

HEALTH CARE

MEDICAL TREATMENT — INFORMED CONSENT — LIFE-SUSTAINING PROCEDURES — ARTIFICIALLY ADMINISTERED SUSTENANCE—LIVING WILL LAW — DURABLE POWER OF ATTORNEY — SURROGATE DECISIONMAKING.

October 17, 1988

The Honorable Rosalie S. Abrams
Director, Office on Aging

This opinion addresses the effect of Maryland law on one of the dilemmas presented by modern medicine: whether to forgo artificially administered sustenance — that is, the use of devices that supply nutrients and liquids through a tube inserted into the body — when a person is terminally ill or permanently unconscious.

These decisions are forged out of personal emotions, medical and ethical judgments, and religious beliefs. No opinion of the Attorney General can really go to the heart of the matter. What we can do, however, is to make clear how the law affects this most private and deeply felt of decisions.

You ask whether a person with the capacity to decide about medical treatment has a legal right to instruct that artificially administered sustenance is not to be used if the person becomes terminally ill or permanently unconscious. You also ask about decisionmaking on behalf of a person who lacks the capacity to decide about medical treatment and has not previously rendered a legally effective instruction about tube feeding.

As your letter requesting this opinion points out, "the Office on Aging regularly receives questions related to the withholding of artificial nutrition. [The Attorney General's] assessment of the legal situation would not only benefit the Office on Aging in carrying out its responsibilities but also would inform the patients, family members, physicians and other health care professionals who must face decisions about artificial nutrition every day in the hospitals and nursing homes of this state."

Addressing these issues has required an opinion of unusual length, the conclusions of which cannot be summarized in a sentence or two. In an effort to be as clear as we can, we shall summarize our main conclusions in a series of specific questions and answers:

1. What is the scope of the opinion? What types of situations does it deal with?

The opinion addresses decisions to refuse insertion or continued maintenance of a feeding tube when a patient is terminally ill or permanently unconscious. We are not stating any conclusions about patients who are badly debilitated but not yet terminal, except to say that if such a patient has not personally decided the question, artificially administered sustenance may not be withheld without court approval. See pages 167-69.

As we explain in detail on pages 168-69 below, the permanently unconscious are those who have irretrievably lost all awareness of self or environment. This category does *not* include those who are mentally retarded or who have other mental or emotional handicaps, even severe ones. We caution against unwarranted extension of this opinion to situations that it does not address.¹

2. Does a person with the capacity to decide about medical treatment choices have a legal right to instruct that artificially administered sustenance not be used when the person is terminally ill or permanently unconscious?

Yes. Every individual has a constitutional and common law right to make that choice. See pages 170-75.

3. Does that decision have to be stated in a formal document?

No. A competent person may simply tell his or her attending physician of the decision. See page 185. But advance written instructions assure that the person's wishes will be known even if the person later becomes disabled.

4. May a person set out a decision about artificially administered sustenance in a living will?

Yes. A person may set out instructions about artificially administered sustenance in a living will. If the person writes a living will that follows the model in the statute and that therefore calls only generally for the withholding of "life-sustaining procedures," that person's living will is *not* sufficient to direct the withholding of artificially administered sustenance. But if the person so chooses, he or she may incorporate in a living will an express, specific directive

¹ This opinion also does not address the special problems of ending life-sustaining treatment for infants. See *Child Abuse Amendments of 1984*, Pub. L. No. 98-457, Title I, Part B, 98 Stat. 1752; 45 C.F.R. §1340.15.

that artificially administered sustenance is not to be used when the person is terminally ill. *See* pages 180-83.

5. May a person set out a decision about artificially administered sustenance in a medical durable power of attorney?

Yes. A person may specify the conditions under which artificially administered sustenance is to be used or not used, or the person may delegate to some other person the power to make that decision. *See* pages 183-85.

6. If a person lacks the capacity to decide about artificially administered sustenance and had not previously written a living will or medical durable power of attorney, does the person have a right to have someone else make that treatment decision?

Yes. A person's constitutional and common law right to decide is not forfeited simply because the person is unable to make the decision personally. *See* pages 175-78.

7. On what basis is the decision about artificially administered sustenance for that disabled person to be made?

In every case, the decisionmaker should first seek to do what the disabled person would want done under the circumstances. In the case of terminally ill patients, if there is no way to know that, the decisionmaker should decide on the basis of the disabled person's best interest. *See* pages 186-90.

8. Who makes the decision for that disabled person?

If there is a guardian of the person, the guardian may authorize artificially administered sustenance or, with court approval, may direct the withholding or withdrawal of such sustenance. *See* pages 190-92.

If there is no guardian, a close family member may consent to artificially administered sustenance under the substituted consent procedures of §20-107 of the Health-General Article ("HG" Article). HG §20-107 does not apply to decisions to forgo treatment. *See* pages 192-95. Nevertheless, a close family member may decide that artificially administered sustenance is to be withheld or withdrawn, without court proceedings, if all of the following conditions are met:

(i) the person is both disabled and terminally ill;

(ii) the attending physicians agree that forgoing treatment is medically proper;

(iii) the family member determines that forgoing treatment is what the disabled person would want done or, if that is unknown, is

in the person's best interest;

(iv) no other family member disagrees with the decision; and

(v) when applicable, the hospital's patient care advisory committee has not advised against forgoing treatment. *See* pages 196-99.

9. May a family member make a comparable decision to end artificially administered sustenance of a permanently unconscious person who has not already made a personal decision on the question?

No. Ordinarily, a family's judgment about what the patient would want is entitled to the greatest respect. Nevertheless, the need to protect those who are not terminally ill against premature or wrongly motivated decisions to end life-sustaining treatment means that a surrogate's decision to end artificially administered sustenance of a permanently unconscious person must be approved by a court. *See* pages 199-201.

10. Does the Nursing Home Patient's Bill of Rights, HG §19-344, authorize a surrogate decisionmaker to refuse artificially administered sustenance on behalf of a disabled resident of a nursing home?

No. The Nursing Home Patient's Bill of Rights does not authorize a surrogate to refuse medical treatment for a nursing home resident. *See* pages 201-02.

11. May a nursing home or hospital discharge or transfer a patient if the patient's (or surrogate's) decision to refuse artificially administered sustenance conflicts with the nursing home's or hospital's policy that it will not withhold such sustenance?

A nursing home may not discharge or transfer a patient for this reason alone. A hospital may discharge or transfer a patient for this reason alone only if doing so would not impose an undue burden on the patient. *See* pages 202-06.

After discussing the medical background, the scope of the opinion, and the reasons why we are writing it (Part I), we turn to an analysis of the common law and constitutional rights of individuals to make their own medical treatment decisions (Part II), including the right to decide about artificially administered sustenance (Part III). Then we consider the ways in which a competent person may express a decision about artificially administered sustenance: in a living will (Part IV), in a durable power of attorney (Part V), and by direct instructions to a physician (Part VI). Next we treat the special problem of decisionmaking on behalf of persons who have not decided themselves and who, at the time the decision needs to be made, lack decision-making capacity (Parts VII, VIII, and IX). Then we assess medical

decisionmaking under the Nursing Home Patient's Bill of Rights (Part X) and limitations on the power of nursing homes and hospitals to enforce policies requiring the use of artificially administered sustenance (Part XI). Finally, we look briefly at pertinent regulatory requirements (Part XII).

I

Background

A. Artificially Administered Sustenance

Physiological problems prevent many patients from adequately fulfilling their need for nutrition and hydration. Strokes, neuromuscular disorders, or cancers of the mouth or throat might result in an inability to swallow; tumors, scarring, or other obstructions might block the gastrointestinal tract; toxic substances or neurologic malfunctions might cause the gastrointestinal tract to fail; and enzymes and other factors necessary to absorb nutrients in the intestines might be inadequate. In addition, a patient might choose not to eat for psychological reasons. Major, *The Medical Procedures for Providing Food and Water: Indications and Effects*, ("Medical Procedures") in *By No Extraordinary Means, The Choice To Forgo Life-Sustaining Food And Water* 21 (J. Lynn ed., 1986).

Various medical techniques, generally divided into "enteral" and "parenteral" procedures, are used to provide food and water. Enteral procedures are those in which nutritional formulas and water are introduced into the patient's stomach or intestine by means of a tube, such as a nasogastric ("NG") tube or a gastrostomy tube. The Hastings Center, *Guidelines On The Termination Of Life-Sustaining Treatment And The Care Of The Dying* 140 (1987) ("Hastings Center Guidelines").² A nasogastric feeding tube is inserted into the nose, through the posterior pharynx and esophagus and into the stomach. A gastrostomy feeding tube is inserted through the abdominal wall

² The Hastings Center devotes itself to the research of ethical problems in medicine, biology, and the life sciences.

directly into the stomach by a simple surgical procedure. Medical Procedures at 25-26.³

An NG tube can be irritating to the nose. It can cause vomiting and aspiration, possibly resulting in a serious aspiration pneumonia. Because an NG tube can be irritating, many patients must be restrained to prevent them from removing the tubes. In some nursing homes, patients on NG tubes have their hands encased in boxing gloves or their arms strapped to the bed. A gastrostomy tube will not cause the nasal, pharyngeal, and esophageal irritation common to the NG tube, although complications from the surgery necessary for insertion can occur. *Id.*

Parenteral nutritional procedures are those in which nutritional formulas and water are introduced into the patient's body by means other than the gastrointestinal tract. Those procedures include total parenteral nutritional support, in which a formula capable of maintaining the patient for prolonged periods of time is infused in a vein, usually a large central vein in the patient's chest; and intravenous procedures, in which water and a nutritional formula are introduced into a peripheral vein. See Hastings Center Guidelines at 140-41. Medical complications can arise from the surgical technique by which intravenous feeding catheters are introduced and from the use of the feeding solutions.

B. Scope of Opinion

Your questions and this opinion address the use of artificially administered sustenance for persons in two medical conditions: the terminally ill and the permanently unconscious. In a few respects, the different medical conditions require different legal responses.

By "terminally ill," we refer to a condition defined as follows in HG §5-601(g), part of the Living Will Law:

"Terminal condition" means an incurable condition of a patient 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.

³ In addition to the often used NG and gastrostomy tubes, another enteral procedure becoming more common is the jejunostomy tube, which is inserted through the abdomen into the small intestine. See U.S. Congress, Office of Technology Assessment, *Life-Sustaining Technologies and the Elderly*, 282 (1987).

In this definition, the General Assembly recognized that the time at which a person's death is both inevitable and "imminent" ought to be identified by the doctors treating a particular patient, not by some arbitrary time limit in the statute. As one court observed, when construing the phrase "imminent danger of death": "Imminent means close in point of time, but closeness is likewise a term of many degrees, according to the circumstances." *State Dep't of Human Serv. v. Northern*, 563 S.W.2d 197 (Tenn. App. 1978). The Tennessee appellate court found that if death would likely occur sometime during a patient's hospitalization, albeit not necessarily immediately, death was "imminent" for purposes of an emergency treatment statute. 563 S.W.2d at 205 and 209. Similarly, a trial court in Virginia, rejecting the contention that "imminent" could only describe a death likely to occur within hours, suggested that a person "within a few months of death" faced "imminent" death. *Hazelton v. Powhatan Nursing Home, Inc.*, 6 Va. Cir. 414, 417 (Cir. Ct. Fairfax County 1986). See *Black's Law Dictionary* 676 (5th ed. 1979) ("imminent" means "near at hand, mediate rather than immediate, close rather than touching, impending, on the point of happening, threatening, menacing, perilous").

