 1994).

63. The end-stage condition evolved from a condition earlier considered by the Conference Committee, at the urging of the Alzheimer's Association, which we had originally termed the "inevitably fatal" condition. It was ultimately not adopted by the Conference Committee because it was so vague. The Conference Committee did not oppose the concept per se, but rather urged its presentation in a separate bill so that it could have proper medical, ethical, and public scrutiny. Although the HCDA does not confine end-stage to Alzheimer's disease, a disease which eventually leaves its victims incapable of caring for themselves, much of the attention was paid to that syndrome.

There is a consensus among physicians that most cases of suspected Alzheimer's cannot be diagnosed with certainty other than by a post mortem autopsy, although it is estimated that "the correlation between premorbid and autopsy findings are probably in the range of 95%." Letter from George A. Taler, M.D. to John Carroll Byrnes (Oct. 4, 1993) (on file with author). The Alzheimer's Association describes the disease this way:

* Alzheimer's Association Statement of Purposes* (1993). A Harvard Medical School study in 1989 estimated that 11.3% of the American population 65 years of age or older probably had Alzheimer's. Of those age 75 to 84, 16.4% had Alzheimer's; and 47.55% of those over 85. RONALD DWORKIN, *LIFE'S DOMINION, AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 219 (1993).

64. The Attorney General's representative testified before the legislature that he was familiar with anecdotal evidence that in many cases if therapy was financed by insurance or public subsidy the surrogate decision was likely to favor its use. However, in situations where the estate of the patient would be depleted by the medical expense, the decision was against the therapy. Jack Schwartz, Assistant Attorney General, on behalf of J. Joseph Curran, Jr., Attorney General of
subjective evaluation of the patient's quality of life. This difference of opinion was highlighted by the debate over the language of the preamble which the Conference Committee successfully supported:

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

The General Assembly adopted the recommendations of the Conference Committee and amended the Westminster Committee Bill to include the disputed preamble language, as well as clear patient oriented standards for surrogate decisions, which contained a more complete definition of "best interest."

Another serious difference concerned the nature of the advance directive model form to be presented in the statute. Although both Bills agreed upon the right of a person to designate a health care agent and to devise his or her own advance directive, the Westminster Committee Bill repealed the existing living will law entirely. The Conference Committee Bill retained the existing living will law as a conservative option for citizens and provided for a post session public process by which a broader model advance directive alternative could be developed. These differences were resolved by retaining the living

Maryland, Testimony in Support of Senate Bill 676, Before the Senate Judicial Proceedings (Feb. 22, 1993) (on file with author). The Conference Committee had taken an unequivocal position against decisions motivated by economics, although recognizing that a surrogate's, health care agent's, or guardian's decision should reflect the patient's wish that expense be taken into account. See Report of the Bill Drafting Committee to the Maryland General Assembly, May 5, 1993, at 17 n.11.


[P]roperly used advance directives can be of significant help to patients, families, and physicians in treatment decisions when patients become incompetent. Improperly used, they can become instruments not of patient preferences but of economic purpose, family bias, or physician's values. The moral uncertainties inherent in the operation of the new law underscore the physician's fiduciary responsibility for a morally nuanced implementation. The physician's obligation is to safeguard the patient against an overzealous legalism that could defeat the intent of the law itself.

Pellegrino, supra, at 355 (it should be noted that the Patient Self-Determination Act requires only that patients be advised of their options according to the laws of their particular state, not that every patient must have an advanced directive).
The sensitive matter of tube feeding, the provision of nutrients and fluids through a tube, was the subject of further disagreement. For example, the family of the comatose Karen Quinlan wanted removal of a respirator, but not of feeding tubes. Although the respirator was removed, Miss Quinlan lived for many years. In contrast, the family of Nancy Cruzan sought removal of the feeding tubes. To make the issue more stark, it has been suggested that it may be appropriate to note dehydration as at least a secondary cause of death when feeding tubes are removed from a patient.

The emotional dimension notwithstanding, many courts, including the Court of Appeals of Maryland in *Mack v. Mack*, have concluded that there is no legally significant difference between tube feeding and other life-sustaining means, and have sanctioned their removal. The Westminster Committee Bill proposed only that its model advance directive give individuals the choice of continuing or declining feeding tubes. The Conference Committee also regarded tube feeding as another means of life support subject to removal. However, in addition to presenting this option in a revised living will, the Conference Committee recommended that discrete feeding tube decisions be made by health care agents, surrogates, and guardians.

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67. This compromise was the suggestion of the Director of the Office on Aging, Rosalie S. Abrams, who, with the encouragement of Governor William Donald Schaefer, played an active and constructive role throughout the legislative process.


71. *In re Johnson*, No. 92219055/CE 152410 (Cir. Ct. Balt. City 1993) (Byrnes, J.) (testimony of neurologist Dr. Tippett); Personal Communication with Louis C. Breschi, M.D., Chairman of the Ethics Committee of the Medical and Chirurgical Faculty of Maryland (July 27, 1993). In the event food and fluids are not made available to a patient, it is obviously difficult to determine whether death resulted from the disease or trauma that was the initial focus of the chronic care or from dehydration and starvation. The distinction is easier in the case of a terminally ill person than one in a persistent vegetative state or end-stage condition.

72. In *Mack*, Judge Rodowsky wrote that "[a]bsent a statutory exclusion of artificially administered sustenance from the medical treatment or procedure referred to in MD. CODE ANN., EST. & TRUSTS § 13-708 (Supp. 1994), artificially administered sustenance is included in those terms." *Mack v. Mack*, 329 Md. 188, 214, 618 A.2d 744, 755 (1993). Since the *Mack* decision interpreted then-existing statutory language governing guardianships, an implication of Judge Rodowsky's language is that the legislature could, if it chose, impose different standards on the withdrawal or withholding of such care.
mise produced model advance directives that distinguish tube feeding from other modes of life support and specific language that emphasizes that distinct judgments can be made regarding nourishment by tubes in the absence of an advance directive to the contrary.73

There was a difference between the Bills' treatment of guardianship standards as well. The Westminster Committee Bill had virtually none, apparently assuming the guardian would act in the capacity of a surrogate.74 On the other hand, the Conference Committee proposed guardianship standards for the Estates and Trusts Article of the Maryland Code. These standards were independent of, but nevertheless consistent with, the proposed standards for the Health-General Article of the Maryland Code that applied to all other types of decision makers. The standards included respecting the choice of the patient, discerning that choice through substituted judgment, and if these were unavailing, permitting a decision serving the defined best interest of the patient. Both the Senate and the House adopted the Conference Committee approach to guardianship with a problematical amendment to be discussed later in this Article.

Two other significant secondary differences involved topics that the Conference Committee had concluded required further study and independent bills. The first was the "end-stage condition" previously discussed. The second was the esoteric area of how to deal with persons in an outpatient setting: For example, those who are in "No-code" or "Do-Not-Resuscitate" status, but are being transported by emergency medical technicians from one facility to another when the need for resuscitation arises. A similar problem arises when emergency medical personnel respond to a 911 call from a person who has executed an advance directive which delineates the extent of life-sustaining treatment to give under certain circumstances. How should these technicians respond? The legislature agreed with the Westminster Committee proposal to address this concern by reference to protocols to be later developed by the Maryland Institute for Emergency Medical Services Systems in conjunction with the State Board of Physician Quality Assurance.

Furthermore, there was a significant difference of opinion on a question that both the Attorney General and the Mack court hesitated to answer in the absence of legislative guidance: Should life sustaining treatment be withdrawn or withheld on a best interest basis from a

74. The intention of the Westminster Committee drafters on this issue was never clarified, apparently because of some communication problem in the drafting process. The guardianship standards in the Conference Committee Bill had been specifically endorsed by the full Conference of Circuit Judges on November 16, 1992. The Conference also endorsed that entire Conference Committee Bill in principle.
person in a presumably painless and unaware persistent vegetative state who has never expressed any preference concerning life support care and has not developed a life ethic from which a preference could be discerned? The view of the Conference Committee was that to allow a surrogate, agent, or guardian to direct or authorize removal of life support in that circumstance would be tantamount to permitting a judgment that it was better for someone to be dead than to be permanently unconscious. Although there was sympathy for the pathetic plight of such persons, there was an equal degree of reluctance to establish such a legal precedent. If a third person can say that you are better off dead than in an X condition, why not equally pathetic Y and Z conditions as well? It might well be argued that the legislature, by adopting the Westminster Committee’s end-stage proposal, has agreed to permit a best interest decision as to medical conditions Y and Z, and A through X as well. However, the end-stage condition is rather carefully defined to require an analysis of all dimensions of the medical syndrome with particular attention to its ravaging and irreversible effects on the life of the patient, despite therapy. There is no equivalent ravaging consequence of the persistent vegetative state per se, despite life support therapy.

The Westminster Committee believed such a decision could rest upon a loosely defined best interest evaluation. This belief was largely based upon the theory that caring families or close friends would be making the decision and could be trusted to properly respect the patient’s welfare and dignity. The General Assembly resolved this dispute by agreeing that the fate of a person in a persistent vegetative state could be decided on a best interest analysis, but only by the application of the Conference Committee’s definition of “best interest.” In making a “best interest” determination, the Conference Committee suggested a balancing of benefits and burdens that would take into account the patient’s medical condition and personal values.

75. This writer represented, in private practice, a client who was put in this condition by medical malpractice. The family insisted that her life be maintained with all available therapy.

76. The Westminster Bill had no statutory definition of best interest. It included the term as a guideline for surrogates who could not determine the wishes of the patient and required only that the “surrogate shall consider: . . . prognosis; . . . risks, benefits, and burdens of any procedure, and alternatives . . .; and . . . religious beliefs and basic values of the patient.” S.B. 664, 1993 Sess. § 5-605(c) (Md. 1993). However, even though the Conference Committee’s definition was more detailed and gave a stronger patient-oriented focus, it cannot be said that anyone is capable of truly defining what is another’s best interest. The most one can do is try to steer the decision as close as possible towards an objective patient-centered medical evaluation.
It remains to be seen whether this solution resolved or begged the clinical question. It can be safely said, however, that merely being in a persistent vegetative state is an insufficient basis, in and of itself, for denial of life support. Further, because there is no known treatment that would restore consciousness, if a permanent persistent vegetative state is diagnosed it may be difficult to rationalize that the benefit of continued life is outweighed by the burden of life support—typically artificial respiration and tube feeding of which the patient is presumably unaware. 77

Finally, there were two important differences of opinion regarding the role of physicians. The first was whether physicians should be given carte blanche to decide in their professional discretion when treatment modalities are ineffective and need not be employed, regardless of the wishes of the patient or the patient’s surrogate, agent, or guardian. The Conference Committee urged that “medically ineffective” treatment be defined. This position was taken because, before enactment of the HCDA, physician judgment was subject at least to negligence standards. Because both the Conference Committee Bill and the Westminster Committee Bill immunized providers who act in good faith 78 in accordance with the HCDA, it was believed necessary to give some definition to this critical concept. Both the Senate and House agreed. 79 By defining “medically ineffective,” the HCDA reduced the possibility that a physician would resort to that justification in order to avoid the patient-protecting best interest standards and other safeguards. The second physician related disagreement concerned the Conference Committee’s recommendation that a health care provider should have the right, independent of the

77. There will presumably be respected opinion to the contrary because one of the driving forces of the death with dignity movement has been concern for patients whose lives are permanently trapped in an unconscious state, as well as for their families. If the intention is to decide that a PVS patient should be allowed to die solely by reason of that condition, the General Assembly, the medical community, and the public should consider confronting and debating the issue directly and honestly. They could do so, first, by accepting the cost of such care as a public responsibility and, second, by considering the ethical and public policy implications of legislation that would amend the statutory definition of death to include this condition. See Veatch, The Impending Collapse of the Whole Brain Definition of Death, 23 Hastings Center Report 18 (1993).

78. One may be considered to be acting in good faith if there is an honest (subjective) belief that his or her actions conform to the law. The focus is on the actor’s state of mind. Negligence, on the other hand, invokes a more objective analysis—whether the actor’s conduct conforms to a standard of reasonable care, usually defined in medical malpractice cases by expert witnesses. It is possible for a person to act negligently but in good faith. See State v. Faulkner, 301 Md. 482, 483 A.2d 759 (1984); Md. CIV. PATTERN JURY INSTRUCTIONS § 4.17(2) (3d. ed. 1993).

health care decision maker, to take a disputable life support instruction to a patient care advisory committee or a court if it is believed that the instruction is "inconsistent with generally accepted standards of patient care." The legislature agreed and amended the Westminster Committee Bill accordingly.80

In summary, the secondary issues were compromised by the adoption of the simplified structure81 of the Hollinger Bill that included an amended version of its proposed "end-stage condition," a broad advance directive model and outpatient-protocol language. Also included in the Bill were these Conference Committee recommendations: (1) standards for surrogates that focus their decisions on the patient's needs and wishes; (2) a full preamble to reflect the philosophy of the law including the balance struck between personal health care autonomy and community respect for life, qua life; (3) the living will, amended to include the persistent vegetative state and the nourishment by tube option, along with a broader advance directive option; (4) clear authority for distinct agent, surrogate, guardian, and physician decisions regarding tube nourishment as distinguished from other life support modalities; (5) the full guardianship proposal of the Conference of Circuit Judges amended to allow a judge to give life support authority in advance in certain circumstances; (6) a full and delineated definition of "best interest" to focus attention on the patient's medical condition and values to preclude decisions made in someone else's best interest; (7) a definition of "medically ineffective treatment," to limit physician discretion; (8) authorization of a health care provider to challenge a disputed life support instruction; (9) clarification of the emergency

80. 1993 Md. Laws 372, § 5-612(a). See S.B. 676, 1993 Sess. § 20A-207 (Md. 1993). The Westminster Committee Bill did provide that "any person" (later restricted by legislative amendment to family members and others who would qualify as surrogates) could go to court to contest an alleged unlawful instruction. Both the Westminster Committee Bill and the Conference Committee Bill provided for the event of disagreement among surrogates, with the Westminster Bill referring the matter to a patient care advisory committee. See S.B. 664, 1993 Sess. § 5-605(b) (Md. 1993).

81. By "structure," it is meant, for example, whether health care agent, surrogate, physician, and guardian decisions are statutorily distinguished; whether a procedural difference, in terms of choice, between tubes supplying food and water and all other life sustaining methods should be articulated; whether a distinction should be drawn between a patient who is terminally ill and one who is in a persistent vegetative state; and whether the difference between the living will and the alternative broader advance directive should be maintained. The structure of the Westminster Committee Bill did not make these distinctions, preferring to fold them into single sections. The consequent brevity in format, the absence of certain definitions and standards, the impression that there were fewer restraints on decision making, and the inclusion of end-stage condition were decisively popular features of the Westminster Bill.
treatment law; and (10) some formality, such as requiring two witnesses in the execution of advance directives.

The compromises regarding the secondary issues and the pre-existing agreement on the primary and other comparatively minor issues facilitated the blending of the Bills. The amended Westminster Committee Bill was given a favorable report by the Senate Judicial Proceedings Committee. There was spirited debate in the Senate, and a series of tightening amendments resulted in a final compromise on several remaining controversies, assuring the Bill's passage there. 82

82. The debate was led by Senator John A. Cade. Among the amendments proposed by Senator Christopher McCabe, which were supported by the Maryland Catholic Conference (the MCC ultimately supported neither bill, largely because of their inclusion of "end-stage"), were: (1) the restoration to the preamble of proposed Conference Committee language that the "balance struck by this law furthers the preeminent societal value that the life of every individual has worth in and of itself"; (2) a clarification of potentially inconsistent language in the use of the terms "medical probability" and "medical certainty"; (3) the substitution of the term "life-sustaining" for "life-prolonging"; (4) a significant tightening of the end-stage condition definition to include the words "resulted in severe and permanent deterioration indicated by incompetency and complete physical dependency; and . . . for which, to a reasonable degree of medical certainty, treatment would be medically ineffective"; (5) a slight tightening of the "best interest" definition to assure that the "religious beliefs and basic values of the patient" are considered only to the extent they may inform the decision maker of the patient's best interest as defined, not as free-standing criteria; and (6) the restoration of certain of the original living will language and language precluding a surrogate's decision as to life-sustaining procedures being "based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic disadvantage." (This amendment added the latter clause and clarified the balance of the recommended committee language.) Another McCabe floor amendment to the committee amendments, strongly urged by Maryland Right To Life, required the provision of life-sustaining treatment pending the transfer of a patient by a health care provider who intends not to comply with a treatment decision instruction. MD. CODE ANN., HEALTH-GEN. § 5-512 (1994 & Supp. 1994). The General Assembly should be credited for rejecting the phobia of some who misconstrued the opinions and suggestions of religious representatives as an advancement of religious doctrine. Instead preferring to welcome, as did the Conference Committee, all reasonable ideological investments in the drafting that served to support the philosophically balanced approach that responsible participants sought. The consistent theme of the Maryland Catholic Conference was to remind legislators that, as argued by Professor Dworkin, "[t]he most basic responsibility of government, after all, is to protect the interests of everyone in the community, particularly the interests of those who cannot protect themselves." RONALD DWORKIN, LIFE'S DOMINION, AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 14 (1993). All of the drafters of the HCDA worked from life respecting values and differed only in their perception of where the greater assault on life's sanctity lay. Was it in the threat of needless and harmful prolongation of life by demeaning technology; or did it lay in the threat of unscrupulous or indifferent life ending decisions? The answer is obvious. It is a dual threat, and how we respond will depend not so much
The House Environmental Matters Committee reported Delegate Hixson's Conference Committee Bill after completely rewriting it to reflect both the Westminster format, as amended in the Senate, and its own amendments. The two Bills were nearly identical as they emerged from their respective houses and the Conference Committee and Westminster Committee were in basic accord, except as to the proposed "end-stage condition." 

Because of the mutual desire of the legislative leadership and all of the various contributing authors of the two Bills that a comprehensive bill be enacted in the 1993 Session, the blended Bills were on this law as on our own individual beliefs about human life. Those beliefs are informed by both religious and secular humanitarian ethics. In Dworkin's words, "our beliefs about human life are decisive in forming our opinions about all life-and-death matters—abortion, suicide, euthanasia, the death penalty, and conscientious objection to war. Indeed, their power is even greater than this, because our opinions about how and why our own lives have intrinsic value influence every major decision we make about how we live."

DWORKIN, supra, at 155. It is interesting to note in this regard that the New York State Task Force On Life And The Law includes seven persons from the religious community among its 26 members. It is discouraging that certain organizations and individuals with influence in this major public policy debate attempt to exclude religious thought, because in point of political fact that exclusion is impossible and because the attempted exclusion both fuels the fires of political discord and diminishes the intellectual content of the debate. See STEPHEN L. CARTER, THE CULTURE OF DISBELIEF (1993). As one studies the literature of organizations professing to study the ethics of bioethics, there is cause to wonder what ethics they are studying. Personal autonomy and dignity are important and constitutionally protected health care ethics. Encouragement of family involvement in health care decisions is also an ethical goal. The Hippocratic Oath and physician discretion are ethically important. Respect for popular opinion in a democracy is a valid ethic. So too is protection of vulnerable life and the establishment of standards of human conduct that avoid debasement of life to serve another person's interests or values.

For other intelligent perspectives on appropriate ethical reference points, see STEVEN A. LEVINSON, MEDICAL DIRECTION IN LONG TERM CARE: A GUIDEBOOK FOR THE FUTURE 418-19 (1993) (personal autonomy, respect for persons, informed consent and information veracity, confidentiality, fidelity in therapeutic relationships, beneficence and non-maleficence, utility, and justice); Care of the Sick and Dying, MARYLAND CATHOLIC CONFERENCE, PASTORAL LETTER, Oct. 14, 1993 (right to life as a precious gift from God, the immorality of hastening death, acceptance of some suffering, the value of health care and maintenance, and a willingness to reject useless and disproportionately burdensome treatment).

83. In the context of inevitable legislative compromise, the Conference Committee viewpoint was strategically enhanced by the decision to adopt the Westminster Committee Bill structure. The subsequent compromise added important substantive recommendations of the Conference Committee. On the other hand, had the Conference Committee Bill structure been adopted, the legislative compromise may have been the deletion of substantive provisions with which the Westminster Committee disagreed.
approved by the Senate and the House of Delegates with relative expedition.84

III. THE TEXT OF THE HCDA

This Section is devoted to the language and meaning of the HCDA.85 The true meaning of this law will be determined in the offices of health care law practitioners, in the corridors and rooms of hospitals and nursing homes, by future opinions of the Attorney General, and by the courts.86 There has been helpful commentary by knowledgeable experts and opinions of the Attorney General to which reference will be made when appropriate.87 Also, because some con-

84. These decisive votes occurred on March 29, 1993. A motion by Senator Cade to recommit the Bill was defeated 33 to 13. The favorable report of the Committee was adopted 31 to 13. His amendments to delete oral directives and the end-stage condition from the Bill lost 24 to 23 and 28 to 19, respectively. The Senate passed Senate Bill 664 (by Senators Hollinger, Boozer, and Boerger) on March 31, 1993 by a vote of 31 to 14 (2 not voting). The Senate passed House Bill 1243 (by Delegates Hixson, Teitelbaum, Callas, Campbell, et al.) on April 9, 1993 by a vote of 32 to 15. The House of Delegates approved Senate Bill 664 on April 4, 1993 by a vote of 106 to 12 (23 not voting) and approved House Bill 1243 on March 31, 1993 by a vote of 110 to 14 (17 not voting). On April 12, 1993 both the Senate (31 to 14, 2 not voting) and the House of Delegates (116 to 15, 10 not voting) adopted the Conference Committee report on Senate Bill 664 which conformed it to House Bill 1243, the Bill ultimately signed by the Governor.

85. MD. CODE ANN., HEALTH-GEN., §§ 5-601 to -618 (1994). Generally, specific subsection citations to the HCDA will be omitted in this Article. As discussed in the preceding Section, the language of the Act is a composite of the Conference Committee Bill, the Westminster Committee Bill, and amendments proposed by the Conference Committee, the Westminster Committee, the Maryland Catholic Conference, various legislators, the Attorney General, the Office on Aging, and Delegate Braun’s House subcommittee.

86. It is the hope of the HCDA authors and the legislature that resort to the courts be avoided if possible by increased family responsibility. In addition to the potential ambiguity inherent in the simplified bill format recommended by the Westminster Committee, there are sociological influences that may militate against that ambition. Sociological trends are not encouraging. Although a recent study by Dr. Thomas Juster of the University of Michigan for the National Institute on Aging suggests that family cohesiveness is strong, the traditional nuclear family (married couple with children) has declined from 40% in the 1970s to 26% in the 1990s and the size of families composed of five or more persons has declined in the same period from 21% to 10%. See Census Bureau Study, THE WASH. POST, June 24, 1993, at A21; Gina Kalata, The American Family Revalued, N.Y. TIMES, May 9, 1993, § 4, at 2. Thus, the number in the family pool available and willing to assist in caring decision making has been reduced. Of course non-traditional families will continue to play an important and positive role but such families tend to be smaller in size and comparatively less stable. Complicating the family capacity to deal with the problem is the increasing number of family members living in distant locales.

87. Steven Levenson & Diane E. Hoffmann, New State Law Covers Life-and-Death
cepts and terms are drawn from the case law of other states, reference to them by the reader will prove useful. Finally, a careful reading of a study by Rutgers University Law Professor Norman L. Cantor of similar legislation enacted in New Jersey in 1991 is encouraged to temper any expectation that such legislation can answer more than the most basic legal questions. Nevertheless, a myriad of interpretive, scientific, moral, and ethical riddles remain.

A. The Preamble

As noted by the recent Mack decision, a legislative preamble, although uncodified, is an important guide to legislative intent. The preamble to this legislation recognizes an individual’s right to control his or her own health care. Additionally, it recognizes the right of the state to safeguard this privilege so that decisions made by others for an incompetent individual will “advance the interests and wishes” of only that individual, whose life “has worth in and of itself.”


90. The differences of opinion over the preamble among the various authors of the HCDA generally mirrored the substantive differences in approach. The Conference Committee originally recommended a preamble which made explicit reference to, among other purposes of the law, the traditional state interests in preserving life, preventing suicide, protecting the integrity of the medical profession, and protecting innocent third parties noted by the Mack decision as qualifying personal health care control. Mack, 329 Md. at 210 n.7, 618 A.2d at 755 n.7. This was objected to because some believed it carried a “pro-life” implication and because these state interests might be understood as free-standing standards further restricting personal, surrogate, agent, and guardian decision making. In response to these objections and because Mack made clear the role of these state interests, the explicit reference was deleted as unneeded. A different formulation was proposed in S.B. 676, 1993 Sess. (Md. 1993) by the Conference Committee and amended into the Westminster Committee Bill. It was well crafted by Jack Schwartz to reflect the balanced approach everyone sought. It adopts the essence of the majority opinion in Cruzan, that the state has an interest in protecting vulnerable life, and the essence of the Brennan dissent in Cruzan, that the state has an interest in protecting the right of a citizen to decide. Cf. Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261, 313 (1990). The preamble to the New Jersey law includes an explicit reference to the traditional state interests, N.J. REV. STAT. § 26:2H-54(d) (1992), as do, for example, those of Pennsylvania
B. Section 5-601. Definitions

This section of the HCDA defines many of the terms used throughout the Act, including advance directive, agent, attending physician, declarant, emergency medical services “do not resuscitate order,” physician, health care practitioner, health care provider, and incapable of making an informed decision.