This opinion does not address the forgoing of life-sustaining treatment for severely debilitated patients, including those with advanced Alzheimer's Disease, who are not terminally ill. For some of these patients, we recognize, the point at which death becomes imminent is not a sharply defined event. But the difficulty of linedrawing does not absolve us from doing so.

At present, we are unable to offer guidance about forgoing artificially administered sustenance for patients who are severely debilitated, not capable of making their own medical choices, but not yet terminally ill.⁴ We can only counsel that those seeking to refuse this form of treatment on behalf of such patients may do so only with court approval.

Our opinion does address, however, one category of patients who are not terminally ill, about whom much case law has developed — the

⁴ To be sure, our analysis of a person's right while competent to decide whether to accept treatment or not is pertinent for these patients as well. See *In re Westchester County Medical Center*, 532 N.Y.S.2d 133 (App. Div. 1988) (artificially administered sustenance may be withheld from severely debilitated patient if there is clear and convincing evidence of patient's decision to refuse, made when competent). Moreover, one case holds that, under some circumstances, stopping artificially administered sustenance might be in the best interest of such a patient. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

permanently unconscious. For these patients, who are sometimes described as being in an irreversible coma or a persistent vegetative state, "all possible components of mental life are absent — all thought, feeling, sensation, desire, emotion, and awareness of self or environment. . . . Only vegetative functions and reflexes persist." President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, *Deciding To Forego Life-Sustaining Treatment* 174-75 (1983) ("President's Commission Report").⁵ According to the American Academy of Neurology, they "do not have the capacity to experience pain or suffering." American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient* at 1 (1988). These patients are permanently unconscious and yet may stay alive for an indefinite period of time because their basic metabolic functions continue.⁶

C. Current Legal Uncertainty

Your request for this opinion arises out of your concern that families, physicians, and institutional administrators are making decisions against a background of legal confusion. Some believe that the Living Will Law prohibits the withholding or cessation of artificially administered sustenance under any circumstances. Others question whether a medical durable power of attorney is a proper means to state a person's decision to forgo artificially administered sustenance. On the question of surrogate decisionmaking, the uncertainty is even worse. There is sharp disagreement over whether HG §20-107, the substituted consent procedure, authorizes a decision to withhold artificially administered sustenance. Moreover, some nursing home administrators view HG §19-344(q), which authorizes certain individuals and entities to exercise the rights of disabled nursing home patients, as a basis for substituted decisionmaking about medical treatment,

⁵ This commission was created by Congress in 1978 to study the ethical and legal implications of questions concerning medical and biomedical or behavioral research. See 42 U.S.C. §300V. The President's Commission believes that the term "permanent loss of consciousness" is more accurate and comprehensive than "coma" or "persistent vegetative state," terms often used in the cases and medical literature. See President's Commission Report at 174-75.

⁶ Permanent unconsciousness is different from the "[i]rreversible cessation of all functions of the entire brain, including the brain stem," which is a basis for a determination that the person is dead. HG §5-202(a)(2).

including artificially administered sustenance. In this opinion, we will try to clarify what current law allows and what it does not.

II

The Right To Make Medical Treatment Choices

A. Competent Persons

We begin with a basic societal concept, long recognized in the common law — the right of an individual to safeguard the integrity of his or her own body.⁷ The Supreme Court endorsed this concept of self-determination in *Union Pacific Railroad Co. v. Botsford*, 141 U.S. 250, 251 (1891):

No right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraints or interference by others, unless by clear and unquestionable authority of law.

Applying this common law doctrine to medical decisionmaking, then-Judge Cardozo wrote what has since become a maxim: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).⁸

⁷ See *Mercy Hospital, Inc. v. Jackson*, 62 Md. App. 409, 418, 489 A.2d 1130, 1134 (1985), vacated as moot, 306 Md. 556, 510 A.2d 562 (1986). Although the decision of the Court of Special Appeals is not true precedent, because it was vacated, we cite it in this opinion for the value of its reasoning. See also, e.g., *Tune v. Walter Reed Army Medical Hospital*, 602 F.Supp. 1452, 1455 (D.D.C. 1985); *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 683 (1987); *Barber v. Superior Court of California*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 489 (1983); *Foody v. Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713, 718 (1984).

⁸ In Maryland, a physician's failure to obtain the informed consent of his or her patient prior to performing an operation or treatment gives rise to a tort action for negligence. See *Sard v. Hardy*, 281 Md. 432, 440 n.4, 379 A.2d 1014 (1977); *Zeller v. Baltimore Medical Center*, 67 Md. App. 75, 81-82, 506 A.2d 646 (1986); *Accord, Leach v. Shapiro*, 73 Ohio App. 3d 393, 469 N.E. 2d 1047, 1055 (1984) (claim for relief exists where treatment is administered without consent and causes pain and suffering).

In recognition of the common law right of self-determination and its modern offspring, the doctrine of informed consent, the Maryland Court of Appeals has held that "[t]he law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment." *Sard v. Hardy*, 281 Md. 432, 440, 379 A.2d 1014 (1977). The patient's right to bodily integrity would mean little unless the right to informed consent included the right to informed refusal as well:

[T]he value of patient autonomy or self-determination . . . establishes the right of the patient to determine the nature of his or her own medical care. This value reflects our society's long-standing tradition of recognizing the unique worth of the individual. We respect human dignity by granting individuals the freedom to make choices in accordance with their own values. The principle of autonomy is the moral basis for the legal doctrine of informed consent, which includes the right of informed refusal.

Hastings Center Guidelines at 7. The right of informed consent encompasses both the right of a competent adult person to consent to, or to decline, the initiation or continuation of treatment.⁹

We perceive no legal or public policy justification for distinguishing between the initiation and the continuation of treatment. As the New Jersey Supreme Court explained:

This distinction [between initiating and withdrawing life-sustaining treatment] is more psychologically compelling than logically sound The line between active and passive conduct in the context of medical decisions is far too nebulous to constitute a principled basis for decisionmaking. Whether necessary treatment is withheld at the outset or withdrawn later on, the consequence — the patient's death — is the same. Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be

⁹ See, e.g., *Rasmussen v. Fleming*, 741 P.2d at 683; *Barber v. Superior Court of California*, 195 Cal. Rptr. at 489; *Foody v. Manchester Memorial Hospital*, 482 A.2d at 718; *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), approved, 379 So. 2d 359 (Fla. 1980); *Mercy Hospital, Inc. v. Jackson*, 62 Md. App. at 418; *In re Farrell*, 108 N.J. 335, 529 A.2d 404, 410 (1987). One Maryland statute codifies this common law right as part of the Nursing Home Patient's Bill of Rights. See HG §19-344(f)(1)(ii), discussed further at page 203 below.

withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die.

In re Conroy, 98 N.J. 321, 486 A.2d. at 1234 (1985). See also President's Commission Report at 75.

In addition to the common law underpinnings that support the right of a competent person to refuse medical treatment, the constitutional right to privacy affords a strong basis for asserting dominion over one's bodily integrity. Although the Supreme Court has not held that the United States Constitution encompasses the right to refuse medical treatment, numerous state courts have concluded that the constitutional right to privacy is broad enough to encompass the competent person's right to make his or her own medical decisions, including the decision to forego life-sustaining treatment.¹⁰ State courts recognizing this right have relied on prior pronouncements by the Supreme Court concerning the right to privacy.¹¹ Citing as authority eleven appellate court decisions from around the country, the Arizona Supreme Court recently held as follows: "The right to refuse medical treatment is a personal right sufficiently 'fundamental' or 'implicit in the concept of ordered liberty' to fall within the constitutionally protected zone of privacy contemplated by the Supreme Court." *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 682 (1987).

The right to refuse treatment, whether emanating from the constitutional right to privacy or premised on the common law doctrine of self-determination, is not absolute, however.¹² Courts have

¹⁰ See, e.g., *Rasmussen v. Fleming*, 741 P.2d at 681; *In re Severns*, 425 A.2d 156, 158 (Del. 1980); *John F. Kennedy Memorial Hospital v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984); *In re Farrell*, 529 A.2d at 410; *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 662-63 (1976). Some courts have also held that the right to refuse treatment is protected by state constitutional law. See, e.g., *Rasmussen v. Fleming*, 741 P.2d at 682; *In re Quinlan*, 355 A.2d at 663.

¹¹ See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception). Although the constitutional right of privacy is not limitless, see *Bowers v. Hardwick*, 478 U.S. 186, 190-91 (1986) (excludes homosexual sodomy), the right to refuse medical treatment entails matters of autonomy and physical integrity similar to the decisions protected by prior Supreme Court decisions. See Merritt, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 Stan. L. Rev. 689, 700 n.71 (1987).

¹² Our general discussion of the right to refuse treatment is not intended to encompass refusals of medication by a person committed to an inpatient psychiatric
continued

recognized four state interests that might outweigh an individual's right to refuse treatment.¹³ These interests are: the preservation of life; the prevention of suicide; the protection of the interests of innocent third parties; and the maintenance of the ethical integrity of the medical profession. But as far as we know, no court has found these interests sufficient in an actual case to override the right of a competent, terminally ill patient to refuse life-sustaining treatment.

One federal district court aptly explained why the state's general interest in the preservation of life must yield to the choice of a person who is about to die:

[W]hile preservation of life in the abstract is no doubt a transcendent goal for any society which values human life, the State's interest in maintaining life must defer to the right to refuse treatment of a competent, emotionally stable, but terminally ill adult whose death is imminent and who is, therefore, the best, indeed, the only, true judge of how such life as remains to him may best be spent.

Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452, 1455-56 (D.D.C. 1985). See also, e.g., *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980).

Courts have also unanimously rejected the notion that the state interest in the prevention of suicide—which is really just a specific application of the state's more general interest in the preservation of life—would warrant placing a limitation on the right of a competent, terminally ill patient to refuse medical treatment. As a legal matter, "suicide is not involved when permission is not being sought to terminate a healthy life by artificial, self-induced means, but merely to allow nature to take its course." *Tune*, 602 F. Supp. at 1455 n.8.¹⁴

Note 12 continued

facility. This specific problem is addressed by HG §10-708. See generally *Johnson v. Silver*, 742 F.2d 823 (4th Cir. 1984).

¹³ See, e.g., *Tune v. Walter Reed Army Medical Hospital*, 602 F.Supp. at 1455; *Rasmussen v. Fleming*, 741 P.2d at 683; *John F. Kennedy Hospital v. Bludworth*, 452 So. 2d at 924; *Mercy Hospital, Inc. v. Jackson*, 62 Md. App. at 415; *In re Farrell*, 529 A.2d at 410-11.

¹⁴ *Accord*, *Bartling v. Superior Court of the State of California*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, 225-26 (1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 426 n.11 (1977)

The third interest, the rights of innocent third parties, has been limited to situations in which the interests of the patient's dependents may be adversely affected. "The State's interest may well be superior to an adult's right of self-determination when the exercise of that right deprives dependents of a source of support and care." *Delio v. Westchester County Med. Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677, 693 (App. Div. 1987) (citations omitted). See *Application of the President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964) (court authorized unconsented blood transfusion partly on basis of state's interest in not allowing patient to abandon her seven-month old child).¹⁵ This state interest does not arise, however, if the patient has no dependents. *Rasmussen v. Fleming*, 741 P.2d at 685; *Delio v. Westchester County Med. Center*, 516 N.Y.S.2d at 693. For a terminally ill patient, moreover, the state's interest is diminished even if the patient does have a dependent. That is, a patient who is not terminally ill will be in a position to care for a dependent after receiving treatment. By contrast, no such outcome is possible for the terminally ill patient. Under typical circumstances, the state's interest in protecting the rights of dependent third parties would not be achieved by prohibiting the competent, terminally ill patient from refusing life-sustaining treatment.

Although courts recognize the importance of the fourth state interest, maintaining the ethical integrity of the medical profession, no court has held that this interest outweighs the right of a competent, terminally ill patient to refuse life-sustaining treatment. To the contrary:

The force and impact of this interest is lessened by the prevailing medical ethical standards. . . . Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather . . . the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role

¹⁵ In *Mercy Hospital, Inc. v. Jackson*, 62 Md. App. at 418, the Court of Special Appeals held "that a competent, pregnant adult has the paramount right to refuse a blood transfusion in accordance with her religious beliefs, where such decision is made knowingly and voluntarily and will not endanger the delivery, survival or support of the fetus." (Emphasis added.)

of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient. Also, if the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity . . . and control of one's own fate, then those rights are superior to the institutional considerations.

Satz v. Perlmutter, 362 So. 2d 160, 163-64 (Fla. Ct. App. 4th Dist. 1978); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 426-27 (1977).

In sum, although courts routinely invoke these state interests, the case law teaches that the balance has already been struck for this category of patient: The right of a competent, terminally ill patient to refuse life-sustaining treatment outweighs these state interests, individually and cumulatively.¹⁶ The only state interest that conceivably might be given controlling weight in a particular case is the protection of dependents.

B. Rights of Disabled Individuals

Disabled individuals, who lack the capacity to make their own treatment decisions, present a more difficult problem. A patient is a "disabled individual," as defined in the law authorizing certain family members to consent on the patient's behalf to medical treatment and as meant in this opinion, when the patient's physical or mental condition is such that the patient "lacks sufficient understanding or capacity

¹⁶ In a few cases, courts have addressed the rights of competent patients to refuse life-sustaining treatment where the patient, although not terminally ill, is suffering from a debilitating disease. In *Bowvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, 302 (1986), the court held that a 28 year old quadriplegic, suffering from severe cerebral palsy and severely crippling arthritis, had the right to refuse life-sustaining treatment, including artificial nutrition and hydration. The *Bowvia* court held that "there is no practical or logical reason to limit the exercise of this right to 'terminal' patients." 225 Cal. Rptr. at 302. The court rejected arguments urged by the hospital, physicians, and administrators that the interests of the state should prevail over the rights of the patient. *Accord, Bartling v. Superior Court*, 209 Cal. Rptr. at 220 (competent, non-terminal patient has right to authorize discontinuation of respirator).

to make or communicate a responsible decision on health care" HG §20-107(a)(2).¹⁷

A person does not come within this description merely because the person disagrees with a physician's suggested treatment plan. As the Court of Appeals held in *Sard v. Hardy*, "[t]he law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment." 281 Md. at 440. As another court explained: "[I]t is the patient, not the physician, who ultimately decides if treatment — any treatment — is to be given at all. . . . The rule has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it." *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. at 1455.¹⁸

¹⁷ The complete definition is as follows:

" 'Disabled individual' means an individual who lacks sufficient understanding or capacity to make or communicate a responsible decision on health care for the individual because of:

- (i) A physical disability;
- (ii) Chronic alcoholism;
- (iii) Drug addiction;
- (iv) A disease; or
- (v) A mental disability, including senility."

A fuller discussion of this law appears at pages 192-95 below. This definition is consistent with that set forth in §13-705(b) of the Estates and Trusts Article, which provides the grounds for the appointment of a guardian of the person: "A guardian of the person shall be appointed if the court determines from clear and convincing evidence that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including provisions for health care. . . ."

¹⁸ The principle was applied not long ago by the Circuit Court for Baltimore City:

"[The patient] is alert and oriented and demonstrates a basic understanding of the proposed treatments and the risks and benefits. She has repeatedly been told the details of the suggested course of treatment and the almost certain consequences [*i.e.*, death] of failure to proceed with treatment. Her negative response is a rational one, *although contrary to the recommendation of the medical staff.*"

In re Cooper, No. 87329035/CE74214 (December 21, 1987) (emphasis added). The case arose when the Baltimore City Department of Social Services sought appointment of a guardian after the patient refused to consent to the proposed treatment. According to expert testimony, without the treatment the probability of death was 90%; with the treatment, 40%.

A necessary starting point for ascertaining the rights of the disabled patient is the New Jersey Supreme Court's analysis in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). Karen Ann Quinlan was "in a chronic, and persistent vegetative state." *Quinlan*, 355 A.2d at 655. Quinlan's father, as guardian, sought court authorization to remove the respirator that was prolonging his daughter's life. Removing the respirator, it was thought, would quickly result in her death. The court approved the father's request on the condition that Quinlan's entire family and attending physician concurred with the decision and that the hospital ethics committee agreed that there was no "reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, [sentient] state." *Quinlan*, 355 A.2d at 671. The court reasoned that Quinlan, were she competent and desired to have the respirator removed, would have a constitutional right to refuse that treatment, even though it was sustaining her life. 355 A.2d at 663. Since she could not express her interest herself, the court permitted Quinlan's father to assert his daughter's right to privacy on her behalf. As the court explained:

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.

355 A.2d at 664.

Relying on this analysis, the Supreme Court of Massachusetts held the next year that there is "a general right in all persons to refuse medical treatment. . . . The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d at 427.¹⁹

Thus, the courts have recognized that the right to refuse treatment is as basic a right for the individual lacking decisionmaking capacity as it is for the competent patient. As the Delaware Supreme Court

¹⁹ *Accord*, *Rasmussen v. Fleming*, 741 P.2d at 685; *John F. Kennedy Memorial Hospital v. Bludworth*, 452 So. 2d at 924.

wrote of a permanently unconscious patient, "to deny the exercise of [the right] because the patient is unconscious would be to deny the right [itself]." *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. Ch. 1980).²⁰ Moreover, courts have consistently recognized that a disabled patient, whether terminally ill or permanently unconscious, has a right to refuse life-sustaining treatment that outweighs the state interests discussed at pages 172-75 above.²¹

III

The Right To Refuse Artificially Administered Sustenance

As discussed at pages 166-67 above, various medical techniques are used to provide nutrition and hydration artificially. Foregoing these procedures is controversial. Some regard these techniques as no different in ethical principle than the non-medical means of sustaining life that must always be provided, for to do otherwise would deprive patients of the ordinary care all persons are entitled to receive. *See, e.g.,* Horan & Grant, *The Legal Aspects of Withdrawing Nourishment*, 5 J. Legal Med. 595, 600-01 (1984); Smith, *Hospital Liability* §13.03[1] at 13-32 (1986); Comment, *Artificial Nutrition and the Terminally Ill; How Should Washington Decide?* 61 Wash. L. Rev. 419, 421 (1986).²² Others consider these techniques artificial means that impose benefits in some circumstances but burdens in others and that, like other medical interventions, ethically may be forgone in some circumstances. *See, e.g.,* Hastings Center Guidelines at 61 (all enteral

²⁰ *See also, Rasmussen v. Fleming*, 741 P.2d at 685-86; *Barber v. Superior Court of California*, 195 Cal. Rptr. at 484; *Foody v. Manchester Memorial Hospital*, 482 A.2d at 718.

²¹ Explaining why the state's interest in the preservation of life does not outweigh the previously expressed wishes of a man who had become permanently unconscious, a New York court observed that "there is no benefit to the State in prolonging [the patient's] existence under circumstances he would have found demeaning and degrading to his humanity and which would serve merely to lessen the value of his life by denying him the right to choose the course of his medical treatment." *Delio v. Westchester Med. Center*, 516 N.Y.S.2d at 692 (citations omitted). *See also Rasmussen v. Fleming*, 741 P.2d at 683; *Barber v. Superior Court of California*, 195 Cal. Rptr. at 484; *Foody v. Manchester Memorial Hospital*, 482 A.2d at 718; *John F. Kennedy Hospital v. Bludworth*, 452 So. 2d at 924.

²² In addition, some participants in the ethical and medical debate have raised concerns that the withdrawal or withholding of artificially administered sustenance causes

continued

and parenteral techniques should be considered procedures that the patient or surrogate may choose to forgo); *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* 12-13 (1986) (in some circumstances it is not unethical to discontinue all means of life prolongation, including artificially supplied nutrition or hydration); President's Commission Report at 3 and 190 (life-sustaining treatment encompasses all health care interventions, including special feeding procedures.)

We do not join this debate; it is not our role to offer ethical judgments or comment on matters of religious doctrine. The legal analysis is clear, however: Every appellate court that has addressed the issue has held that there is no difference as a matter of law between artificially administered sustenance and other forms of life-sustaining treatment.²³ As the New Jersey Supreme Court summarized the point, "[a]nalytically, artificial feeding by means of a nasogastric tube or intravenous infusions can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own." *Conroy*, 496 A.2d at 1236.²⁴

Note 22 continued

pain and suffering. However, one court that canvassed the literature found to the contrary: "Patients who are near death and not receiving nourishment may, in fact, be more comfortable than comparable patients who receive conventional amounts of nutrition and hydration." *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 453 (1987). Recent empirical evidence suggests that dehydration does not cause pain for a terminally ill patient; to the contrary, artificially administered sustenance can cause the terminally ill patient pain and discomfort. *See Cox, Is Dehydration Painful?*, 9 Ethics & Medics 1-2 (1987). Moreover, since a permanently unconscious patient is by definition unaware of sensation, he or she will not experience pain from dehydration. *Id.* at 1.

²³ *See, e.g., Barber v. Superior Court*, 195 Cal. Rptr. at 490 (1983); *Corbett v. D'Alessandro*, 487 So. 2d 368, 371 (Fla. Dist. Ct. App. 1986); *In re Gardner*, 534 A.2d 947, 954 (Me. 1987); *In re Jobs*, 108 N.J. 394, 529 A.2d 434, 444 n.9 (1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419, 427 (1987); *In re Conroy*, 486 A.2d at 1236; *Delio v. Westchester County Medical Center*, 129 A.D. 2d 1, 516 N.Y.S.2d 677, 689 (1987); *In re Grant*, 747 P.2d at 454; *Accord, In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); *Bowria v. Superior Court*, 255 Cal. Rptr. at 306; *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626, 637 (1986).