One of the more controversial terms is “best interest.” According to section 5-601, treatment is in a patient’s best interest when the benefits of the treatment outweigh the burdens, taking into account various objective patient-centered medical and patient values criteria.91

One respected commentator has observed that

read closely, in the case of a decision to withhold or withdraw care, the definition [of best interest] does not

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91. As noted in Section II of this Article, this was the subject of significant disagreement among the drafters. The Westminster Bill contained a laissez faire definition of “best interest.” Thus, in the view of the Conference Committee, the Ethics Committee of the Medical and Chirurgical Faculty of Maryland, and ultimately the legislature as well, its meaning would have been determined too much in the mind of the beholder. When the absence of a definition was combined with strong surrogate and agent powers, along with the end-stage condition and the immunization of good faith actions taken pursuant to this law, there was a real possibility of active euthanasia decisions, or worse. The contrary view would have been that caring families and physicians would consider these “best interest” criteria instinctively and that no definition was necessary. Further, anyone with malevolent or indifferent intent could have translated these criteria subjectively. The decision to include a defined “best interest” standard is fairly considered as a legislative decision that special care should be taken in best interest decisions to protect incompetent and vulnerable patients. It also should be of significant assistance to surrogates, agents, and guardians who are often in a serious emotional and ethical quandary over life-sustaining decisions. The criteria include: effect of the treatment; degree of pain or discomfort; consequent “extreme humiliation and dependency” and impairment of the patient’s “dignity”; life expectancy; prognosis; risks and benefits; and to the extent they assist in determining the best interest, religious beliefs and basic values. It can be fairly assumed that in many cases these “pros and cons” will not resolve the question and that it will come down to a de facto decision whether continued life is a greater benefit or burden. In these close questions, absent clear, legally acceptable direction from the patient, the decision should not be by a preponderance of the evidence, and the tradition of our law respecting life preservation should prevail.
require an affirmative finding that the withholding or withdrawal of a treatment is in the patient's best interest. Rather if a proposed or existing treatment is not in the best interest, the Act permits that treatment to be withheld or withdrawn. In this respect, the evaluation is of particular treatments, not whether it is in an individual's best interest to be allowed to die. 92

Several medical states and conditions are defined by the Act. One such condition is the "persistent vegetative state," which the Act terms 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. 93


93. MD. CODE ANN., HEALTH-GEN. § 5-601(o) (1994 & Supp. 1994). Although it was extensively discussed in Mack, Cruzan, Quinlan and other cases of that genre, recognition of the persistent vegetative state is new to Maryland statutory law. There was universal agreement that it should be included in this law and was recommended by both the Conference and Westminster Committees. However, as an example of what I earlier termed "tertiary" differences, there was and is disagreement in the various answers to the question: How long should one wait before concluding that the condition is permanent? Justice Brennan's dissenting opinion in Cruzan referred to a study which reported that "the longest any person has ever been in a persistent vegetative state and recovered was 22 months." 497 U.S. at 309-10 n.8. Speaking at the November 18, 1992, Westminster Conference, Thomas E. Finucane, M.D., of the Johns Hopkins Medical Institutions commented that twelve months was a frequently referenced standard. The Conference Committee included in various drafts twelve, six, and three months in ambiguous cases and no fixed period in unambiguous cases. The Westminster Committee proposal contained no reference to a minimum waiting period. The argument against a specific waiting time is that in the end it is a medical decision driven by the nature of the condition, and that stating a time may tend to overemphasize an arbitrary calendar criterion over science. The argument for a fixed time is that since the HCDA gives priority to the authority of persons other than trained physicians, laypersons deserve some statutory guidance. In the end this was compromised by the recited language recommended in substance by the author with the intention of emphasizing both medical judgment and the importance of waiting in those cases where the condition is not obviously permanent, e.g., catastrophic injury as contrasted with the more ambiguous stroke. There is also an intention to avoid facilitating hurried decisions to remove life support, not because it is believed the condition is permanent,
Another defined medical state is the "terminal condition," that is explained as "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."\(^{94}\)

By far the most controversial provision in the law is the recognition of an "end-stage condition." End-stage is a newly legislated medical condition, separate from persistent vegetative condition and short of terminal illness and imminent death. It is characterized by an irreversible condition, severe and permanent deterioration, incompetency, and complete physical dependency for which treatment would be medically ineffective.\(^{95}\)

but rather to avoid the sometime medically problematic recoveries which might leave the patient alive but impaired to some unforeseeable degree. It is arguable that a decision solely so motivated would likely violate this law and perhaps criminal law as well.


95. See id. § 5-601(i). This provision was strongly resisted on the Senate floor. The practical consequence of the provision is that a person in this condition may be regarded as if terminally ill or in a persistent vegetative condition. It is drafted somewhat tightly, but nevertheless will give greater allowance than the former law to those who, in the absence of patient instruction, do not believe it is in the patient's best interest to wait for the point in time when the person is terminally ill to withdraw or withhold life support. The Attorney General has addressed this concern already. He has referred to "complete physical dependency" as a "key phrase" and opined that the end-stage of such diseases will have arrived only when the patient's physical deficits are such that the patient is generally unable to perform independently a broad range of activities of daily living. According to the Senate Floor Report on House Bill 1243, the Senate's intent on insisting on the "complete physical dependency" language was "to emphasize that the category of 'end-stage condition' only applies to patients who have suffered severe and permanent generalized infirmity from an untreatable irreversible condition." The Attorney General concluded that the condition would be present when the "patient needs help in all aspects of personal care," and if medical treatment would prevent or reduce the patient's deterioration, the condition would not be end-stage. 78 Op. Att'y Gen. Md. No. 93-019 (June 1, 1993).

The difficulty with such vague concepts as end-stage is illustrated by the remarks of a respected physician-ethicist discussing his approach to the HCDA in general:

Well, it gives sort of a general intent. At least for me the new law allows you to use more nebulous information than in the past, and use it as an intent to use the substituted judgment standard. So even if you can't do that it still gives you some clues to the best interest standard, which is the lower standard, so that one of the good things, for me, about the law is that it gives you a lot of different potential avenues to get the desirable medical conclusion. If one of them doesn't work, you back up and go down another avenue, and eventually you find something. And why I think that's a very important point—I understand that there's, to me, two ways to approaching this law and any other law. One is the legalistic approach, and the other is the right way ....
Another important term, "life sustaining procedure," is defined as:

any medical procedure, treatment, or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function; and is of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition, persistent vegetative state, or end-stage condition . . . including artificially administered hydration and nutrition, and cardiopulmonary resuscitation. 96

Being semi-facetious, the legalistic approach says "let's look at how your decision making conforms to the law, and then you can get to your conclusion." And the way I would prefer to see it used, and prefer to see physicians do this, which I think many of them don't out of the fear of the consequences, is to say "let's see what the appropriate medical condition is and we're dealing with this individual and their condition as it relates to the potential for the treatment to do any good, and their quality of life, their wishes, etc., and then let's look back up and see how we can justify, document, and support that decision based on the affirmative avenues within this law." I think that's not to say that you have to circumvent the law, but rather, there's a great deal of flexibility in what I would call "creative stretching" that's possible under this law that's covered specifically by the statute that should alleviate a lot of this fear factor, of not wanting or being able to make a decision because of the fear of the consequences.

Steven A. Levenson, M.D., Remarks at the University of Maryland School of Law's and the Maryland Office of the Attorney General's Law and Health Program, Implementing the Maryland Health Care Decisions Act (Sept. 14, 1993). If one did not know the physician to be very compassionate, dedicated, and well versed in the nuances of the genre of law, it would be reasonable to interpret these remarks as justifying ethically subjective and result-oriented medical decision making behind the facade of the HCDA. It must be conceded that doctors are not the only professionals who rationalize the result they want; but it must also be said that if such an approach can be taken by as scrupulous and informed a physician as Doctor Levenson, it can also be taken by those with a lesser understanding and fewer scruples. The HCDA is neither designed nor intended to facilitate subjective, result-oriented decision making, no matter how well-intentioned.

Nevertheless the elements of this definition, particularly "complete dependency," will remain a matter of judgment and discretion, and the legislative recognition of this condition unquestionably expands the envelope just short of active euthanasia. Interestingly, in its legislative findings, the New Jersey statute prohibits active euthanasia (it is unclear whether this is an implicit recognition of passive euthanasia) and also permits termination of life-sustaining treatment in prescribed circumstances "when the patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention . . . may reasonably be judged to outweigh the likely benefits . . . or . . . would be inhumane." New Jersey Advanced Directives for Health Care, N.J. Rev. Stat. § 26:2H-67(4) (1993). However, that law is designed primarily to encourage and honor advanced directives and gives little independent responsibility to surrogates.

It applies only in cases of terminal illness, persistent vegetative states, and end-stage conditions.

Section 5-601 also defines "medically ineffective treatment"—"to a reasonable degree of medical certainty, a medical procedure will not: (1) prevent or reduce the deterioration of the health of an individual; or (2) prevent the impending death of an individual." 97

C. Section 5-602. Advance Directives

Any competent individual 98 may make a written or oral directive appointing an agent to make health care decisions for the individual. 99 The directive will be effective when the person is declared incompetent 100—sometimes referred to as "springing"—unless it provides for earlier effectiveness. Procedural safeguards as to signatures and witnesses are provided. 101 If an agent is appointed "under this subtitle," that agent has priority over all other decision makers. 102 It is the duty of the patient to notify the agent and to tell the "attending physician" 103 of the existence of an advance directive. It is the duty

interpretable problem with this definition was the subject of a May 3, 1994 opinion of the Attorney General. The opinion also offers important guidance regarding the authority of various decision makers to approve "Do Not Resuscitate" (DNR or "no code") orders. 79 Op. Att'y Gen. Md. No. 94-023 (May 3, 1994). Excerpts of this important opinion are found in Appendix A.

98. A competent person under the Act is at least 18 years of age or who, under § 20-102(a) of the Health-General Article, has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision. Md. Code Ann., Health-General §§ 5-601(h), 20-102(a) (1994 & Supp. 1994). Although the language of the § 5-603 forms include an affirmation of emotional and mental competency of the declarant, this is not an ingredient of the quoted definition of "competent individual." Id. § 5-601(h). Presumably this subjective affirmation is rebuttable, as is the competency of a person who is simply "at least 18 years of age" and is not covered by § 20-102(a).
99. Id. § 5-602(a).
100. See id. § 5-602(e).
101. Id. § 5-602(c).
102. Id. § 5-602(b)(3). "Although the Act does not expressly state this, one might presume that among all individuals with authority to make decisions on behalf of an incapacitated individual, an agent has paramount authority over all except a guardian." Howard Sollins, Legal Issues Arising from the Maryland Health Care Decisions Act Chapter 372 of the Laws of Maryland, MICPEL, June 18, 1993, at 5. Presumably a guardian would be required only if an agent is unavailable or acting contrary to the welfare of the ward. Sollins also comments: "Attorneys often advise clients wishing to name more than one candidate for appointment. There is no barrier to multiple individuals being named as agent, each of whom has independent authority to act." Id. at 7.
103. The first health care provider contact of the conscious chronic care patient is as likely to be with the admitting institutional provider as with an attending physician, and it is at that point that discussion regarding declarations initially occurs. However, the attending physician would normally be informed by the admitting information if not by the patient.
of the attending physician to record that existence. An agent is to follow the instructions of the declarant in an event covered by those instructions. Otherwise, an agent is guided by the same standards governing surrogate decisions. An owner, operator, or employee of a health care facility may not be an agent unless also qualified as a surrogate.

Oral advance directives, witnessed and documented in the medical record, are also permitted as a means of making life-sustaining health care decisions, including the appointment of an agent.

104. Although the reference in the text of the HCDA is to § 5-606(c), that section does not exist. The reference should have been to § 5-605(c): “Surrogate Decision Making.” See Md. Code Ann., Health-Gen. §§ 5-605(c), 5-606(c) (1994 & Supp. 1994).

105. Although the word “facility” is not defined here, it is defined for the purposes of § 5-615 as in § 19-101. Md. Code Ann., Health-Gen. § 19-101 (1994 & Supp. 1994). It is highly likely that the § 19-101 definition will be applied here as well. That definition generally includes hospitals, nursing homes, ambulatory surgical facilities, in-patient rehabilitation facilities, home health agencies, and hospices. Id.

106. In one of the few truly trivial pre-enactment disagreements, there were some within the Westminster Committee who preferred not to expressly exclude from this prohibition religious organizations whose members live in the community and are celibate and thus have neither a spouse nor children. It was ultimately agreed that such organizations would have members who would qualify as surrogates in the absence of other ranking family members; but religious tolerance suffered a slight and unnecessary bruise.

107. As noted, there was an unsuccessful effort on the Senate floor to delete oral advance directives. They are allowed, but restricted to authorizing “the providing; withholding, or withdrawing of any life-sustaining procedure,” whereas an orally appointed agent can be authorized “to make [all] health care decisions for the individual.” Although the text of the HCDA is not entirely clear on the point, it is presumed that this restriction was not intended to compromise the fundamental right of a patient to orally direct the physician in routine health care, that is, one would not need an agent to transmit routine health care decisions to her physician. In other words, when is an oral directive also a lawful “advanced directive”? Is it only when the instruction concerns life support?

Section 5-606(b) provides that life-sustaining withdrawal decisions cannot be made by a health care provider on “the basis of an advance directive” when there is no agent, or on the authority of a surrogate, unless there is certification of a terminal, end-stage, or persistent vegetative condition. Md. Code Ann., Health-Gen. § 5-606(b) (1994 & Supp. 1994). It is intended that for the purpose of this limitation, an oral directive pursuant to § 5-602(d) having “the same effect as a written advance directive,” is similarly restricted. Id. § 5-602(d). If life support is to be withdrawn on the authority of an advance directive that has appointed an agent, that instruction would not be limited to one of the three physical conditions. Of course the agent would have to act in accordance with the directive if there were particularized instructions. However, if the directive, or an agent with unspecified plenary authority, requested withdrawal or withholding of life support in circumstances where the patient was not terminally ill, not in persistent vegetative state, and not in an end-stage condition, the instruction
Finally, the absence of an advance directive "creates no presumption as to the patient's intent to consent to or refuse life-sustaining procedures." 108

D. Section 5-603. Suggested Forms

Two model advance directive forms are presented in the HCDA, although individually tailored directives are also permitted. 109 Form I is the former "living will," 110 which was originally applicable only in the event of imminent death from a terminal illness but not in the event of pregnancy. It has been amended to allow advance decisions during pregnancy or in a persistent vegetative state. 111 The end-stage condition is not included in this form.