²⁴ In another case, the New Jersey Supreme Court rejected the argument that "the withdrawal of artificial feeding directly causes death while the withdrawal of other forms of life-support only indirectly causes death." As the court observed:

"Just as a patient does not die because of the withdrawal of a kidney dialysis machine, but because his underlying disease has destroyed the proper functioning of his kidney, so [the patient] will not die from the withdrawal of the

continued

Thus, we conclude that the constitutional and common law right to refuse treatment includes the right to refuse artificially administered sustenance. In Parts IV, V and VI below, we consider the ways in which a competent person may make this choice. In Parts VII, VIII, and IX, we discuss the ways in which a surrogate may make this choice on behalf of a person without decisionmaking capacity.

IV

The Living Will Law

The Living Will Law is an express statutory procedure through which a competent person may exercise choice about treatment decisions that might have to be made when the person is terminally ill and no longer able to decide.²⁵ As this office summarized: "In authorizing living wills, the General Assembly recognized the importance of individual self-determination and dignity in death." 70 *Opinions of the Attorney General* 138, 139 (1985).

Under HG §5-602(a), a competent person over 18 "may execute a declaration . . . directing the withholding or withdrawal of life-sustaining procedures under this subtitle."²⁶ If a declaration has been properly executed, the individual has a statutory right to have his or her decisions about life-sustaining procedures carried out. HG §5-604(a)(2). Correspondingly, those who carry out the provisions of a living will are afforded certain statutory protections when they do so. HG §§5-607(b) and (c) and 5-613.

Note 24 continued

nasogastric tube, but because of her underlying medical problem, *i.e.*, an inability to swallow. Withdrawal of the nasogastric tube, like discontinuance of other kinds of artificial treatment, merely acquiesces in the natural cessation of a critical bodily function. The cessation is the cause of death, not the acquiescence."

In re Peter, 529 A.2d at 428.

²⁵ The statute is formally termed the Life-Sustaining Procedures Act. For simplicity's sake, and to reflect common usage, we refer to it as the Living Will Law.

²⁶ "Life-sustaining procedures" are defined as follows: "Any medical procedure, treatment, or intervention which uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and which, when applied to a patient in a terminal condition, would serve to secure only a precarious and burdensome prolongation of life."

Artificially administered sustenance falls within the term "life-sustaining procedures." Had the General Assembly not specially addressed the question of sustenance, a declaration generally "directing the withholding or withdrawal of life-sustaining procedures" would be applied to forgo artificially administered sustenance.

In fact, however, the General Assembly sought to prevent a generally worded living will from being applied in that way. The Living Will Law contains two provisions that expressly address the provision of food and water to a terminally ill patient who has executed a declaration. HG §5-605(1) provides that a declaration "may not be implemented . . . [b]y the denial of food, water, or of such medication and medical procedures as are necessary to provide comfort care and to alleviate pain." Similarly, the model declaration in HG §5-602(c)(1) sets out the qualified person's instruction that he or she "be permitted to die naturally with only the administration of medication, the administration of food and water, and the performance of any medical procedure that is necessary to provide comfort care or alleviate pain."

The legislative history confirms the General Assembly's recognition that, for some patients, food and water can only be provided through artificial means. The House Environmental Matters Committee report states that a "common method of giving comatose patients food and water is through tubes. Therefore, this [bill] requires if food and water are provided through tubes, that food and water could not be withheld." Report on House Bill 453, at 6-7 (February 19, 1985). As the preamble to the Living Will Law states, the law "is intended to ensure that such basic measures as nursing care, nutrition, and hydration will be maintained out of respect for the human dignity of every patient." See generally Kronmiller, *A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act*, 47 Md. L. Rev. 1188 (1988).

In light of this legislative history, we understand HG §5-605(1) to mean that a declaration calling generally for the withholding of life-sustaining procedures may not itself serve as the basis for withholding artificially administered sustenance.²⁷

²⁷ Two commentators have suggested that the Living Will Law's provisions on food and water can be construed to mean that "medically administered . . . food and water . . . are to be discontinued except as they are appropriate for comfort and pain control." Landsman and Mertes, *Slow Death in a Nursing Home*, Md. Bar J. March-April 1988, at 45, 47. This construction seems to us somewhat strained, given the language of HG §5-605(1) and the legislative history.

Yet, as the preamble also recognizes, "it is the fundamental right of competent adults, based on the autonomy and sanctity of the individual, to control decisions relating to the rendering of their medical care and treatment." This right finds statutory recognition in HG §5-610(1), which states that the provisions of the Living Will Law "are cumulative and may not be construed to impair or supersede any legal right or responsibility that any person may have to effect the initiation, continuation, withholding, or withdrawal of life-sustaining procedures."

As discussed at pages 171-72 above, a person has a constitutional right to refuse consent to the insertion or the continued presence of a feeding tube. HG §5-610(1) should be construed to recognize that right. Put differently, HG §5-610(1) leads us to conclude that the General Assembly did not intend to require that a feeding tube be inserted into or be maintained in the body of a person who has *expressly* rejected that form of treatment.²⁸

Taking account of all pertinent provisions, we conclude that the Living Will Law applies as follows to artificially administered sustenance:

1. If a declaration specifically refers to artificially administered sustenance and states that the declarant wishes the continuation of sustenance in this form, those providing care may not terminate this form of treatment. *See* HG §5-611.

2. If a declaration specifically refers to artificially administered sustenance and states the declarant's instruction that this form of treatment not be initiated or be discontinued if already initiated, those providing care should carry out this instruction. Because such a provision effectuates a right recognized by HG §5-610(1), the provision is "not inconsistent with" the Living Will Law and therefore may be included in a declaration. HG §5-602(c)(2).

3. If a declaration does not specifically address artificially administered sustenance but instead simply follows the model declaration set out in HG §5-602(c)(1), the declaration cannot rightly be

²⁸ The Living Will Law's provisions on food and water apply only to persons who have executed a declaration. They do not address the artificial administration of sustenance to those without living wills. If the Living Will Law were construed to require artificially administered sustenance for all declarants, the law would create a striking anomaly: Those who have taken advantage of a law designed to give expression to individual choice would have *less* right to choose than those who have not prepared a living will. We cannot suppose that the General Assembly intended so absurd a result. *See, e.g., Coerper v. Comptroller*, 265 Md. 3, 6, 288 A.2d 187, 188 (1972).

construed to state an intention regarding tube feeding. On the one hand, HG §5-605(1) prevents such a declaration from serving as the basis for withholding artificially administered sustenance. On the other hand, we think it likely that the average person executing a declaration calling for "the administration of food and water" does not understand these words to be a consent to medical treatment — that is, consent for a feeding tube to be inserted or kept in the person's body. If a living will follows the model form, it should be viewed as not stating any decision about artificially administered sustenance. Hence, the question of artificially administered sustenance would then be resolved through application of the other forms of medical decisionmaking discussed in this opinion.

This approach to the Living Will Law seeks to harmonize HG §5-605(1) and HG §5-610(1). Properly construed, HG §5-605(1) assures that a declaration calling only generally for the cessation of life-sustaining procedures will not itself result in the cessation of sustenance in any form. At the same time, HG §§5-602(c)(2) and 5-610(1) together mean that a person is not barred from embodying in a living will the specific expression of the person's constitutional and common law right to refuse artificially administered sustenance.

Moreover, our construction is also necessary to avoid serious constitutional difficulties. Like a court, we "will, whenever reasonably possible, construe and apply a statute to avoid casting serious doubt upon its constitutionality." *Yangming Transport v. Revon Products*, 311 Md. 496, 509, 536 A.2d 633 (1988). *See also, e.g., Davis v. State*, 312 Md. 172, 179, 539 A.2d 218 (1988). If the provisions on food and water in the Living Will Law were construed to prohibit a person's exercise of the right to refuse artificially administered sustenance, those provisions would likely be found unconstitutional. *See In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, 859-60 (1988); *Corbett v. D'Alessandro*, 487 So. 2d 368, 370 (Fla. Dist. Ct. App. 1986); *In re Gardner*, 534 A.2d 947, 952 n.3 (Me. 1987).

V

Durable Power of Attorney

Section 13-601 of the Estates and Trusts Article ("ET" Article) authorizes the creation of a "durable power of attorney," a legal instrument authorizing another to act on a person's behalf when the person is incapacitated. Although durable power of attorney statutes "were enacted primarily to avoid the expense of full guardianship or conservatorship proceedings when dealing with small property

interests, . . . the language of these statutes can accommodate the appointment of a surrogate for [health care decisionmaking] and nothing in the statutes explicitly precludes such a use." President's Commission Report at 147. Indeed, although ET §13-601 does not expressly authorize the delegation of health care decisionmaking, nothing in the statute or other law prevents it.

Moreover, specific references to a durable power of attorney for health care decisionmaking appear in three places in the Health-General Article. HG §20-107(d) provides:

In the absence of a durable power of attorney that relates to medical care and is executed under §13-601 of the Estates and Trusts Article, or in the absence of a judicially appointed guardian, conservator, committee, or trustee who has the authority to consent to medical care, any of the following individuals may give a substituted consent for furnishing medical or dental care and treatment to a disabled individual

(Emphasis added.) HG §19-370(d)(7) includes within the definition of "petitioner" (that is, one who may request advice from a hospital's patient care advisory committee) "[a]n individual with a power of attorney to make a decision with a medical consequence for a patient." Finally, newly enacted HG §19-344(b)(3)(i) authorizes a nursing home to ask (but not require) prospective residents "to execute valid durable powers of attorney designating an attorney in fact to make . . . medical . . . decisions in the event of the applicant's disability." Chapter 452, Laws of Maryland 1988. These statutory references confirm the General Assembly's recognition that a medical durable power of attorney is a legally effective instrument.

A person (the principal) may use a durable power of attorney to direct an agent (the attorney in fact) to carry out the principal's specific directive concerning medical treatment, including the withholding or withdrawing of artificially administered sustenance under specified circumstances. Alternatively, a principal may choose to empower the attorney in fact to make all medical decisions on his or her behalf, rather than directing a specific treatment decision. *See In re Peter*, 108 N.J. 365, 529 A.2d 419, 426 (1987) (recognizing the right of a principal to authorize an agent to make health care decisions on the agent's behalf if the principal lacked the capacity to make treatment decisions).

Although a medical durable power of attorney is legally effective, no law spells out important safeguards like formalities for its execution. We recommend that the General Assembly consider legislation

specifically addressing these matters²⁹

VI

Prior Instructions to Physician

A person need not execute a formal document to make a choice about artificially administered sustenance. Instead, a person who is competent to make medical decisions at the time of decision about insertion of a feeding tube can decide whether to allow that procedure or not by simply telling the attending physician, who should document the decision in the patient's record.³⁰

The right of self-determination about medical treatment means that a competent person may engage in direct decisionmaking when the person and the physician are discussing a future course of treatment. That discussion might well deal with questions of the person's consent to treatment if various contingencies were to arise.