Potential problems will be avoided by carefully drawn directives.

109. Sollins makes pertinent comments regarding potentially confusing language in the law, for example, an agent's authority in Part A of Form II to make a life support decision "in appropriate circumstances." Since the HCDA requires such decisions to conform to the statutory standards, Sollins suggests that this presents a question "as to whether the declarant intends that some other or additional measure of 'appropriateness' be considered when a life-sustaining procedure is at issue." Howard Sollins, Legal Issues Arising from the Maryland Health Care Decisions Act Chapter 372 of the Laws of Maryland, MICPEL, June 18, 1993, at 8. Potential problems will be avoided by carefully drawn directives.
111. The attorney general has clarified the pregnancy option language in Form I which refers to an "agent." Form I is not intended for the appointment of an agent and the model forms which will be distributed to the public will conform the language to the obvious legislative intent. See 78 Op. Att'y Gen. Md. No. 93-019 (June 1, 1993).
Form II is designed to accommodate virtually all health care decisions, including end-stage conditions, and allows an appointed health care agent to make those decisions.\textsuperscript{112} Both forms present important choices in a check-off format. In a recent opinion, the Attorney General addressed section 5-603, including Form II’s ambiguous option: “I direct that no matter what my condition, medication not be given to relieve pain and suffering, if it would shorten my remaining life.”\textsuperscript{113} The opinion concludes that this problematic language is intended for patients desiring not to accept pain relieving medication that, for example, depresses respiration and thereby in-

\textsuperscript{112} See Md. Code Ann., Health-Gen. § 5-603 (1994 & Supp. 1994). As noted earlier, this was one of the disagreements regarding secondary issues. The Conference Committee had proposed a durable power of attorney for health care decisions and the retention of the living will—without the pregnancy exception. It proposed that the living will be amended to include decisions concerning artificially provided fluids and nutrients and the persistent vegetative condition. It was also recommended that a post-legislative session conference of all interested organizations and individuals draft a model general advance directive. On the other hand, the Westminster Committee Bill proposed the elimination of the living will in favor of a single model advance directive which would encompass all possible decisions and the appointment of a health care agent. The compromise previously discussed resulted in the availability of both forms. Although having two model forms might be slightly more cumbersome, it is an objective of this legislation to encourage advance directives and therefore both alternatives should be available.

It is expected that the HCDA combined with the federal Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115 to 1388-117, 1388-204 to \textsuperscript{3}1388-206 (1990), will encourage greater use of advance directives. There is evidence, however, that no matter what the state of knowledge is about such documents, not many people have executed them. See Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261, 289 n.1, 323 n.21 (1990). This author attended a conference of senior citizens in the spring of 1993 attended by approximately 125 persons, of whom only approximately 5 had executed a living will. Informal surveys by this writer of advocates of advance directives for others have revealed a notable lack of personal investment in the process. This should not be surprising. Advance directives require a person to not only confront their own death but also either make decisions about future events which cannot be well defined for them at the moment they sign, or surrender their own autonomy \textit{in futuro}. Additionally, many may fear that signing will mean less, not more care. Another reason for this historic lack of enthusiasm might be the expectation that trusted physicians and family members will make the appropriate decision for them. To this can be added that in many more cases than in the past this law will give physicians greater leeway, without fear of malpractice retaliation, in discontinuing what they deem to be ineffective medical care. Md. Code Ann., Health-Gen. § 5-611 (1994 & Supp. 1994). Because approximately 80\% of deaths occur in an institutional setting, Cruzan, 497 U.S. at 302, this latter aspect of the HCDA may have greater real influence on the duration of life-sustaining therapy than advance directives.

creases the risk of an earlier death.\textsuperscript{114} If this option is not selected, "pain relief in accordance with customary medical practice" will be provided.\textsuperscript{115}

E. Section 5-604. Revocation of an Advance Directive

An advance directive may be revoked at any time "by a signed and dated writing, by physical cancellation or destruction, by an oral statement to a health care practitioner or by the execution of a subsequent directive."\textsuperscript{116} To the extent it is reasonable to do so, it is the duty of the declarant to tell everyone who has a copy of his or her declaration of any revocation.\textsuperscript{117}

F. Section 5-605. Surrogate Decision Making

A hierarchy of available family members and close friends are authorized to make health care decisions for someone who is "certified to be incapable of making an informed decision and who has not appointed a health care agent."\textsuperscript{118} Disputes among surrogates of

\begin{footnotes}
\item[115] \textit{Id.} A related question is whether pain medication dosage can be increased with the intention of relieving pain but also with knowledge that it will hasten death. The implicit answer is, yes. Earlier drafts of this legislation made this explicit, but it was decided that this was unnecessary.
\item[116] MD. CODE ANN., HEALTH-GEN. § 5-604 (1994).
\item[117] \textit{Id.} It is likely that these necessarily liberal revocation options will be trouble-spots in the future. The genesis of advance declarations is the traditional last will and testament, from which was derived the living will, and onto which was grafted what is typically known as the "durable power of (health care) attorney." Health care declarations are obviously unlike property dispositions. One can be somewhat more objective and emotionally detached in property dispersal. Life and death decisions stir the emotions. Consequently, we can expect some confusing and mixed signals from declarants, particularly in the form of what might constitute partial revocations, about which the law is silent. The most intelligent approach would be to benignly accept partial revocations and give effect to the latest as repealing or revoking the earlier only to the extent of particular conflict. It should also be noted that the HCDA gives the highest priority to the expressed preferences of the patient, regardless of advance directives. MD. CODE ANN., HEALTH-GEN. § 5-611(e)(2) (1994 & Supp. 1994). Unless one reads into this "competently" expressed preferences, this priority may come under stress when a patient lacking full intellectual capacity, but who is not legally incompetent, contradicts a directive earlier given while fully competent. \textit{See} Sanford H. Kadish, \textit{Letting People Die: Legal and Moral Reflections}, 80 CAL. L. REV. 857, 870-78 (1992). Additionally, there is no requirement that there be only one agent. \textit{See generally} Howard Sollins, \textit{Legal Issues Arising from the Maryland Health Care Decisions Act Chapter 372 of the Laws of Maryland}, MICPEL, June 18, 1993, at 7, 9-10.
\item[118] MD. CODE ANN., HEALTH-GEN. § 5-605(a)(2) (1994 & Supp. 1994). There is not yet any constitutional principle requiring recognition of family or other
\end{footnotes}
equal rank concerning a patient in a hospital or related institution are to be considered by the patient care advisory committee. The physician may follow the advice of the committee or transfer the patient from her care in accordance with section 5-613. Surrogates surrogate decision making. Although medical decisions have been routinely authorized by family members, definitive legal authority for these decisions have been lacking in cases other than minor dependents, guardianships, and emergency treatment. Physicians typically consult with available family members for humanitarian reasons as well as to minimize exposure to medical malpractice allegations in the future. The HCDA institutionalizes surrogate decision making by family and close friends. This policy decision has the great potential advantage of granting control to the family, who presumably knows the patient far better than the medical staff. In some cases, however, it also carries the potential disadvantage of favoring lay, uninformed, and disinterested decision making over professional medical judgment.

As will be seen, the law gives physicians recourse in the event of certain conflicts between their own and surrogate judgment. See id. § 5-611 (permitting the withholding or withdrawal of medically ineffective and ethically inappropriate treatment); id. § 5-612 (providing for referral to patient advisory committee or court if the conflict concerns life-sustaining treatment); id. § 5-613 (permitting provider to transfer the patient to another provider). These fail-safes will be sometimes awkward in practice and the extent to which physicians utilize them will depend in part on their individual ethics. In contrast, New Jersey's law gives little statutory authority to surrogates. See New Jersey Advance Directives for Health Care, N.J. REV. STAT. § 26:2H-61 (1993). In that State, if an advance directive is ambiguous, the attending physician, "in consultation with a legally appointed guardian, if any, family members, or others acting on the patient's behalf, shall exercise reasonable judgment to effectuate the wishes of the patient, giving full weight to the terms, intent, and spirit of the instruction directive." Id.

119. See Md. Code Ann., Health-Gen. § 5-605(b)(1) (1994 & Supp. 1994). Patient care advisory committees are required in hospitals and related institutions. Id. § 19-371. One of their purposes is to "offer advice in cases involving individuals with life-threatening conditions." Id. § 19-373. There was some hesitation in conferring this semi-arbitration responsibility to these committees, as they were not originally intended to have adjudicatory authority, and also because their composition in some facilities may be fluid and transitory. Moreover, it cannot be assumed that all members will be available in full array at every given moment of need. However, it was concluded that if strangers must make health care decisions, the comparative simplicity of the patient care advisory committee was preferable to the potential complexity of a court proceeding. If the decision involves life-sustaining treatment, but not in a hospital or related institution, there must be unanimity within the surrogate class before a physician can act. Id. § 5-605(b)(2) (1994 & Supp. 1994). By resorting to a patient care advisory committee, the physician has certain immunity if he or she acts in accordance with its recommendation. Id. § 5-601(b)(1); accord id. § 5-609. By negative implication, if an action is taken contrary to the recommendation there may be liability for a claim based on lack of consent or authorization.

120. See id. § 5-605(b)(1). By following the advice of the committee, a physician receives some immunity for that decision. Id.
are to base their decisions on the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient’s best interest.\textsuperscript{121} Standards for those determinations are recited,\textsuperscript{122} however, 

\begin{itemize}
  \item \textsuperscript{121} Id. § 5-605(c)(1).
  \item \textsuperscript{122} Section 5-605(c)(2) provides as follows:
    \begin{enumerate}
      \item In determining the wishes of the patient, a surrogate shall consider the patient’s:
        \begin{enumerate}
          \item Current diagnosis and prognosis with and without the treatment at issue;
          \item Expressed preferences regarding the provision of, or the withholding, or withdrawal of, the specific treatment at issue or of similar treatments;
          \item Relevant religious and moral beliefs and personal values;
          \item Behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;
          \item Reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and
          \item Expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.
        \end{enumerate}
    \end{enumerate}
  \end{itemize}

The substituted judgment standards were drawn in part from \textit{Brophy v. New England Sinai Hosp.}, 497 N.E.2d 626 (Mass. 1986), and \textit{In re Jobes}, 529 A.2d 434 (N.J. 1987). The \textit{Mack} court also explored the substituted judgment standards. See Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993). The Westminster Committee Bill originally had no surrogate standards beyond the wishes and values of the patient. The Bill did have guidelines which were discretionary reference points. The intent was to limit surrogate decision making as little as possible. The Conference Committee believed, and the legislature agreed, that since surrogate decisions are substituted judgments, it was important to codify required surrogate considerations. This obligates the surrogate to focus on the patient’s medical circumstances, prior expressions regarding life-sustaining treatment, personal, religious, and moral values, previous relevant behaviors, and the patient’s expressed and related concerns about the effect of treatment on family and intimate friends. See Md. CODE ANN., HEALTH-GEN. § 5-605(c)(2) (1994 & Supp. 1994); see also Mack, 329 Md. at 215, 618 A.2d at 758 (citing Jobes, 529 A.2d at 445).

This last standard is potentially troublesome. The intention is to recognize these concerns among the many pieces of evidentiary history that might better inform substituted judgment. It does not permit the surrogate to independently consider the impact of a health care decision on the family of the patient, but only evidences that the patient has expressed herself about such a consequence of the medical decision. On the one hand, a patient may have said that she did not want her estate devoured by expensive and speculative medical treatments, or that she did not want to be a burden to her family by a prolonged dying process. On the other hand, she may have expressed a strong desire to try everything in order to maintain the family income or its stability. Isolated statements made under medical stress may or may not be discounted, but in any event should be considered only as a piece of the evidentiary puzzle. No one piece of the variety allowed by these standards should suffice for substituted judgment; all should be considered. As noted in Mack, “because the right is one of self-determination, the inquiry focuses on whether the ward had deter-
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consideration of a "patient's preexisting, long term mental or physical disability, or a patient's economic disadvantage" is prohibited if the decision involves life-sustaining treatment. A surrogate is required to "inform the patient, to the extent possible," of what is happening. Finally, a surrogate "may not authorize: (1) sterilization; or (2) treatment for a mental disorder."

G. Section 5-606. Certification by Physicians

A patient's incapacity to make a personal decision must be certified by two physicians within two hours after an examination. Only one physician is necessary if the patient is unable to communicate. If no health care agent has been appointed, life-sustaining treatment may not be denied on the authority of an advance directive without an agent or on the authority of a surrogate, unless there is also certification by two physicians of terminal illness, end-stage condition, or persistent vegetative state. This certification must include the opinion of a specialist in cognitive functioning.

H. Section 5-607. Treatment Without Consent

Emergency life saving treatment may be provided without consent if a person authorized to consent is not immediately available.

I. Section 5-608. Authorization to Follow Emergency Medical Services "Do Not Resuscitate Order" in the Outpatient Setting

Life-sustaining decisions by certified emergency medical services personnel in an outpatient setting—for example, responding to a 911 call or transporting patients from one facility to another—will be governed by "protocols established by the Maryland Institute For Emergency Medical Services Systems, in conjunction with the State..."
Board of Physician Quality Assurance.” These protocols require that “do not resuscitate” orders be followed. Whatever the protocol, however, a wish of the patient to be resuscitated, expressed to those personnel, must be honored; comfort, care, and pain relief must be provided in all events.