To take a common example, a person about to undergo a biopsy procedure might well discuss with the doctor the question of further surgery if the tumor were found to be malignant. That is, the patient might be asked whether he or she consented to further surgery immediately after the biopsy results are known, or whether the patient would rather make a separate decision later about follow-up surgery. The same principle — that a person has a right to decide about future treatment alternatives — would permit the patient to make a choice about life-sustaining procedures, including artificially administered sustenance, should that situation arise. Just as the person's other contingent decisions about treatment must be given effect, so must this one. *See, e.g., In re Farrell*, 108 N.J. 335, 529 A.2d 404, 410 (1987).³¹

²⁹ *See* Cal. Civil Code §§2430-2444 and 2500 (West 1988).

³⁰ Similarly, the patient may decide in the same way to have a feeding tube withdrawn that previously had been inserted with his or her consent, or without such consent under the emergency provisions of HG §20-107(e). *See* note 48 below.

³¹ A patient's exercise of the right to refuse a particular form of treatment in the course of discussion with the patient's doctor, properly recorded in the patient's medical records, is an extraordinarily reliable form of decisionmaking. Thus we characterize it as "direct decisionmaking," to be carried out even if the patient later becomes disabled. A few cases treat a patient's discussions with family or friends as potentially a comparable form of direct decisionmaking, if there is "clear and convincing" evidence of the patient's

VII

Standards For Surrogate Decisionmaking

A. Introduction

In this part we discuss the substance of surrogate decisionmaking — decisions about life-sustaining treatment made on behalf of a patient who is unable to decide personally. Two underlying values govern surrogate decisionmaking: respecting patient self-determination and promoting patient welfare. See *In re Jobes*, 108 N.J. 532, 529 A.2d 434, 436; *In re Conroy*, 486 A.2d at 1227; *In re Grant*, 109 Wash 2d 545, 747 P.2d 445, 457 (1987). See also President's Commission Report at 132. If a surrogate decisionmaker knows enough to judge what the disabled person would decide if he or she were able to, the surrogate should make that choice. This preferred form of decisionmaking is called "substituted judgment." If this subjective standard cannot be used, the surrogate decisionmaker must base a decision on the objective costs and benefits of treatment for the terminally ill patient, to determine what is in the patient's "best interest." These two standards should guide every surrogate decision, whether made by a guardian, a family member, or the court.³²

B. Substituted Judgment

The substituted judgment standard requires that a surrogate decisionmaker attempt to reach the decision that the patient would have made if he or she were able to choose.³³ This standard respects the patient's own definition of well-being as well as his or her interest in self-determination. President's Commission Report at 132-33. The

Note 31 continued

decision to refuse treatment. See *In re Gardner*, 534 A.2d at 953; *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 443 (1987); *In re Storar*, 52 N.Y.2d 363, 420 N.E. 2d 64, 72 (1981). In our view, the sounder and more cautious practice is to view a now-disabled person's prior conversations with persons other than the attending physician as evidence to be weighed under the "substituted judgment" form of surrogate decisionmaking, rather than as a form of direct decisionmaking by the patient. See pages 186-87 below.

³² These standards should also guide an attorney in fact if a medical durable power of attorney delegates decisionmaking authority to the attorney. See pages 183-85 above.

³³ See, e.g., *In re Severns*, 425 A.2d at 159; *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E. 2d at 634-35; *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d at 431; *In re Jobes*, 529 A.2d at 444; *In re Conroy*, 486 A.2d at 1229.

best proof of a patient's wishes are the patient's own previous expressions. President's Commission Report at 133. This standard, however, can only be used if a patient was once capable of developing views relevant to the decision at issue. See, e.g., *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 72 (1981).

Two cases illustrate the kind of evidence that can lead to a decision based on substituted judgment.³⁴ In *Brophy v. New England Sinai Hosp., Inc.*, 298 Mass. 417, 497 N.E.2d 626 (1986), the court identified the following factors in determining whether a patient in a "persistent vegetative state" would refuse a feeding tube:

- (1) the patient's expressed preferences;
- (2) the patient's religious convictions and their relation to the refusal of treatment;
- (3) the impact on the patient's family;
- (4) the probability of adverse side effects;
- (5) the prognosis with and without treatment; and
- (6) the impact on the patient of his present and future incompetency.

The court affirmed the trial judge's determination that if Brophy, the patient, were presently competent, he would choose to forgo the administration of nutrition and hydration through artificial means. 497 N.E.2d at 635.³⁵ The trial court based its conclusion on Brophy's prior vehement objections to the use of life-sustaining treatment and the fact that his religious convictions would not bar the refusal of such treatment. In another case, the New Jersey Supreme Court, relying on the substituted judgment standard, found that a patient would, if competent, choose to withdraw artificially administered sustenance. The court was convinced of this result, based on testimony confirming the patient's repeated prior statements that "under no circumstances would I want to be kept alive on a life-support system." *In re Peter*, 529 A.2d at 426.

³⁴ The caselaw does not permit us to generalize about an evidentiary standard. As the two cases discussed in the text illustrate, courts simply evaluate the evidence in a particular case for its reliability and application to the treatment decision in question.

³⁵ Brophy suffered serious and irreversible brain damage. He lacked cognitive functioning. The court found it highly unlikely that he would ever regain cognitive behavior and thus would forever lack the ability to communicate and the capability to interact with his environment. Since he was not terminally ill and his other organs functioned relatively well, he could live in a "persistent vegetative state" for several years. 497 N.E.2d at 630.

C. Best Interest

Although a surrogate decisionmaker should always be guided by evidence of the patient's own wishes if possible, in many cases the surrogate will have no basis for substituted judgment. Furthermore, some patients have never had decisionmaking capacity: their subjective wishes would be impossible to discern with any certainty. President's Commission Report at 134.³⁶ In these circumstances, a surrogate decisionmaker must make a decision that seeks to implement what the surrogate believes would be in the patient's best interest.³⁷ The value underlying a best interest analysis is the protection of a patient's welfare, rather than the value of self-determination.³⁸ The President's Commission observed that, when "assessing whether a procedure or course of treatment would be in a patient's best interests, the surrogate must take into account such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained." President's Commission Report at 135. But "quality . . . of life" does *not* mean "the value that others find in the continuation of the patient's life, perhaps in terms of their estimates of the patient's actual or potential productivity or social contribution." Rather, the best interest standard looks only to "the value of the patient's life *for the patient*." President's Commission Report at 135 n.43 (emphasis added). For a terminally ill patient, the surrogate decisionmaker should consider "whether forgoing treatment will allow the patient to avoid the burden of prolonging dying with pain or suffering, and whether the patient has the potential benefit of achieving some satisfaction if he or she survives longer." Hastings Center Guidelines at 28.

³⁶ See, e.g., *In re Storar*, 420 N.E.2d at 72; *In re Grant*, 747 P.2d at 445-46; *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1378 (1984). But see *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d at 431 (court applied substituted judgment standard in making decision on behalf of patient who had never been competent to make treatment decisions.)

³⁷ See, e.g., *Rasmussen v. Fleming*, 741 P.2d at 689; *In re Drabick*, 245 Cal. Rptr. at 846; *Barber v. Superior Court of California*, 195 Cal. Rptr. at 498; *In re Grant*, 747 P.2d at 457. But see *In re Storar*, 420 N.E.2d at 71 (best interest test inapplicable to terminally ill patient who was never competent).

³⁸ Although a patient may lack the capacity to make a decision about forgoing artificially administered sustenance, a patient's conduct—for instance, forcible resistance to the insertion of a feeding tube or continued efforts to remove a tube — nonetheless should be considered in determining whether continuation of artificially administered sustenance is in the patient's best interest.

A recent Washington case illustrates application of the best interest standard. In *In re Grant*, the Washington Supreme Court recognized that it was in the best interest of a 22 year old patient suffering from an incurable neurological disorder to withhold life-sustaining procedures, including artificially administered sustenance. 747 P.2d at 457. Barbara Grant's intellectual and cognitive functions had virtually disappeared; she was in the end stages of a terminal disease with no hope of improvement. She could not move her body and had to be tied down in bed to avoid harmful movement caused by seizures. Although she had never expressed her desires concerning the use of life-sustaining measures, her mother believed she would not have wanted such treatment based on her prior dislike for medication and medical procedures as well as her dislike for the medical staff. 747 P.2d at 448.³⁹ The court set forth the following factors that a surrogate decisionmaker should use in determining whether the withdrawal of life-sustaining measures is in the best interest of the patient:

[E]vidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life-expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

747 P.2d at 457. In recognizing that it was in Grant's best interest to withhold all life-sustaining treatment, the court held that "the individual's right to die with dignity must not be ignored A terminally ill patient may wish to avoid not only prolonged suffering, but also '[t]he ultimate horror . . . of being maintained in limbo, in a sterile room, by machines controlled by strangers.'" 747 P.2d at 451 (quoting *In re Torres*, 357 N.W.2d 332, 340 (Minn. 1984)).

Patients who are permanently unconscious pose a difficult problem for application of the best interest standard. According to medical experts, someone who is permanently unconscious does not experience suffering, either physically or emotionally. See page 169 above. Nor is the person capable of experiencing any of life's satisfactions. The

³⁹ This kind of evidence is relevant to both substituted judgment and best interest. The boundary between these two categories is not an exact one. See President's Commission Report at 132.

balancing of costs and benefits to the patient that a surrogate must undertake for a terminally ill patient cannot be done in the same way for a patient who is permanently unconscious. See *In re Peter*, 529 A.2d at 425.

To be sure, the traditional benefits of treatment cannot be obtained. President's Commission Report at 181. The American Academy of Neurology, in a recent position paper, declared that: "Medical treatment, including the medical provision of artificial nutrition and hydration, provides no benefit to patients in a persistent vegetative state . . ." Position of the American Academy of Neurology at 3. The only value to the patient in continuing treatment resides in the exceedingly small possibility that the prognosis of permanent unconsciousness is incorrect. President's Commission Report at 182 and 459.⁴⁰ To continue treatment to maintain a patient in a state of permanent unconsciousness when treatment provides no medical benefit imposes severe emotional burdens on a patient's family — people for whom the patient, if conscious, presumably would be most concerned. President's Commission Report at 183.

Still, we are very reluctant to conclude that the best interest standard, properly applied, takes into account anything other than the patient's actual interest alone. Until the issue is addressed more fully by Maryland courts or the General Assembly, we reach no conclusion about the application of the best interest standard to the permanently unconscious.

VIII

Guardianship

ET §13-704 authorizes the appointment of a guardian of the person for a disabled person: "The court may superintend and direct the care of a disabled person, appoint a guardian of the person, and pass orders and decrees respecting the person as seems proper, including

⁴⁰ But see *W. May et al., Feeding And Hydrating The Permanently Unconscious And Other Vulnerable Persons*, Issues in Law & Medicine No. 3, at 203, 209 (1987) (providing fluids by tube is not useless because it benefits the permanently unconscious by preserving their lives and preventing their death).

an order directing the disabled person to be sent to a hospital."⁴¹ ET §13-101(d) defines a disabled person as:

[A] person other than a minor who:

(1) (i) Has been judged by a court to be unable to manage his property for reasons listed in §13-201(c)(1) of this subtitle; and

(ii) As a result of this inability requires a guardian of his property; or

(2) (i) Has been judged by a court to be unable to provide for his daily needs sufficiently to protect his health or safety for reasons listed in §13-705(b) of this subtitle; and

(ii) As a result of this inability requires a guardian of the person.