J. Section 5-609. Immunity from Liability; Burden of Proof; Presumption

Health care providers, health care agents, and surrogates are immunized from civil liability and criminal prosecution if they act in good faith in accordance with this law. There is a presumption that advance directives are voluntarily executed by competent individuals and that lawful decisions regarding life-sustaining procedures are made in good faith.

131. Id.
132. Id. This section of HCDA was requested by the Maryland Institute for Emergency Medical Services. Letter from George P. Smith, Director, State Office of Commercial Ambulance Licensing and Regulation for the Maryland Institute for Emergency Medical Services Systems, to the Honorable John Carroll Byrnes, Judge for the Circuit Court of Baltimore City (Feb. 8, 1993) (on file with author). It is traceable as well to H.B. 1602, 1993 Sess. (1993), proposed by the Medical Chirurgical Society. Memorandum from the Medical and Chirurgical Faculty of Maryland, The Committee on Professional Ethics to Jose Martinez, M.D., Chair, Legislative Committee (Feb. 3, 1993) (on file with author). Other than in some hospice situations, it was the practice of emergency medical personnel to administer life-sustaining treatment, particularly CPR, despite some contrary medical order or advance declaration. Letter from Smith, supra. The Conference Committee originally thought the inclusion of this provision to be problematic because it has the effect of delegating legislative authority over the subject matter of this law (in the limited context of emergency medical services) to an administrative agency without substantive standards. On the other hand, it can be said that the ultimate regulations are likely to be guided by the legislative intent of this law and should be subject to COMAR administrative publication and comment. Further, at least there are some minimum standards requiring that the expressed wish of the patient be honored, see Md. Code Ann., Health-Gen. § 5-608(b) (1994 & Supp. 1994), comfort, care, and pain relief be continued, see id. § 5-608(a), and that the emergency medical technicians act in accordance with the protocol, see id. § 5-608(a), (c)(1), or as instructed by a physician who is either on the scene or is authorized to instruct by telephone, see id. § 5-608(c)(2). (3) Considering the number of patients who may be in this setting, and the absence of a sufficiently controlled medical and emotional environment in which these decisions will be made, it may be useful for the legislature to give future attention to the justification and implementation of this section. Cf. 78 Op. Att’y Gen. Md. No. 93-019 (June 1, 1993).

134. Id. § 5-609(d). This immunity has statutory precedent in former § 5-607 of the living will law. See id. § 5-607 (1990) (repealed 1993). It was this immunity,
K. Section 5-610. Willful Destruction, Concealment, Damage, etc., of Declaration or Revocation; Penalties

This section generally provides that in addition to “any other penalties provided by law,” any forgery, or falsification of an advance directive, or the concealment, cancellation, defacement, obliteration, or damage to the advance directive of another, that causes the use of life-sustaining procedures against the express wishes of the patient, or is intended to cause the denial of life-sustaining procedures with the result that death is hastened, is punishable as a misdemeanor with a maximum fine of $10,000, or imprisonment not exceeding one year, or both.135

L. Section 5-611. Medically Ineffective Treatment not Required; Mercy Killing or Euthanasia Prohibited; Construction of Subtitle

Ethically inappropriate and medically ineffective treatment is not required of a physician.136 A decision of medical ineffectiveness must be endorsed by a second opinion, unless only one physician is available in an emergency room. Furthermore, such a decision must be communicated to the patient or the patient’s agent or surrogate.137

coupled with the relaxation of the traditional life conserving ethic inherent in this legislation, that caused the Conference Committee to be interested in legislating greater protection of vulnerable patients. Most of those protections were enacted. There is particular concern for poor minority populations in Baltimore City and elsewhere in Maryland. Poorer citizens do not usually have consistent relations with the same physician, relying more often on emergency room treatment. It is reported that “blacks are significantly more likely to suffer and die from sudden heart failure than whites, and that whites with heart disease are far more likely to undergo surgery to correct it than blacks.”
Cheryl Stolberg, Black Heart Patients Found to Get Key Surgery Less, THE SUN (Balt.), Aug. 26, 1993, at 1A. Also, the poor generally have little access to private lawyers, although the Legal Aid Bureau does excellent work in providing advice regarding advanced declarations. Although the Legal Aid Bureau did not take an official position on the HCDA, several of its attorneys—Leslie Fried, Eileen Franch, and Joan O’Sullivan—made significant contributions to the Conference Committee Bill, the Westminster Committee Bill, and to the Hixson Bill, which became law.

135. MD. CODE ANN., HEALTH-GEN. § 5-610 (1994). Section 5-610 recognizes degrees of culpability, including the possibility of unmitigated homicide. Although that extreme situation is very unlikely to occur, it is possible that a close family member or close friend may attempt to alter, forge, or conceal a directive made much earlier and forgotten until the critical moment, to reflect a more recently expressed view of the patient. The benevolent purpose of such an action may negate any criminal intent.


137. Id. § 5-611(b)(2). “Medically ineffective” was intended to cover the myriad of circumstances where a physician’s medical judgment should be protected. It was not intended to be a convenient alternative to the HCDA standards.
If, however, a failure to honor an instruction to render what might governing denial of life support. On October 26, 1994, anecdotal evidence was
given to the Governor's Health Care Decisions Act Advisory Council (of which
the writer is a member) that some physicians are certifying that the provision
of CPR in some cases is medically ineffective. There are several concerns with
this practice.

First, the HCDA is, among other things, a carefully constructed set of
standards governing the circumstances under which life support decisions are
made. If life support decisions can be lawfully made simply on the basis of
medical ineffectiveness, those carefully constructed life support standards are
obviated and a primary purpose of the law is negated. "[t]his is a well-settled
principle [of statutory construction] that specific terms covering given subject
matter prevail over general language of the same or another statute which
might otherwise prove controlling." Perryman v. Suburban Dev. Corp., 33

The General Assembly was quite particular in detailing when and by whom
life support can be denied. The Assembly was notably general in recognizing
the physician's right to declare a potential therapeutic response to be medically
ineffective. To the extent there is overlap between the two provisions, the
particularization of LSMT standards must prevail over the generality of medical
ineffectiveness and therefore a physician is only free to resort to medical
ineffectiveness in a very limited number of cases. This is the thrust of the
023 (May 3, 1994).

Second, if such extensive discretion is to be allowed physicians, those who
have responsibility as health care agents, surrogates, or guardians, not to
mention the patients themselves, have very little recourse, particularly when
the decision is made, as presumably it can be, without the necessity of prior
consultation with agents, guardians, family, or other surrogates. Section 5-611
(b)(2)(i) requires only that the guardian be informed.

While the Attorney General clearly advises that in, for example, a guardi­
nianship, "the attending physician must inform the patient's guardian because
the guardian is also a surrogate" and that "the guardian should ordinarily
inform the court promptly of the attending physician's determination and
provide a copy of the written certification [of medical ineffectiveness] and the
physician's order to implement it"; there is no clear procedure in the circuit
court for this to have any practical effect. Id. In Baltimore City, the practice
has developed of simply filing the certification of medical ineffectiveness in
the court file. While this, in a very superficial sense, informs the court, it does
not truly inform any one judge who might respond to it. As the Attorney
General comments in his opinion,

[the guardian would be reporting . . . an event of potentially great
significance to the welfare of the ward. The court would then have
the opportunity to review the situation and decide on an appropriate
course of action, including, potentially, instructing the guardian to
invoke the transfer process in HG § 5-613 if the court concludes that
CPR should be performed but the physician adheres to the view that
it would be medically ineffective.

Id.

Finally, typically the provision of CPR would prevent an impending death
by cardiac arrest, even if not by reason of the pathology which has caused the
hospitalization in the first instance, such as, cancer, infection, pneumonia, or
be considered unethical or ineffective treatment would result in death during the transfer of a patient occasioned by a disagreement over a proposed medical decision,\textsuperscript{138} that instruction must be followed.\textsuperscript{139}

vital organ failure. Therefore, unless life would not be sustained, even if CPR were to be employed, CPR would not be properly regarded as medically ineffective. The Attorney General posits a situation where cardiac arrest might, in some cases, represent "the start of an inexorable dying process that cannot be prevented by CPR" and therefore CPR might lawfully be regarded as medically ineffective. \textit{Id.}

The potential problem with this comment by the Attorney General is that it introduces, virtually, a new LSMT standard. The HCDA states clearly that, absent some other declaration by the patient, life support can be denied when the patient is terminally ill, is in a persistent vegetative state, or is in an end-stage condition. There is no provision for "the start of an inexorable dying process" as a fourth circumstance. If a patient is not, at the time CPR is indicated, in an inexorable dying process and is not terminally ill, nor in a persistent vegetative, nor end-stage condition, CPR should be provided if it would "prevent the patient's impending [by reason of cardiac arrest] death." If the patient is in one of those three states, at the time of cardiac arrest, CPR may be withheld pursuant to the pertinent provisions of the HCDA, not as medically ineffective. In the language of the Attorney General's opinion, if a patient is facing impending death and a treatment [e.g., CPR] foreseeably would prevent the patient's impending death, the treatment is not medically ineffective as a matter of law. Under these circumstances, it does not matter that the treatment will not "prevent or reduce the deterioration of the death of the patient."

\textit{Id.} at 14.

138. \textit{See} Md. Code Ann., Health-Gen. § 5-613 (1994) (providing that a physician who disagrees with an instruction of a health care agent or surrogate may request that the patient be transferred to another health care provider).

139. \textit{Id.} §§ 5-611(a) (1994 & Supp. 1994), 5-613(a)(3) (1994). The drafters of the HCDA anticipated conflicts between physicians and surrogates; for example, a surrogate seeking maximum available treatment considered ineffective by the physician, or conversely, a surrogate demanding what the physician might consider in his judgment a premature cessation of life. With regard to the expected conflicts, Sollins argues that

\textit{[t]he Act should not reasonably be read to require physicians to act, under the exception identified, in an ethically inappropriate way. Rather the Act should be read to mean that a physician following the Act and continuing to render care, pending transfer, requested by a patient or another individual authorized to act in the patient's behalf, is not engaging in unethical conduct.}

Howard L. Sollins, \textit{Legal Issues Arising from the Maryland Health Care Decision Act Chapter 372 of the Laws of Maryland}, MICPEL, June 18, 1993. The ethics that would be invoked here would likely include a broad range of moral, religious, humanitarian, and medical practice precepts or norms.

The life-sustaining ethic of the medical community is evolving and is articulated to some extent by the Committee on Professional Ethics of the Medical and Chirurgical Faculty of Maryland (whose chairman, Louis C. Breschi, M.D., ably consulted with the Conference Committee and the Westminster Committee); the Council on Ethical and Judicial Affairs of the American Medical Association; religiously based organizations, such as the Maryland
Although, "[n]othing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any Catholic Conference (whose Executive Director, Richard J. Dowling, was active in the various drafting discussions); and medical-legal organizations such as the Hastings Center and the American Society of Law, Medicine, and Ethics. The American Medical Association states:

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. If the patient is incompetent and did not previously indicate his or her preferences, the family or other surrogate decision maker, in concert with the physician, must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death.

Even if death is not imminent but a patient is beyond doubt permanently unconscious, and there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging medical treatment.

The Council on Ethical and Judicial Affairs for the American Medical Association, CODE OF MEDICAL ETHICS: CURRENT OPINIONS, 1992, at 14. The absence of any explicit reference to conditions such as "end-stage" is notable, as is the "beyond doubt" diagnostic standard for the permanently unconscious. This opinion also has the physician acting in concert with authorized surrogates in determining the best interest of the patient. If this intends a coequal status, it may be frustrated by the HCDA, which gives authority only to the surrogate or agent. However, in the typical case, they will be acting at least in close collaboration, if not in concert. Opinions 2.21 and 2.22 of the Code of Medical Ethics address advance directives and "Do-Not-Resuscitate" orders. Id. at 15.

The Medical and Chirurgical Faculty of Maryland "directs itself to situations of a non-emergency nature where there is doubt about the patient's outcome in the near future." MEDICAL & CHIRURGICAL FACULTY OF MARYLAND, GUIDELINES CONCERNING TERMINATION OF MEDICAL CARE 58. The guidelines advise the physician to document the decisions, and honor informed personal or written (e.g., living will) instructions by patients or their authorized representatives. Id. If there are disputes, recourse to second opinions and hospital ethics committees is encouraged; and if disagreement persists, "it is appropriate for the physician to resign from the care of that patient and transfer the care to another accepting physician, if possible." Id. at 59. These guidelines contain no explicit reference to either the persistent vegetative or "end-stage" conditions; but it is anticipated that they will be supplemented to reflect the enactment of the HCDA. The guidelines also appear merely to track the law and give procedural advice in the context of the law. The ethic is not as pronounced. Appropos, the AMA Code includes the statement: "Ethical standards of professional conduct and responsibility may exceed but are never less than, nor contrary to, those required by law." The Council on Ethical and Judicial Affairs for the American Medical Association, CODE OF MEDICAL ETHICS: CURRENT OPINIONS, 1992, at 1.
affirmative or deliberate act or omission to end life other than to permit the natural process of dying.""140 Reasonable efforts to provide food and water without tubes are required.141 Moreover, when a decision to end life-sustaining procedures is to be made by an agent or surrogate, nothing precludes a separate decision as to tube feeding.142 Finally, no medical treatment decision, with which the patient

141. Id. § 5-611(d). This was in part a response to the alleged practice of convenience intubation, by which patients would be fed artificially, not because they were unable to take nutrients and fluids naturally, but because of lack of staff or time or patience. This practice is not wrong per se, but in the context of this law serious questions were raised that, given the blending of this life-sustaining procedure with all other life-sustaining procedures and understanding that no other life-sustaining procedure is as likely to be used for convenience, there needed to be a requirement that natural feeding be done whenever feasible.
142. Id. § 5-611(e)(1). The state of the law on this point is that there is no required legal distinction between sustaining life by artificial feeding through tubes and sustaining life by more commonly recognized devices such as the respirator. In Cruzan, the majority opinion concluded, for purposes of that case, "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 279 (1990). The Mack decision took up this question only in the context of the 1990 amendment to the Estates and Trusts Article § 13-708(b) and (c), which clarified the power of the circuit court to authorize a guardian to withhold or withdraw life-sustaining treatment. See Act of May 29, 1990, ch. 709, 1990 Md. Laws 2934 (codified as amended at MD. CODE ANN., EST. & TRUSTS § 13-708(b), (c) (Supp. 1994)). The majority opinion concluded that "[a]bsent a statutory exclusion of artificially administered sustenance from the medical treatment or procedure referred to in § 13-708, artificially administered sustenance is included in those terms." Mack v. Mack, 329 Md. 188, 214, 618 A.2d 744, 757 (1993).

The Mack decision cited appellate holdings in nine other states which reached the same substantive conclusion. See id. at 213 n.8, 618 A.2d at 756 n.8. On the other hand, the Supreme Court of Missouri saw a legal distinction. Cruzan v. Harmon, 760 S.W.2d 408, 423-24 (Mo. 1988), aff'd sub nom., Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990); see also In re Conroy, 464 A.2d 303, 312-14 (N.J. Super. Ct. App. Div. 1984). In light of the leeway afforded the states by the Supreme Court in Cruzan, and by the implication in Mack that the General Assembly could make a due process or other distinction, a higher burden of proof of patient intent could be legislatively required before food and water could be withheld or withdrawn.

Moreover, there are many who see a medical and moral difference. The family of Karen Ann Quinlan did not seek removal of her feeding tubes. In re Quinlan, 355 A.2d 647, 651 (N.J. 1976). The family of Nancy Cruzan did. Cruzan, 497 U.S. at 265. Presumably, if feeding tubes were removed, as could be done in the patient's best interest by a surrogate or an agent, significantly before the fatal pathology would have run its natural course, the death certificate would likely have to record the primary cause of death as dehydration. But see McConnell v. Beverly Enters., 553 A.2d 596, 605 (Conn. 1989). Opinion in the medical community appears to be divided, as revealed in a recent survey of 1400 physicians and nurses, 42% of whom believed that even
when other life-sustaining treatment is withdrawn, "food and water should always be continued." **Doctors, Nurses Troubled over Dying Patients' Care, THE SUN (Balt.), Jan. 14, 1993, at A6.** A recent CBS 60 Minutes program documented a case where artificial feeding was ordered removed from a severely disabled patient who was neither terminally ill nor comatose. **60 Minutes** (CBS television broadcast, Mar. 3, 1994); see also, Wendy A. Kronmiller, Comment, *A Necessary Compromise: The Right to Forgo Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act, 47 MD. L. REV. 1188 (1988).*

The Conference Committee recommended that the statutory life-sustaining decision tree include a separate branch for tube feeding. The legislature agreed in principle but provided only a large twig in § 5-611(e), which makes clear that an independent tube feeding decision is still permitted. **See MD. CODE ANN., HEALTH-GEN. § 5-611(e)(1) (1994 & Supp. 1994).** The HCDA approach may be the best possible solution. In addition to the explicit authority to distinguish this form of life support, the suggested advance directive forms in § 5-603 give a declarant the option to request the continuation or discontinuation of artificial feeding, although the language—"the administration of nutrition and hydration artificially"—may not be fully understood by an untutored declarant at first glance. This clinical language was considered to have less emotional overtone than the plain-speak "food and water," and would presumably in any event be translated for proper "informed consent." **Id. § 5-603.**

143. **MD. CODE ANN., HEALTH-GEN. § 5-611(e)(2) (1994 & Supp. 1994).** In this section the delicate ball bearings of the Bill's ethical machinery are found. This section states that ethically inappropriate and medically ineffective treatment are not required, mercy killing and euthanasia are forbidden, and any deliberate action intended to end life is not permitted by this law unless that action is intended "to permit the natural process of dying." *Id.* Of course virtually every medical response to a serious trauma or disease, (for example, the introduction of antibiotics and tube feeding) to some degree, interferes with the natural process of dying; and it is unclear, except perhaps metaphysically, how an act intended to end life can be transformed into an act to permit the natural process of dying, as the text literally implies. Further, there are physicians whose personal ethics might rationalize a decision not to act to save the life. Examples of this might be a sincerely held belief that recovery would deny the patient a quality of life that he should enjoy, that post-recovery life would be a great burden to the patient or to their family, or that the patient has already suffered enough. **See, e.g., It's Over Debbie, 259 JAMA 272 (1988).** The intention of this section is to express two important ideas: homicide, including euthanasia and mercy killing, is forbidden; but a decision to not act to save life is permitted if that decision is based upon a professionally informed judgment that treatment would be ineffective to save the life or if a life-sustaining intervention would contravene some objective ethical norm. In no event, however, should a medical ineffectiveness decision circumvent the standards of the HCDA governing denial of life support. Additionally, § 5-611(e)(2) makes clear that no decision, including a decision to not act, is permitted with which there is reason to believe the patient disagrees. **See MD. CODE ANN., HEALTH-GEN. § 5-611(e)(2) (1994 & Supp. 1994).** Whether this is qualified in a patient transfer setting is unclear. **See id. § 5-613(a)(3) (1994).** Nevertheless, this core philosophy of the law should give strong guidance to respect a
M. Section 5-612. Petition by Health Care Provider; Court Action

A health care provider who believes that an instruction to withhold or withdraw a life-sustaining procedure from an incapacitated patient is inconsistent with generally accepted standards of patient care, must take the matter to a patient advisory committee or a court. If the matter goes to court, it will be governed by sections 13-711 through 13-713 of the Estates and Trusts Article of the Annotated Code of Maryland. Various family members and certified surrogates may also obtain an injunction against a proposed health care action if they can demonstrate to the court by a preponderance of the evidence that the action is unlawful. Courts are to give priority to such cases.

patient's wishes however reliably expressed, to use ethically and medically sound judgment, and, when in doubt, to preserve life. This philosophy was succinctly expressed by Judge John F. Fader, II, one of the architects of the HCDA structure, speaking at the 1992 Westminster meeting. He stated that, "life and the preservation of life is the role of law unless there is some manifestation by a person who is competent or, in the alternative, a person who is incapacitated who has the same constitutional right, that life-sustaining systems should be withdrawn or withheld." Video tape of Westminster Meeting (1992) (on file with author).

144. MD. CODE ANN., HEALTH-GEN. § 5-612(a)(1) (1994). This section of the HCDA and § 5-611 implement the State's interest in protecting the integrity of the healing professions. It is also the principal safety valve for patients who may be victimized by abusive or questionable health care decisions made pursuant to this Act. For example, a premature decision by a surrogate, agent, or guardian to remove a feeding tube if it was the only life-sustaining apparatus in place might be challenged pursuant to this "appeal" proceeding. Id. Also subject to such a challenge might be a premature conclusion that the persistent vegetative state has lasted long enough to permit a certification of permanency, or a decision against critical surgery or other medical intervention in an end-stage case at a point in time when any of its definitional elements (e.g., "irreversible condition," "severe and permanent deterioration," or "complete physical dependency") are reasonably debatable. Of course, referral to a patient advisory committee or a court to some extent begs the question, since a judge will have little more legislative guidance on these medically, legally, and morally sensitive questions than anyone else. In the long run, what is "appealable" will come down to evolving community values and the over-arching philosophy of this legislation that the patient's wishes and personal dignity are to be respected; but the burden should be on those deciding to end or permit an end to a life, rather than on those who would sustain it to its natural end.

145. Id. § 5-612(a)(2).
146. Id. § 5-612(b).
147. Id. § 5-612(c). Most, if not all, circuit courts give priority to these cases. In Baltimore City they are placed on the "Fast Track" docket and can be before a judge in a matter of days or hours. In Baltimore City there is either a circuit or district court judge available on a 24 hour basis. District court judges are authorized to entertain, determine, and act upon any applications to the circuit
Section 5-613. Transfer of Patient by Health Care Provider who Refuses to Comply with Advance Directive or Treatment Decision

If a health care provider does not intend to comply with a health care instruction, the provider must so state and advise the agent that the patient can be transferred to another provider and that the transferring provider will offer reasonable transfer assistance.148 Treatment must be continued pending the transfer “if a failure to comply with the instruction would likely result in the death of the individual.”149 However, this section does not authorize “a health care provider to provide health care to: (1) A competent individual over the objection of that individual; or (2) An individual incapable of making an informed decision over the objection of another person authorized by law to consent [to the treatment].”150

149. Id. § 5-613(a)(3).
150. Id. § 5-613(b). Section 5-612 refers to “an instruction to withhold or withdraw...
Denial of life support pursuant to this law is not suicide.\(^{151}\)

Making an advance directive does not affect the sale, procurement, or issuance of life insurance policies nor does it modify existing policy terms.\(^{152}\)

Lawful denial of life support does not invalidate such a life-sustaining treatment” and requires a petition to a patient advisory committee or the court if the instruction “is inconsistent with generally accepted standards of medical care.” See id. § 5-612(a)(1) (1994 & Supp. 1994). Section 5-613 covers all treatment decisions and does not specifically authorize referral to the patient advisory committee, although there is nothing to preclude it. See id. § 5-613 (1994). When a provider objects to an instruction as “inconsistent with generally accepted standards of patient care,” which might include not just practice standards, but also legal interpretation, ethics, or provider treatment philosophy that provider is to give notice of an intended transfer to another provider (which could be another physician or another institution) and offer to assist in transferring the patient to where presumably the instruction will be honored. Id. § 5-613(a). This section assumes that there would be a willing transferee provider prepared to do what the first provider believed to be a breach of the standard of care. If there was no such willing transferee, the provider would be at a stalemate unless the refusal was based upon ethical or medically ineffective grounds. In such an event, the provider, if a physician, could simply refuse pursuant to § 5-611. Id. § 5-611(a), (b) (1994 & Supp. 1994). However, if the objectionable instruction is to not provide treatment, and that instruction came from a competent patient or a surrogate, agent, or guardian, then the treatment could not be provided. Id. § 5-613(b) (1994). This might on occasion put a physician, who believes that not to provide treatment is a dimension of treatment and unethical in a particular case, at risk in the event of a conflict between §§ 5-611 and 5-613. It should also be noted that while § 5-611 gives a physician an ethical and ineffective treatment “out,” the out apparently does not apply if, while the patient is pending transfer to another provider pursuant to § 5-613, a failure to comply would put the patient at risk. See id. A complete and clarifying analysis of §§ 5-611, 5-612, and 5-613 and their inter-relationship is beyond the scope of this Article; but their combined intent is to find the balance between the obligation to honor health care decisions and the practice standards and ethical obligations of providers and physicians, without jeopardizing the life of the patient in the process.

\(^{151}\) Id. § 5-614(a). A deliberate withholding or withdrawal of life support with the intent to cause or permit death which would otherwise not occur would be homicide unless the action was taken pursuant to this law. An actor other than the patient who withholds or withdraws a life-sustaining procedure may be criminally liable for assisted suicide, which may violate Maryland common law. See 78 Op. Att’y Gen. Md. No. 93-036 (Sept. 8, 1993); Note, Criminal Liability of Participants in Suicide: State v. Williams, 5 MD. L. REV. 324 (1941). The intent of this section is nonetheless clear—that a person is not committing suicide if, pursuant to this law, he instructs that life support be withheld or withdrawn from him. Further, anyone who acts, pursuant to that instruction and this law, to cause the withholding or withdrawal of life support has immunity from criminal prosecution. Md. CODE ANN., HEALTH-GEN. § 5-609 (1994).

a policy. Also, "[a] person may not be required to make an advance directive as a condition for being insured for, or receiving, health care services." Finally, "[a]ny declaration of a patient or any designation of an agent made prior to October 1, 1993 shall be given full force and effect as provided in this subtitle."

P. Section 5-615. Provision of Information

Health care facilities are required to inform admittees of their right to make treatment decisions by advance directives or otherwise.

Q. Section 5-616. Preservation of Existing Right; Advance Directives Executed Before Effective Date

Section 5-616 provides that

[i]the provisions of this subtitle are cumulative with existing law regarding an individual’s right to consent or refuse to

153. Id. § 5-614(b)(2).
154. Id. § 5-614(c).
155. Id. § 5-614(d). This latter sentence is intended to "grandfather" advance declarations and designations of health care agents in durable powers of attorney for health care prior to the effective date of this law. There was some small shadow of doubt about the validity of these in Maryland absent express legislative approval; but the 1988 opinion of the Attorney General, see 73 Op. Att'y Gen. Md. 162 (1988), and the Cruzan decision gave health care agents at least some federal constitutional support. Also, oral declarations or instructions to physicians by patients would likewise be "grandfathered." The phrase "as provided in this subtitle" is not easily understood literally, as there is nothing expressly providing for them elsewhere in the HCDA subtitle (subtitle 6). A reasonable interpretation is that their employment will be in accordance with the standards of this law. For example, the expressed wish of the patient, short of mercy killing or euthanasia (including assisted suicide), will be honored; in the absence of such expression, the decisional standards for agents would apply.