In *Kicherer v. Kicherer*, 285 Md. 114, 118-19, 400 A.2d 1097, 1100-1101 (1979), the Court of Appeals provided the following framework for guardianship proceedings: "[A] court of equity assumes jurisdiction in guardianship matters to protect those who, because of illness or other disability, are unable to care for themselves. In reality the court is the guardian; an individual who is given that title is merely an agent or arm of that tribunal in carrying out its sacred responsibility [A]ppointment to that position rests solely in the discretion of the equity court and the administering of that office as it pertains to both the person and property of the ward is subject to judicial control."

ET §13-708(b)(8) authorizes a guardian of the person "to give necessary consent or approval for medical or other professional care, counsel, treatment, or service." By necessary implication, this authority includes the power to withhold or withdraw consent to medical treatment. ET §13-708(b)(8) cannot logically be read as authorizing only the power to consent, since "often times a patient's interests are best served when medical treatment is withheld or withdrawn. To hold otherwise would . . . reduce the guardian's control over medical treatment to little more than a mechanical rubberstamp for the wishes of the medical treatment team." *Rasmussen v. Fleming*, 741 P.2d at 688.⁴² Thus, what is contemplated is not only the power to accept

⁴¹ A disabled person might also have a guardian of the property. See ET §13-201.

⁴² See also *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 746 (1983); *In re Hamlin*, 689 P.2d at 1375.

medical treatment but also the power to refuse medical treatment, terminate already existing medical treatment, or choose among alternative medical treatments. See generally Horan, *Euthanasia, The Right To Life And Termination Of Medical Treatment: Legal Issues*, in *Moral Responsibility in Prolonging Life Decisions* 170 (D. McCarthy, A. Morawski, eds. 1981.)

The guardian's power is limited, however, since "the court must authorize any medical procedure that involves a substantial risk to life." Although ET §13-708(b)(8) generally authorizes a guardian to refuse medical treatment, the guardian may not direct the withholding or withdrawing of artificially administered sustenance or any other life-sustaining treatment, since to do so would involve "a substantial risk to life." Instead, the guardian must petition the court for authorization to withhold or withdraw artificially administered sustenance.⁴³ In deciding whether to approve this treatment decision, the court, like the guardian, should apply the substantive standards discussed in Part VII above.⁴⁴

IX

Surrogate Decisionmaking By Family Members

A. Scope of HG §20-107

In general, HG §20-107 addresses the problem of medical decision-making on behalf of "an individual who lacks sufficient understanding or capacity to make or communicate a responsible decision on health care for the individual" because of several specified physical and

⁴³ Read literally, ET §13-708(b)(8) would not require court approval of a guardian's decision to decline life-sustaining treatment, for it speaks only of the court's "authoriz[ing]" an affirmative "medical procedure." So literal a construction does not comport with the apparent legislative purpose, however. Suppose doctors recommend surgery for a patient who would die without the surgery, even though the surgery itself poses a high risk of death. ET §13-708(b)(8) requires court approval of the guardian's decision to consent to the surgery; it would make no sense to say that the guardian may decline the surgery without court approval. The purpose of ET §13-708(b)(8) is to assure that the court itself will make the decision when the consequences are so grave.

⁴⁴ In a recent decision in the Circuit Court for Prince George's County, the court applied the substituted judgment standard in approving a guardian's request to remove a feeding tube from a permanently unconscious patient. The court has sealed the case to protect the privacy of the family involved, so we omit the specific citation.

mental ailments.⁴⁵ HG §20-107(d) grants decisionmaking authority to family members, as follows:

In the absence of a durable power of attorney that relates to medical care and is executed under §13-601 of the Estates and Trusts Article, or in the absence of a judicially appointed guardian, conservator, committee, or trustee who has the authority to consent to medical care, any of the following individuals may give a substituted consent for furnishing medical or dental care and treatment to a disabled individual in accordance with the following priorities provided the provisions of subsection (e) of the section have been met:

- (1) A spouse, or, if not reasonably available;
- (2) An adult child, or, if not reasonably available;
- (3) A parent, or, if not reasonably available;
- (4) An adult sibling, or, if not reasonably available;
- (5) A grandparent, or, if not reasonably available;
- (6) An adult grandchild.⁴⁶

A "health care provider" who carries out treatment based on substituted consent gains immunity from liability based on his or her reliance on the consent. HG §20-107(g)(2).⁴⁷

⁴⁵ These are:

- (i) A physical disability;
- (ii) Chronic alcoholism;
- (iii) Drug addiction;
- (iv) A disease; or
- (v) A mental disability, including senility."

HG §20-107(a)(2). Another subsection, HG §20-107(e), specifies careful protections to assure that the patient really is medically disabled.

We note that the term "senility" is no longer recognized as a valid medical description. The General Assembly should consider revising this language.

⁴⁶ HG §20-107(e) requires written certification by two physicians that the person "is incapable of making a responsible decision regarding the proposed health care" HG §20-107(f) sets out circumstance under which substituted consent may not be given, including when "the health care provider is aware that the person for whom the health care is proposed has expressed disagreement with the decision to provide health care."

⁴⁷ The term "health care provider" includes a "hospital administrator or his designee" but does not include a "nursing home administrator" or the "administrator's designee." This omission suggests to some that HG §20-107 does not apply to decisions made within nursing homes. Although the legislative history of §20-107 does not explain the omission, the underlying rationale for allowing surrogate decisionmakers to provide consent for proposed treatment is applicable to residents of nursing homes as well as patients in other facilities. Moreover, "treatment" of a nursing home resident would typically be administered by a physician, a registered nurse, or a licensed practical nurse — all of whom are within the definition of "health care provider." HG §20-107(a)(3)(iii), (vii), and (ix).

The insertion or continued use of a feeding tube is the "furnishing [of] medical . . . care and treatment"; hence, it is within the scope of HG §20-107, and a family member may surely consent under HG §20-107(d) for its insertion or maintenance, as recommended by a physician.⁴⁸ The harder question is whether the family and physicians may likewise invoke HG §20-107 as a basis for a decision to decline the use of a feeding tube.

The argument in favor of an expansive reading of HG §20-107 is a respectable one. Medical decisions often involve a choice among treatments: consent to one form of treatment impliedly rejects alternate treatments. If the demonstrable purpose of HG §20-107 were to provide a means by which a family member may broadly make "a responsible decision regarding the proposed health care" when the patient cannot [HG §20-107(e)], we would be inclined to a reading of the statute that would encompass decisions not to treat.

In our view, however, neither the statutory language nor the legislative history sustains so expansive a construction of HG §20-107. HG §20-107(d) speaks of "a substituted consent for *furnishing* . . . treatment." The ordinary meaning of "furnish" is to "supply, provide, or equip, for accomplishment of a particular purpose." *Black's Law Dictionary* 608 (5th ed. 1979). For medical treatment, the term is synonymous with "administer." *State v. Wilson*, 71 Kan. 263, 80 P.565 (1905). The term "treatment" likewise ordinarily refers to actions

⁴⁸ In an emergency, a physician may insert a feeding tube without consent, under HG §20-107(c):

"A health care provider may treat a disabled individual without consent if:

(1) A person who is authorized to give the consent is not available immediately;

(2) The attending physician determines:

(i) There is a substantial risk of death or immediate and serious harm to the disabled individual; and

(ii) With a reasonable degree of medical certainty, the life or health of the disabled individual would be affected adversely by delaying treatment to obtain consent; and

(3) Treatment is of an emergency medical nature."

A health care provider who provides treatment under HG §20-107(c) is afforded limited immunity under HG §20-107(g)(1).

This provision authorizes emergency treatment only if a decisionmaker "is not available immediately." It does not countenance a physician's evasion of the need to obtain consent if possible.

rather than inaction. See *Pfahler v. Eclipse Pioneer Div.*, 21 N.J. 486, 122 A.2d 644, 646 (1956).⁴⁹

The legislative history of the bill that enacted the substituted consent mechanism underscores the General Assembly's exclusive focus on the issue of how consent is to be given, when a family member wants to give it for a treatment that a physician recommends. A committee report states: "This bill provides that a health care provider may treat a disabled individual, even if that individual is not able to give consent, if certain relatives of the individual have given consent . . ." Senate and Finance Committee Report on Senate Bill 433 (1984). Similarly, a floor statement observes that: "Currently there is no provision in the law which would enable a family member to consent to medical or dental treatment for a disabled individual who is unable to give consent, if certain relatives of the individual have given consent . . ." Senate and Finance Committee Report on Senate Bill 433 (1984). Similarly, a floor statement observes that: "Currently there is no provision in the law which would enable a family member to consent to medical or dental treatment for a disabled individual who is unable to give consent — short of going through guardianship proceedings which can be expensive and which can be too time-consuming and public for handling non-controversial medical treatment in which there is no expressed disagreement between the patient, the substitute decisionmaker and the health care provider." Floor Statement on Senate Bill 433 (1984). There is no discussion anywhere within the legislative history that HG §20-107 would be a mechanism for allowing surrogate decisionmakers to direct the withholding or withdrawing of life-sustaining treatment.

Thus, in our view, the better reading of HG §20-107 is that it does not apply to decisions to refuse a form of treatment. It neither authorizes nor prohibits family decisions to refuse treatment on behalf of a disabled family member; instead, it simply does not address this form of surrogate decisionmaking and leaves it to other legally recognized procedures.

⁴⁹ Other portions of HG §20-107 likewise reflect an exclusive focus on affirmative treatment steps. HG §20-107(b) precludes reliance on the section for "treatment . . . against the religious belief of the disabled individual." HG §20-107(e) speaks of "proposed health care." Finally, HG §20-107(f)(4) refers to "the performance of the treatment."

B. Family Decisionmaking Under Common Law

If HG §20-107(d) does not authorize decisions to forgo life-sustaining treatment, what does? That is, if a disabled person has no living will or durable power of attorney and did not previously instruct the attending physician about treatment choices, must a spouse or other family member initiate a guardianship proceeding in order to forgo life-sustaining treatment when the disabled person has become terminally ill? In practice, every day in this State doctors are recommending and families are confirming decisions not to use various means of treatment for terminally ill patients who cannot decide for themselves. Many of these decisions — not to resuscitate, not to use a respirator, not to treat an infection with antibiotics, not to insert or maintain a feeding tube — mean that a terminally ill patient will die a little sooner, but without unduly prolonged suffering.