157. Id. § 5-615 (1994 & Supp. 1994). The federal Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115 to 1388-117, 1388-204 to 1388-206 (1990), became effective on December 1, 1991, and requires hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations receiving Medicare or Medicaid reimbursements to give similar information concerning the law of their state, and to give patients a copy of that facility's policy of implementation of that law. Additionally, it requires medical record documentation of patient instructions and public education of the advance declaration options. Id. However, it is uncertain that emergency room arrivals, outpatient clinics, and the offices of physicians are covered. The HCDA would plug any holes in this informational coverage.
The Health Care Decisions Act

consent to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the provision, withholding, or withdrawal of life-sustaining procedures under the common law or statutes of the State.¹⁵⁸

¹⁵⁸. Md. Code Ann., Health-Gen. § 5-616(a) (1994 & Supp. 1994). In addition to protecting rights existing as of October 1, 1993, this section assumes the common and constitutional law of this state and nation will continue to evolve, and to the extent that such later law expands the rights of citizens beyond those in this law, those rights would apply as well. Although it is not likely that the United States Congress will legislate beyond the existing Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115 to 1388-117, 1388-204 to 1388-206 (1990), preferring the states to act as the nation's laboratories in this field, it is not as likely that the federal courts will follow suit. The Cruzan decision was limited in its reach, and the Brennan dissent in that case presents another potentially less restrictive approach to these questions. Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 301-30 (1990) (Brennan, J., dissenting). For example, after acknowledging the potential influence of the state interests in medical self-determination, Justice Brennan wrote that "the State's general interest in life must accede to Nancy Cruzan's particularized and intense interest in self-determination in her choice of medical treatment. There is simply nothing legitimately within the State's purview to be gained by superseding her decision." Id. at 314.

This proposition is not too far removed from the intended routine effect of the HCDA in terms of self-determination. Opinions divide, however, on the proper answer to the important question of how to assure that a decision truly reflects a patient's self-determination, and is not violative of this law and the fundamental life-respecting and protective ethic which influenced its enactment. Justice Brennan acknowledged the State's "parens patriae interest in providing Nancy Cruzan, now incompetent, with as accurate as possible a determination of how she would exercise her rights under these circumstances." Id. at 315. He disagreed, however, with Missouri's "heightened evidentiary standard" of clear and convincing evidence. See id. at 316-21. A standard that was sanctioned by the Court of Appeals of Maryland in Mack. See Mack v. Mack, 329 Md. 188, 618 A.2d 744, 754-55 (1993). The Mack court also acknowledged the potential influence of the four traditional state interests. Id. at 210 n.7. The formula of the HCDA is to account, using the language of the statute, for these state interests by specific provisions in order to minimize the need for court resolutions based upon abstract state interests. However, the HCDA does not preclude a state's interest analysis in extraordinary cases. For example, the language recommended by the Conference Committee which was intended to account for the state interest in protecting minor dependents was withdrawn, thus giving wider latitude to the application of this interest by the State in its parens patriae role. Cf. Md. Code Ann., Health-Gen. §§ 5-502, 5-702, 5-1062 (1991); Wentzel v. Montgomery Gen. Hosp., 293 Md. 685, 447 A.2d 1244 (1982). The law concerning the right of parents to make potentially life-ending decisions on behalf of impaired infant children is still forming.
This section, somewhat redundant of section 5-614(d), “grandfathers” valid living wills and durable powers of attorney executed prior to October 1, 1993. They are to be “given effect as provided in this Article, even if not executed in accordance with the terms of this Article.”

R. Section 5-617. Reciprocity

Advance directives and emergency medical services “Do Not Resuscitate” orders, if validly executed in accordance with the laws of another state or this state, will be honored in Maryland. Such orders executed in another state “shall be construed to give effect to the patient’s wishes to the extent permitted by the laws of Maryland.”

S. Section 5-618. Short Title

This new law is formally entitled the “Health Care Decisions Act.”

T. The Judicial Standards

As noted earlier, the genesis of the HCDA included the desire of Maryland’s circuit court judges to have legislated standards for judicial life support decisions. These standards were incorporated into the HCDA and enacted as amendments to the Estates and Trust Article.

IV. THE ESTATES AND TRUSTS ARTICLE

A. Section 13-601. Disability, Incompetence, etc., of Principal

To the extent that a power of attorney contains an advance directive appointing a health care agent, it will be governed by the HCDA.

160. Id.
161. Id. § 5-617 (1994).
162. Id.
163. Id. § 5-618.
164. Md. Code Ann., Est. & Trusts §§ 13-601, 13-707, 13-711 to -713 (Supp. 1994). The enacted standards were those proposed by the Conference Committee with one amendment to be discussed below. They govern decisions regarding life-sustaining care, including those that come to court in a dispute mode. However, some disputed decisions and petitions for appointment of a guardian of the person might arrive in court concerning a non-life-sustaining health care decision, for example, dental care. The HCDA provides no express standards for those decisions because it was assumed that the courts would continue to make them on the basis of the ascertainable preferences of the patient and expert testimony that evidences the best medical judgment.
165. Id. § 13-601(d).
B. Section 13-701. Persons Entitled to Appointment

A health care agent appointed by a disabled person in accordance with the HCDA is given second priority for appointment as guardian of that person, following a person previously designated as guardian by the disabled individual.\(^{166}\) The balance of the existing hierarchy (spouse, parents, et seq.) is undisturbed. It also includes a provision for a close friend.\(^{167}\)

C. Section 13-708. Rights, Duties, and Powers of Guardian

Section 13-708 provides that “[t]he court may appoint a guardian of the person of a disabled person for the limited purpose of making one or more decisions related to the health care of that person.”\(^{168}\) The balance of this section continues the language of the former law, requiring court authorization of a guardian’s consent or approval of a medical procedure that “involves a substantial risk to the life of a disabled person,” or the withdrawing or withholding of that procedure.\(^{169}\) However, subsection (c)(2) is new law, and permits a court, “upon such conditions as the court considers appropriate,” to authorize a guardian to make those decisions in the future without further court authorization if the disabled person has executed an advance directive containing such authority but not designating a health care agent.\(^{170}\) A guardian who is also the disabled person’s spouse, adult child, parent, or adult brother or sister may be similarly authorized.\(^{171}\) This section subjects “a petition seeking the authorization of a court that a life-sustaining procedure be withheld or withdrawn” to a new Part III of section 13-711, “Life-Sustaining Procedures.”\(^{172}\) The new Part III consists of a definitional

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166. Id. § 13-707(a).
167. Id.
168. Id. § 13-708(a)(2). This change in the law was recommended by George T. Tyler, Esq., who made many useful suggestions in the drafting process, so that the law clearly permits a guardian of the person to have only limited authority, such as petitioning only for a change of abode, rather than the responsibilities of a general guardian of the person. Letter from George T. Tyler, Esq., Special Study Committee of Maryland Judicial Conference: Withholding or Withdrawal of Medical Procedures Involving “Substantial Risk” to the Life of a Disabled Person, (Mar. 13, 1992) (on file with author).
170. Id. § 13-708(c)(2).
171. Id.
172. Id. § 13-708(c)(3). This “advance authorization” language was an amendment to the language of the Conference Committee recommended by the Senate and House committees. It apparently was the suggestion of the AARP to eliminate, in specified circumstances, the necessity of a return trip to the court by the guardian when a life support decision is required. It was unclear how the
section, authority for substituted judgment by the guardian, and authority for a guardian’s best interest decision.

D. Section 13-711. Definitions

“Best interest” is again defined to mean “that the benefits to the disabled person resulting from a treatment outweigh the burdens to the disabled person resulting from that treatment.” It takes into account various clinically ascertainable conditions, subjectively and objectively assessable circumstances such as “pain and discomfort,” and the “religious beliefs and basic values of the disabled person... to the extent these may assist... in determining best interest.”

... standards of the law that apply to everyone else pursuant to the HCDA in the Health-General Article, or the standards applied to guardians in the new Part III, would reach these guardians if they are given advance authorization at a time when, presumably, the need for the life support decision was not present. It was not the intent of the drafters to allow this species of guardians to float freely. The Attorney General has already issued a formal clarifying opinion in which he opines that if the guardian is implementing a pre-existing advance declaration, the guardian’s duty is to fulfill its terms, if possible. 78 Op. Att’y Gen. Md. No. 93-019 (June 1, 1993). Also, the HCDA regards a guardian as a surrogate, and the guardian is therefore “subject to the standards for surrogate decision making set out in HG § 5-605(c), whether or not the court imposes any conditions.”

... This advanced authorization amendment is troubling for another reason. The majority opinion in Mack, makes clear that it is the judge who is ultimately responsible for the welfare of the disabled person, who is a protected ward of the court. Mack v. Mack, 329 Md. 180, 200-01, 618 A.2d 744, 750-51 (1993). Otherwise, why is a guardian of the person typically required? To give someone advance authority to make a life or death decision for a ward of the court is tantamount to delegating the power of the court, if not abdicating it. The intent of this section is nevertheless a reasonable one: When the ward has already given clear advance instructions regarding the use of life support in given circumstances, or when the guardian of the person is someone who would in any event have surrogate authority absent the guardianship, it may be sensible for the court, at the time of appointment, to authorize the guardian to carry out the terms of that advance directive or to authorize the guardian surrogate to exercise her normal surrogate authority when future circumstances require it. The judge can keep faith with her responsibility for the ward by imposing appropriate conditions on the exercise of this advance authority, for example, by requiring the guardian to give the court immediate notice of when, why, and how the guardian will exercise the power, and requiring prompt medical documentation.

174. See id. § 13-712.
175. See id. § 13-713.
176. Id. § 13-711(b).
177. Id. Once the policy judgment was made to permit the patient’s best interest to be a life support decision standard, as opposed to requiring the decision to
“Life-sustaining procedure” is defined in Health-General section 5-601(m). Also defined in Estates and Trusts section 13-711 is “substituted judgment,” which is “a determination by a court that a disabled person would, if competent, make the same health care decision regarding a life-sustaining procedure taking into account any information that may be relevant to the decision,” including the medical condition, personal and religious values, and a variety of behaviors and comments of the disabled that evidences what he or she would decide if able to do so.

E. Section 13-712. Substituted Judgment; Evidence

The court may make a substituted judgment based upon clear and convincing evidence. Such evidence may include hearsay that might be otherwise inadmissible but which is material, probative, and the best evidence available.

F. Section 13-713. Best Interest of a Disabled Person

If the court cannot make a substituted judgment, it may decide, based upon clear and convincing evidence, what is in the best interest of the disabled individual, without regard for the patient's preexisting, long-term mental or physical disability, or economic disadvantage.
V. THE PUBLIC POLICY INTENT OF THE HCDA

To demonstrate the philosophical balance of this legislation, this Act has given particular attention to its sources—legislators, advocacy groups and individuals, bar association specialists, religious and other ethicists, academicians, judges, and health care professionals—all of whom expressed variations of the important ideas that ultimately became this law. The creative tension between the philosophies which characterized and gave life to this important law are representative of similar bioethical conflicts in every state, in the United States Congress, and in the United States Supreme Court. This law would not be as useful to the public if one particular viewpoint prevailed over the others. In the end, no one ambition for this legislation prevailed. The various factions cooperated more than they warred. As a result, a composite of viewpoints formed the public policy of Maryland in one of the most important of its expressions—continued life or death.

Although there were reasonable differences in emphasis, there was consensus as to the intent of this legislation—to honor both the individual’s right to make personal health care decisions, free of needless court or other intervention, and the community’s obligation to respect and protect the sanctity of human life. Artificially prolonging life which is very near its natural end can be unduly burdensome, intrusive, and sometimes painful. It should be discouraged. Patients should be free to refuse an artificially prolonged life and physicians obliged to honor that refusal.

Neither the individual’s nor the state’s interests are absolute. Each is relative and might be in conflict with the other. The tension will be minimal in most cases because the patient’s preference will be clear and the medical circumstances, common sense, ethics, and humanitarian instincts will support a responsible medical judgment. In the smaller number of cases where the medical path is less certain and the patient’s choice unclear, health care providers and agents, family members, lawyers, and judges will be called upon to make value judgments in life or death contexts. The HCDA gives strong direction in such cases in order that a medically and ethically informed decision which reflects the likely choice of the patient is circumscribe best interest considerations and focus the decision on the medical judgment that must be made at that time for the benefit of the patient in light of the medical syndrome which requires that judgment. Therefore, someone with terminal cancer who also suffers from, for example, long-term schizophrenia or paraplegia, is not a more suitable candidate for life support discontinuation because of the long term mental affliction or physical handicap. The application of this prohibition in an end-stage case will be challenging. Similarly, an impoverished person’s life has the same intrinsic worth as the life of an affluent person.
made. In the comparatively few cases where that choice cannot be discerned and bodily intrusion, degradation, and suffering is plainly disproportionate and violative of the patient's values, the patient's best interest will be the standard. Care must be taken to avoid subjective "quality of life" or financially driven decisions. Euthanasia, homicide, and mercy killing remain forbidden, and society's instinctive respect for impaired life remains paramount. Medical decisions that debase life, compromise the integrity of the medical professions, or place third parties at unnecessary risk are disfavored. This legislation is in concert with the Constitution's assurance of "life, liberty and the pursuit of happiness" that encompasses both control of one's own body and protection of life. The HCDA is intended only to extend a peaceful hand to those who want to control their own dying process, to give them dignity in their final hours, days, or weeks, not to push them into their graves.