The General Assembly not long ago recognized this reality, indirectly but distinctly. In Chapter 749 of the Laws of Maryland 1986, the General Assembly required each hospital to establish a patient care advisory committee. HG §19-371(1). Among other duties, the committee on request "shall give advice concerning the options for medical care and treatment of an individual with a life threatening condition." HG §19-374(a). The statute recognizes family members as potential participants in the decision about which "option" to choose. See HG §§19-370(d)(5), 19-372(a)(3)(iii), 19-373(b)(1), and 19-374(b)(1). The bill's preamble spoke of "[d]octors, patients, relatives, and the courts . . . being forced to make difficult choices with respect to medical treatment and care" and of the "need for . . . policies to help families and care providers who face these difficult choices. . . ." (Emphasis added).⁵⁰

Because decisions about treatment of a terminally ill patient usually must be made quickly, an informal parallel to HG §20-107 procedures has developed, albeit without a direct basis in that statute. If the attending physicians have concluded that forgoing life-sustaining treatment is consistent with proper standards of patient care, the physicians make that recommendation. If close family members agree with that recommendation, the decision to forgo treatment is carried out without court involvement.

⁵⁰ At the same time, Chapter 749 reaffirmed the primacy of an individual's own decision: "Any information or document that indicates the wishes of the patient shall take precedence in the deliberations of the advisory committee." HG §19-374(b)(2).

In our view, this kind of surrogate decisionmaking is a legally proper means of effectuating the constitutional and common law rights of a terminally ill patient. We start with the premise, set out in Part IIB above at pages 175-78, that a disabled person has a right to refuse life-sustaining treatment, including artificially administered sustenance.

If a terminally ill patient is forced to endure the burdens of unwanted treatment and a prolonged dying process while awaiting a court decision, the person's rights will have been defeated in practice even if upheld eventually. Some of the leading decisions establishing the right to refuse treatment were announced, with unintended irony, after the person's dying had been prolonged by that very treatment.⁵¹

For that reason, some courts have articulated a common law procedure "to allow the surrogate decision maker, the family, to make the decision free of the cumbersomeness and costs of legal guardianship proceedings." *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1377 (1984). As the New Jersey Supreme Court put it:

Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds to him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests, . . . and they who treat the patient as a person, rather than a symbol of a cause.

In re Jobes, 108 N.J. 394, 529 A.2d 434, 445 (1987) (citations omitted). See also, e.g., *John F. Kennedy Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984).

The California Court of Appeals has expressly rejected the argument "that only duly appointed legal guardians have the right to act on behalf of another. While guardianship proceedings might be used in this context, we are not aware of any authority requiring such procedure." *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal.

⁵¹ See *Corbett v. D'Alessandro*, 487 So. 2d at 369; *In re Farrell*, 529 A.2d at 409-10; *In re Storar*, 420 N.E.2d at 66 n.1 (1981).

Rptr. 484, 492 (1983) (emphasis in original).⁵² In the case before it, the court continued, the attending physicians had "consulted with and relied on the decision of the immediate family, which included the patient's wife and several of his children. . . . In the absence of legislation requiring [guardianship] proceedings, we cannot say that failure to institute such proceedings made [the doctors'] conduct [in discontinuing life-sustaining treatment] unlawful." *Id.*⁵³

These cases emphasize the importance of collaborative decision-making among physicians and family members (and sometimes an advisory group like a hospital's ethics committee). If any participant in the decision to withhold life-sustaining treatment objects, treatment must be continued until a court decides the matter. *Rasmussen v. Fleming*, 741 P.2d at 691; *In re Grant*, 747 P.2d at 456. "Where, however, all affected parties concur in the proposed plan of medical treatment, court approval of the proposed plan of medical treatment is neither necessary nor required." *Rasmussen*, 741 P.2d at 691.⁵⁴

⁵² Decisions recognizing a guardian's right to refuse life-sustaining treatment on behalf of a disabled person cannot be read to require guardianship proceedings. Since a previously appointed guardian petitioned the court to have the life-sustaining procedures withdrawn, the courts focused primarily on the authority of the guardian and not on a situation in which a guardian had not been appointed. See, e.g., *Rasmussen*, 741 P.2d 674; *Brophy*, 497 N.E. 2d 626. But see *In re Conroy*, 486 A.2d at 1240 (guardian must be appointed to act on behalf of patient who was neither terminal nor experiencing a permanent loss of consciousness before withholding or withdrawing life-sustaining treatment).

If a close family member is the guardian of the person, one might argue that the family member may invoke either decisionmaking process, that available to guardians or that available to close family members. Nevertheless, the legislative policy reflected in the introductory language to HG §20-107(d), which we believe a court would apply in this analogous situation, gives primacy to decisionmaking under a guardianship, with no distinction made between family member guardians and stranger guardians. Until the General Assembly addresses the matter further, a family member who is a guardian of the person should follow the decisionmaking procedures applicable to guardians. See pages 190-92 above.

⁵³ For a discussion of one aspect of *Barber* that we are unable to endorse, see page 200 below.

⁵⁴ See also *Barber*, 195 Cal. Rptr. at 493; *Corbett*, 487 So. 2d at 370; *In re Gardner*, 534 A.2d at 949-50; *Brophy*, 497 N.E. 2d at 635; *In re Jones*, 529 A.2d at 451; *In re Peter*, 529 A.2d at 430; *In re Quinlan*, 355 A.2d at 669; *In re Grant*, 747 P.2d at 456; *Compare*, (1981); *Leach v. Shapiro*, 469 N.E.2d 1047 (1984). Cf. *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d at 434 (court approval required where treatment would extend a patient's normal cognitive functioning).

Relying on this body of case law, and mindful of the fact that protection of the terminal patient's right requires swift decisionmaking, we conclude that a decision to forgo life-sustaining treatment, including artificially administered sustenance, may lawfully be made on behalf of a disabled person if:

- (i) the disabled person is terminally ill;
- (ii) the attending physicians advise that forgoing treatment is medically proper;⁵⁵
- (iii) a close family member determines that forgoing treatment is what the disabled person would want done or, if that is unknown, is in the person's best interest;⁵⁶
- (iv) no other family member disagrees with the decision; and
- (v) where applicable, the hospital's patient care advisory committee has not advised against forgoing treatment.⁵⁷

We are unable to reach the same conclusion about nonterminal, permanently unconscious patients. In our view, any decision to end artificially administered sustenance for these patients must be made by a court, unless the patient, while competent, decided the matter directly or executed a medical durable power of attorney.

⁵⁵ The Council on Ethical and Judicial Affairs of the American Medical Association has stated its view that, "[f]or humane reasons, with informed consent, a physician may . . . cease or omit treatment to permit a terminally ill patient whose death is imminent to die." A physician has no duty to initiate or continue useless treatment. See *Barber v. Superior Court of California*, 195 Cal. Rptr. at 491. Accord, *In re Dinnerstein*, 38 N.E.2d at 139 n.10; President's Commission Report at 191 n.50. See generally Horan, *Euthanasia and Brain Death: Ethical and Legal Consideration*, 315 Annals N.Y. Acad. Sci. 363, 367 (1978).

We note that a health care provider's decision not to treat is outside the scope of the limited immunity in HG §20-107(g)(2), which applies only to treatment in "reliance on the substituted consent." However, if the decision not to treat were in accordance with accepted standards of practice, the decision would not be a basis of liability in any event.

⁵⁶ In our view, although HG §20-107(d) is inapplicable, its priority ranking of family members reflects a legislative judgment that can be applied in this context. Those listed in HG §20-107(d) are "close family members," as we use the term. We recognize that, in some situations, no such family member is available to discuss the situation. If the attending physician has concluded that artificially administered sustenance is medically improper, the physician should take steps to obtain court approval, through a guardianship proceeding, before terminating treatment. See *In re Hamlin*, 689 P.2d at 1378 (where patient is incompetent and where there is no family available, a guardian must be appointed to represent the patient's best interests).

⁵⁷ Nursing homes are not required to establish patient care advisory committees. The General Assembly may wish to consider extending the requirement of HG §19-371 to nursing homes.

We readily acknowledge that the case law approving family decisionmaking deals with the permanently unconscious as well as the terminal. In fact, more cases involve the permanently unconscious. In *Barber v. Superior Court of California*, for example, the court approved a spouse's authorization of the withholding of all life-sustaining treatment from a patient who was "in a deeply comatose state from which he was not likely to recover." 195 Cal. Rptr. at 486. The court held that the patient's family was best able to know what was in the patient's best interest since they knew his feelings and desires and were most concerned for his comfort and welfare. 195 Cal. Rptr. at 493 n.2.⁵⁸

But we cannot be content merely to report these cases. We must analyze them as well, for if their reasoning is questionable, then our confidence that Maryland courts would take the same position is lessened.

We have serious reservations about the reasoning of decisions that allow families to decide, without court approval, to end artificially administered sustenance for a patient whose death might otherwise be averted indefinitely.⁵⁹ Undoubtedly, in most cases involving the permanently unconscious, family members are sincerely trying to do what the patient would want. Yet we must also recognize the possibility that a family's decision to refuse substituted consent for artificially administered sustenance might be the product of selfish or other wrong motives.

If the family has unsupervised decisionmaking power, there is little safeguard against aberrant decisions. To be sure, the same risk of wrong motives attends decisionmaking about the terminally ill. In that situation, though, the right of the *patient* to avoid needless suffering is compromised as judicial proceedings take their course or,

⁵⁸ See also, e.g., *In re Jobs*, 529 A.2d at 446-47; *In re Grant*, 747 P.2d at 456; *In re Hamlin*, 689 P.2d at 1379. So far as medical ethics are concerned, the Council on Ethical and Judicial Affairs of the American Medical Association has advised that "it is not unethical to discontinue all means of life prolonging medical treatment" when "a patient's coma is beyond doubt irreversible . . ." AMA, "Withholding or Withdrawing Life Prolonging Medical Treatment" (1986). According to a recent survey, when a cross-section of physicians was asked, "Would you favor or oppose withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it?," 78% favored withdrawing; 15% opposed it. *AMA Survey of Physician and Public Opinion on Health Care Issues* 24 (1988).

⁵⁹ We are not referring to a family member who is empowered to act under the patient's medical durable power of attorney.

faced with this burden, the decisionmaker abandons the effort to refuse treatment. The permanently unconscious, who are neither on the verge of death nor suffering, are not themselves comparably harmed by a more deliberate course of decisionmaking.⁶⁰

It may well be that, like courts in other states, the Court of Appeals ultimately will conclude that families, not courts, ought to decide for themselves whether to end life-sustaining treatment for the permanently unconscious.⁶¹ Until that happens, however, it is our opinion that a family member who wishes to end life-sustaining treatment of a permanently unconscious patient must seek court approval through a guardianship proceeding (unless the family member has power to decide under the patient's medical durable power of attorney).

X

Nursing Home Patient's Bill of Rights

As part of the Nursing Home Patient's Bill of Rights, HG §19-344(f) provides that "a resident of a facility . . . [m]ay refuse medication or treatment."⁶² In addition, HG §19-344(r) provides:

[I]f a resident is adjudicated a disabled person, is found to be medically incompetent by the attending physician of the resident or is unable to communicate with others, the rights of the resident may be exercised by:

- (1) The next of kin of the resident;
- (2) The guardian of the person of the resident;
- (3) The sponsoring agency of the resident; or

⁶⁰ The family, it is true, must bear a considerable financial and emotional burden if court approval is required.