It is hoped that more citizens will think, in advance, of possible health care decisions; but even in cases where there is some form of advance directive, physicians, agents, guardians, and surrogates will be sensitive to the reality that no declarant can predict the exact circumstances from which a decision will be required. Thus, to know the preference of an incompetent patient at the time of medical choice will be frequently difficult and sometimes impossible. The same can be said about the large number of cases where there will be no formal advance directive and, in some cases, no supportive family. It should be assumed, particularly when death is not imminent, that people normally want life-preserving therapy continued unless its burden is plainly disproportionate to its benefit in the long term. It is expected that the medical community will adhere to its ethical canons and its raison d'être to cure illness, repair wounds, alleviate suffering, and sustain life, but not to employ needlessly intrusive and obviously futile therapy. It is anticipated that judges, lawyers, guardians, health care agents, surrogates, and health care professionals will not neglect vulnerable patients because of economics, mental, emotional, or physical impairment, or because the life style of the patient is or might become, from someone else's own healthy perspective, less than ideal. Nor will the inconvenience, burden, or emotional drain on family and friends be decisive. It is not their life that hangs in the balance. All of the authors of this law share a basic confidence in the good faith and intelligence of the various possible decision makers empowered by it. The authors are optimistic that the decision makers will appreciate the heavy responsibility of protecting the health and well-being of the person in their care, not to hasten the person's death.

Is there a "slippery slope" danger? Undeniably there is; but the grade of the slope depends upon our public policy. By enacting this law, the General Assembly concluded that as we descend the hill we
do so with great care and a good brake system, and also a good steering mechanism to stay on an ethically safe roadbed.\textsuperscript{182}

I close by again drawing upon the thoughts of Professor Dwor-kin:

The idea that human life is sacred or inviolable is ... central to discussions of [euthanasia] ... .

Three distinct issues come together in decisions about euthanasia. We must be concerned how best to respect the patient's autonomy, his best interests, and the intrinsic value or sanctity of his life. We can properly understand none of these issues, however, or whether they argue for or against euthanasia in a given circumstance, until we better understand why some people want to remain biologically alive so long as they can, even in appalling circumstances, and why others in such straits want to die as soon as possible. Both these ambitions will seem unintelligible if we try to understand them as reflecting people's opinions about the relative badness of future experiences, for it makes no sense to ask whether it feels worse to be permanently unconscious or wholly demented or dead. We must ask, instead, about the retrospective meaning of death or the diminution of life, about how the last stage of life affects its overall character. We understand how one life can be more pleasant or enjoyable or full of achievement than another. But the suggestion that a period of unconsciousness or dementia before death might make that life worse as a whole than if death had come sooner introduces a very different kind of standard for judging lives; it judges lives not just by reckoning overall sums of pleasure or enjoyment or achievement, but more structurally, as we judge a literary work, for example, whose bad ending mars what went before.

[There are] a great number of intense personal convictions about abortion and euthanasia, some of them liberal and others conservative. They are honorable convictions, and those who have them must live and die in their light. But it is unforgivable to ignore the high importance of these matters altogether, to choose or counsel abortion out of unreflective convenience, or to leave the fate of an unconscious or demented friend to strangers in white coats on the ground that what happens to him no longer matters. The

\textsuperscript{182} Governor Schaefer, by executive order, established the Health Care Decisions Act Advisory Council, consisting of 19 members, to monitor the implementation of this Act. Md. Exec. Order No. 01.01.1994.11 (Mar. 29, 1994).
The greatest insult to the sanctity of life is indifference or laziness in the face of its complexity.\textsuperscript{183}

VI. POSTSCRIPT

Coincidently with the passage of the HCDA, and largely overshadowing it in the media, was the enactment by the Maryland General Assembly and proposals to the United States Congress of changes in health care financing. There is little doubt that changes in financing will affect availability of health care and eventually a rationing-by-triage approach to benefits. Not every therapy would be available to every patient in a fully managed system. Historically, the discrimination has been largely against those who are uninsured or underinsured. In the future, it may be against those who are comparatively less likely to gain long term benefit; for example, a transplant might be provided to the young, but not to the elderly. A new rationing principle may be based on this statement by Hillary Rodham Clinton to the Congress: "[No one will be] denied treatment for any reason other than it is inappropriate . . . [or that it] will not enhance or save the quality of life."\textsuperscript{184}

The economic rationing standard today is often unfair, but clear: Can you pay? A new rationing standard of appropriateness and quality of life enhancement is less clear and perhaps even more problematic if it is considered in conjunction with the President’s own public comment encouraging the use of living wills: "We do have a lot of extra costs that most people believe are unnecessary in this system, and that’s one way to weed some of them out."\textsuperscript{185} It is uncertain how the traditional living will would put much of a dent in the substantial cost of chronic care. They are executed by relatively few people and, in Maryland, they are effective only when death is imminent or when a patient is in a persistent vegetative state. The remarks of President and Mrs. Clinton\textsuperscript{186} were not intended as a serious pronouncement linking the need for health care cost control to living wills, and certainly not to the broader advance directives of the HCDA. However, there is undeniably some hint of a possible relationship. If one fails to say in advance that they want no extraordinary means of life preservation, are they being, in a public policy sense, selfish? Will a national health care financing plan...

\textsuperscript{184.} John Fairhall, Experts See Rationing Under Health Care Plan, \textit{The Sun} (Balt.), Oct. 12, 1993, at 1A.
\textsuperscript{185.} Clinton Cites Living Wills, \textit{The Sun} (Balt.), Nov. 8, 1993, at 5A.
\textsuperscript{186.} Id.; see also John Fairhall, Experts See Rationing Under Health Care Plan, \textit{The Sun} (Balt.), Oct. 12, 1993, at 1A.
provide less for Medicare beneficiaries than for the younger members of the population? Given that the percentage of the elderly in our population will increase to 21.8% in 2030 from 12.6% in 1990, how could it not in a fully managed program?

Dr. Willard Gaylin has expressly linked these issues. He criticized the level and content of the debate over the President’s proposals:

What could have been a wide-open, far-ranging public debate about the deeper issues of health care—our attitude towards life and death, the goals of medicine, the meaning of “health,” suffering versus survival, who shall live and who shall die (and who shall decide)—has been supplanted by relatively narrow quibbles over policy.

The kinds of questions we will need to debate can be divided into three: issues of access (how do we decide who gets to receive a scarce health resource?), egress (how long may they receive it?), and allocation (what medical services can the system as a whole provide to everyone?).

The HCDA prohibits health care coverage discrimination against a person who has not executed an advance directive and it is not likely that overt pressure will be brought to bear on those who have not done so. The larger risk lies in the cumulative health ethic consequence of advance directives, surrogate-agent-guardian “best interest end-stage” determinations, and health care rationing which allocates less to those who will benefit least. Age and preexisting physical and mental conditions and other elements in the quality of life formula could become considerations in deciding the appropriateness of a therapy in health care financing and whether it is in a patient’s best interest pursuant to the HCDA. Whether this is a sound life-respecting public policy should be confronted, not evaded, and the ethical implications given as much attention as the economic.

187. This is the fear AARP Chairwoman Judith Brown expressed to Congress. As of the fall of 1993, Medicare financed health care for 32 million elderly and 4 million disabled enrollees at an annual cost of $143 million. Robert Pear, *Influential Group Says Health Plan Slights the Aged*, N.Y. TIMES, Oct. 24, 1993, § 1, at 1, 18.


The Honorable Rosalie S. Abrams
Director
Office on Aging
301 West Preston Street
Baltimore, Maryland 21201

Dear Senator Abrams:

You have requested our opinion on a number of issues related to the interpretation of the Health Care Decisions Act, particularly as it affects decisions concerning “do not resuscitate” orders. Your specific questions, and our responses, are as follows:

1. Under what circumstances, if any, may a “surrogate decision maker” consent to the withholding or withdrawing of a life-sustaining procedure or the entry of a “do not resuscitate” (DNR) order on a chart of a patient? Must the patient be certified to be in a terminal condition, persistent vegetative state, or end-stage condition before a life-sustaining procedure may be withheld or withdrawn or before the entry of a DNR order can be authorized by the surrogate?

In general, when the issue presented to a surrogate is whether to authorize or decline a life-sustaining procedure that, if authorized, would be performed at a predictable time the very near future should the patient’s condition continue along its present course (for example, kidney dialysis), the surrogate may decline the life-sustaining procedure on behalf of the patient only if the patient has been certified to be in a terminal condition, persistent vegetative state, or end-stage condition. Although cardiopulmonary resuscitation (CPR) is a “life-sustaining procedure” within the meaning of the Health Care Decisions Act, the issue posed by a DNR order is somewhat different, for such an order speaks to a form of treatment, CPR, that would be applied, if at all, only after an unpredictable and dramatic change in the patient’s condition—that is, if the patient were to suffer a cardiac arrest. A surrogate may approve the entry of a DNR order on behalf of patient who has not been certified to be in a terminal condition, persistent vegetative state, or end-stage condition if, but only if, two physicians concur that the event of cardiac arrest itself would signify that, at that future time, the patient would be in a terminal or end-stage condition.
2. Under what circumstances, if any, may a guardian consent to the withholding or withdrawing of a life-sustaining procedure or the entry of DNR order on the chart of a patient? Must the patient be certified to be in a terminal condition, persistent vegetative state, or end-stage condition before a life-sustaining procedure may be withheld or withdrawn or before the entry of a DNR order can be authorized by a guardian?

A guardian of the person of a patient may consent to the withholding or withdrawing of a life-sustaining procedure, including entry of a DNR order if, but only if, (i) the court has approved the decision to forgo the life-sustaining procedure, including entry of a DNR order, whether or not the patient has been certified to be in a terminal condition, persistent vegetative state, or end-stage condition; or (ii) under circumstances specified by law, the court has authorized the guardian in advance to make decisions concerning life-sustaining procedures and the patient has been certified to be in a terminal condition, persistent vegetative state, or end-stage condition.

3. What is the responsibility of the guardian when the patient’s attending physician indicates that a life-sustaining procedure should be withheld or withdrawn or that a DNR order should be entered because such procedure, or any effort to resuscitate the patient, would be medically ineffective? What type of documentation is necessary under these circumstances by the physician, by the guardian, or by the court?

A guardian should report to the court that the patient’s attending physician has determined that CPR or another life-sustaining procedure is medically ineffective. This determination by the attending physician must be certified in writing, with the concurrence of a second physician, and the guardian should supply the court with a copy of the written certification.190

4. Does a health care agent have authority to instruct that a life-sustaining procedure be withheld or withdrawn from, or that a

190. At page 16 of this opinion it states:

The guardian would be reporting, however, an event of potentially great significance to the welfare of the ward. The court would then have the opportunity to review the situation and decide on an appropriate course of action, including, potentially, instructing the guardian to invoke the transfer process in HG § 5-613 if the court concludes that CPR should be performed but the physician adheres to the view that it would be medically ineffective.

DNR order be entered for, a patient who has not been certified to be in a terminal condition, persistent vegetative state, or end-stage condition?

If the grant of authority to the agent encompasses decision-making as to life-sustaining procedures without limitations linked to the patient’s condition, a health care agent may instruct that a life-sustaining procedure be withheld or withdrawn from, or that a DNR order be entered for, a patient without a physician’s certification of the patient’s condition. If the agent’s instruction is inconsistent with generally accepted standards of patient care, the health care provider must bring the matter to the attention of a facility’s patient care advisory committee or a court.

5. What is the effect of a patient’s advance directive on the physician’s, surrogate’s, or guardian’s ability to authorize the withholding or withdrawing of a life-sustaining procedure or the entry of a DNR order?

The primary standard for decision-making by surrogates and guardians, and health care agents as well, is to make the decision about life-sustaining procedures that the patient would have wanted to be made under the circumstances. If an advance directive affords guidance about the patient’s wishes, the advance directive must be followed. However, a physician has authority independent of any advance directive to determine that a particular life-sustaining procedure, including CPR, would be medically ineffective.

6. What is the status of DNR orders currently in the medical files of patients in related institutions who have not been certified to be in a terminal condition, persistent vegetative state, or end-stage condition?

A DNR order for such a patient that was valid prior to the effective date of the Health Care Decisions Act remains valid. Under prior law, a DNR order was valid for a patient who was not already in a terminal condition only if the order was entered at the instruction of a competent patient after informed consent, with the consent of a properly authorized health care agent, including an attorney-in-fact under a durable power of attorney for health care; or with the consent of the patient’s family prior to October 1, 1993, in accordance with the standards set out in 73 Opinions of the Attorney General 162, 196-99 (1988), and with a physician’s certification that, in the event the patient suffered a cardiac arrest, the patient would then be in a terminal
condition. A DNR order entered since the effective date of
the Act for such a patient is valid under the circumstances
discussed in this opinion.

7. May related institutions that handle chronic care cases re­quire consent to the withholding or withdrawing of life-sustaining
procedures or the entry of a DNR order as a condition of admission
to the facility?

No, they may not.