⁶¹ As the President's Commission pointed out, judicial review of a family's decision is frequently "merely a formality. Judges may feel that they are unable to add much to the decisions already worked out among those most intimately involved, particularly in cases that are brought simply to obtain judicial sanction for a course of conduct on which all are agreed." President's Commission Report at 160.

⁶² A "facility" is a "comprehensive care facility or an extended care facility." HG §19-343(a). For ease of reference, we will simply speak of "nursing homes."

(4) Unless the facility is the representative payee, the representative payee that the Social Security Administration designates for the resident.⁶³

See also 42 C.F.R. §§405.1121(k) and 442.312.

Some contend that HG §19-344(r) authorizes a surrogate decision-maker to refuse medication or treatment on behalf of a patient. We do not agree with this construction. As we read it, HG §19-344(r) authorizes a surrogate to ensure that the general rights granted to a resident by HG §19-344 are protected but does not provide a mechanism for surrogate decisionmaking for medical treatment.

This interpretation is supported by a comparison of HG §19-344(r) and HG §20-107. Unlike HG §20-107, HG §19-344(r) fails to set priorities among the persons who may exercise the rights of the patient. We do not think it possible that the General Assembly intended to give equal authority over medical decisions to the nursing home resident's next of kin and the resident's Social Security Administration representative payee. Nor do we think that the General Assembly meant to give persons power to refuse treatment on behalf of the patient even though those persons are without authority to consent to treatment. Hence, we conclude that HG §19-344(r) does not authorize a surrogate to refuse treatment on behalf of the patient. Surrogate decisionmaking on behalf of a nursing home patient is to be accomplished in the same way as it is on behalf of a hospital patient.

XI

Institutional Policies And Procedures

What happens when a patient (or a surrogate, acting for a disabled patient) decides to refuse artificially administered sustenance but the hospital or nursing home has a policy that disallows this choice?

First of all, the institution may not enforce its policy by simply inserting or maintaining a feeding tube without the consent of a competent patient or properly authorized surrogate. Such an action would make a nullity of the doctrine of informed consent. See *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977). See generally pages 170-75 above. In a nursing home, forced insertion of a feeding tube over objection

⁶³ This subsection formerly was designated as HG §19-344(g). It was redesignated by Chapter 452, Laws of Maryland 1988.

would also violate the patient's statutory right to "refuse medication or treatment." HG §19-344(f)(1)(ii). Nor would it matter that the patient, explicitly or implicitly, had agreed at admission to abide by the policy on artificially administered sustenance. The right to reject medical treatment means that after consenting to treatment, one may change one's mind.⁶⁴

The practical question, as we see it, is whether the institution may discharge or transfer a patient whose choice is ruled out by the policy.⁶⁵

When an institution seeks to discharge or transfer a patient because the patient will not follow its rules, it is enforcing a contract — the agreement by which the patient entered the facility.⁶⁶ But when a person needs hospital or nursing home care, he or she is hardly in a position to bargain over the terms of admission. "The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract." *Tunkl v. Regents of Univ. of Calif.*, 60 Cal.2d 92, 32 Cal. Rptr. 33, 39 (1963). Rather, the admissions agreement "possesses all the characteristics of a contract of adhesion." *Wheeler v. St. Joseph Hosp.*, 63 Cal. App. 3d 345, 133 Cal. Rptr. 775 (1977).⁶⁷ Contracts of this kind are not necessarily invalid, but "courts . . . review adhesion contracts for fairness, and refuse to enforce those adhesion terms which are demonstrably unfair to the stuck party." *Corbin on Contracts* §559A at 566 (Kaufman supp. 1984). So, for example, a hospital may not extract from a patient a release of liability as a condition for

⁶⁴ See cases cited in note 9 above and accompanying text.

⁶⁵ The few out-of-state cases bearing on this question are mixed. Compare *Jobes*, 529 A.2d at 450, and *Requena*, 517 A.2d at 870 (institutions not permitted to discharge patients) with *Brophy*, 497 N.E.2d at 639 (hospital permitted to transfer patient).

⁶⁶ Compliance with an institution's policy on artificially administered sustenance cannot be said to be part of the patient's contractual undertaking if the policy is articulated only after the patient is admitted. *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870.

⁶⁷ A contract of adhesion has the following characteristics:

"a standardized contract prepared entirely by one party to the transaction for the acceptance of the other; such a contract, due to the disparity in bargaining power between the draftsman and the second party, must be accepted or rejected by the second party on a 'take it or leave it' basis, without opportunity for bargaining and under such conditions that the 'adherer' cannot obtain the desired product or service save by acquiescing in the form agreement."

Steven v. Fidelity & Casualty Co., 58 Cal. 2d 862, 27 Cal. Rptr. 172, 185 (1962) (emphasis added).

admission. *Tunkl*, 32 Cal. Rptr. at 39. This approach to adhesion contracts is but a special application of the general principle that a "contractual provision that violates public policy is invalid," to the extent of the conflict. *State Farm Mut. v. Nationwide Mut.*, 307 Md. 631, 643, 516 A.2d 586, 592 (1986).⁶⁸

This State's public policy objective of protecting an especially vulnerable group is declared in a statute that imposes limits on a nursing home's power to transfer or discharge a patient:

A resident of a facility may not be transferred or discharged from the facility involuntarily except for the following reasons:

- (1) A medical reason;
- (2) The welfare of the resident or other patients;
- (3) Knowingly transferring personal assets in violation of a contract provision and only to become eligible for Medicaid benefits;^[69] or
- (4) A nonpayment for a stay.

HG §19-345(a). See also 42 C.F.R. §§405.1121(h)(4) and 442.311(c). A provision in a nursing home's admission agreement (or in any policies incorporated by reference) that purported to authorize transfer or discharge for any other reason would be void as a violation of this statute.

A patient's refusal of artificially administered sustenance could justify involuntary discharge only if that refusal were a "medical reason." But the patient's exercise of the right to refuse a particular treatment cannot be, in and of itself, a "medical reason" justifying transfer. While the medical facts about a patient's condition are crucial to a decision about life-sustaining treatment, they are not the only factors. The decision may turn on religious, moral, or family concerns. See *Brophy*, 497 N.E. 2d at 635. Perhaps, as a collateral consequence of the decision, the patient will prove to need — and will consent to —

⁶⁸ Contractual waiver of a statutory right is ineffective if the statute declares the State's public policy. *Spruell v. Blythe*, 215 Md. 117, 137 A.2d 183 (1957). See generally *Brooklyn Savings Bank v. O'Neil*, 324 U.S. 697, 704-05 (1945). Any purported waiver of the Nursing Home Patient's Bill of Rights is ineffective. *Summit Nursing Home v. Medical Care Programs, DHMH*, Medicare and Medicaid Guide (CCH) ¶33, 977 (DHMH Hearing Referee) (May 8, 1984).

⁶⁹ This office has advised that this provision conflicts with federal law and therefore is unenforceable. Letter from Attorney General Stephen H. Sachs and Assistant Attorney General David F. Chavkin to Lawrence R. Payne, Director of the Medical Assistance Compliance Administration (July 7, 1982).

care beyond the capacity of the nursing home to provide. In this unusual circumstance, there might be a legitimate "medical reason" for a transfer to an institution that could meet those needs. But the patient's (or surrogate's) decision itself, though contrary to the nursing home's policy, is not. Therefore, the decision may not serve as a basis for involuntary discharge or transfer.

For hospitals, there is no comparable statutory restriction on discharge or transfer.⁷⁰ However, the General Assembly has enacted a provision, HG §19-308.2, designed to assure the well-being of a patient transferred from one hospital to another.⁷¹ This provision reflects an obvious public policy concern for the protection of patients. The same concern animates judicial decisions that balance the institution's right to enforce its policy against the harm to the patient caused by discharge or transfer. "[A]pplication [of a hospital's policy prohibiting withholding of artificially administered sustenance] should be limited to the circumstances where it is reasonable and equitable to apply it without undue burden to the patient." *In re Requena*, 213 N.J. Super. 443, 517 A.2d 869, 870 (1986). See also *Jobes*, 529 A.2d at 450. Cf. *Brophy*, 497 N.E.2d at 639 (transfer to enforce policy permissible if hospital assists in securing placement in another facility); *Delio*, 516 N.Y. 2d at 694 (hospital may either assist in discontinuance of treatment or assist in transferring patient to a suitable facility or to his home). Put differently, a hospital cannot enforce a term in its adhesion contract in a way that unfairly burdens a patient.

In sum, we conclude that:

- (i) A nursing home may not discharge or transfer a patient solely because the patient (or a surrogate) has refused artificially administered sustenance; and
- (ii) A hospital may not discharge or transfer a patient solely because the patient (or a surrogate) has refused artificially administered sustenance, if the discharge or transfer would impose an undue burden on the patient.

⁷⁰ Accredited hospitals must meet the standards of the Joint Commission on Accreditation of Hospitals. See HG §§19-301(b), 19-308(c), and 19-319(c)(2)(i). We are aware of no standard, however, expressly delineating permissible bases for discharge or transfer.

⁷¹ HG §19-308.2 provides as follows, in pertinent part: "The Department shall adopt guidelines . . . governing the transfer of patients between hospitals to ensure that transfers of patients between hospitals are accomplished in a medically appropriate manner and in accordance with the health care policies of the State. . . ."

Our conclusion refers to institutional policies formulated by a nursing home or hospital on the basis of its view of proper patient care. We do not address the question of whether a religiously affiliated institution, whose policy disallowing the refusal of artificially administered sustenance is founded on religious doctrine, has a right under the Free Exercise Clause of the First Amendment to discharge or transfer patients who will not comply with that policy.

XII

Regulatory Requirements

Both federal and State regulations require hospitals and nursing homes to meet the nutritional needs of their patients. *See* 42 C.F.R. §405.1125; 42 C.F.R. §482.28; COMAR 10.07.02.13E and 10.07.03.11A(2). Nothing in these regulations, however, mandates the administration of artificial sustenance. Rather, the regulations recognize that the nutritional needs of patients are to be met in accordance with the orders of the attending physician and the consent of the patient. If a physician has documented that a patient or the patient's authorized surrogate has refused artificially administered sustenance, the institution's honoring of that treatment decision would not violate either State or federal nutritional regulations.

Apart from these nutritional regulations, we are not aware of any other regulations bearing on the issues treated in this opinion. However, the Department of Health & Mental Hygiene has proposed new regulations applicable to nursing homes. 14:26 Md. Reg. 2758 (Dec. 18, 1987). The proposal, generally intended to ensure patients' rights, has a section dealing with medical decisionmaking. Proposed COMAR 10.07.09.04. The Department, we understand, is now evaluating comments about the proposal and considering what changes, if any, to make.

XIII

Conclusion

We hope that this opinion provides useful guidance about current law to families and doctors, who must struggle with decisions about their loved ones and patients. We also hope that the General Assembly will address itself to these questions, so that those best able to fashion

public policy will strike the right balance between affirming individual choice and protecting the vulnerable among us.

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