HEALTH CARE

MEDICAL TREATMENT – INFORMED CONSENT – LIFE-SUSTAINING PROCEDURES – *CRUZAN V. DIRECTOR, MISSOURI DEP'T OF HEALTH* – LIVING WILL LAW – DURABLE POWER OF ATTORNEY – GUARDIANSHIP

September 24, 1990

The Honorable Joan B. Pitkin
Maryland House of Delegate

The Honorable Rosalie S. Abrams
Director, Office on Aging

You have each requested our opinion on the effect in Maryland of the Supreme Court's recent "right to die" decision, *Cruzan v. Director, Missouri Dept. of Health*, 110 S.Ct. 2841 (1990).

As you know, in 1988 this office issued a comprehensive opinion concerning decisions to forgo life-sustaining treatment, including artificially administered food and water. 73 *Opinions of the Attorney General* 162 (1988). Most broadly, both of you have asked us to consider whether any of our conclusions in that opinion must be changed in light of *Cruzan*. In addition, you have posed more specific questions about decisionmaking on this subject.

1. Our overall response to your inquiries is that *Cruzan* does not require any change in our basic conclusions: that a competent person has a right to decide whether to accept life-sustaining treatment, including artificially administered sustenance; that a competent person can use an advance directive to plan for decisionmaking even if the person later becomes disabled; and that a disabled person who has not prepared an advance directive nonetheless has a right to have a surrogate–a family member in certain circumstances, a guardian with court approval in others–make the decision on the person's behalf. In fact, *Cruzan* strengthens several of our conclusions.

2. Senator Abrams asked whether we could identify the standard of proof that would be applied in determining whether the decision to forgo artificially administered food and water on behalf of a disabled person reflects the choice that the person would have made. This question presupposes that the disabled person had neither stated a decision in an advance directive nor designated an agent with power to make such decisions.

In our opinion, Maryland courts would most likely require clear and convincing evidence that a decision to forgo life-sustaining treatment on behalf of a disabled person is what the disabled person would have decided under the circumstances.

In addition, Delegate Pitkin posed a series of specific questions concerning the Living Will Law and other methods of advance decisionmaking about life-sustaining treatment:

3. Does Maryland's Living Will Law prescribe language to be used if a person wishes to forgo artificially administered food and water?

No. In the 1988 opinion, we concluded that the Living Will Law permits a person to insert in a living will a statement that the person does not want the use of artificially administered food and water when the person is terminally ill. We reiterate that conclusion. However, the law does not specify any language for such a statement. Any phrasing that clearly reflects the person's intention would be legally sufficient.

4. Does Maryland's Living Will Law apply to all situations in which a person might decide to forgo artificially administered food and water?

No. The Living Will Law applies only when death is imminent as a result of a terminal illness. Should a person wish to make decisions in advance about the use of life-sustaining treatment, including artificially administered sustenance, in other circumstances – for example, if the person were to become permanently unconscious and yet able to live in that condition indefinitely – we recommend that the person state those decisions in a durable power of attorney for health care.

5. Does Maryland permit a person to delegate decisionmaking authority about life-sustaining treatment to a trusted friend or relative?

Yes. As explained in our 1988 opinion, a person may execute a durable power of attorney for health care that designates someone to serve as decisionmaker should the person become disabled. A durable power is typically written to give the agent general decisionmaking authority, together with several more specific grants of authority–for example, to forgo life-sustaining treatment. But a durable power of attorney for health care can do more; it can also reflect the person's own decisions. The agent's inevitably difficult task can be made easier if the durable power gives the agent guidance about the use of life-sustaining treatment.

6. In lieu of a living will or a durable power of attorney for health care, "would a simple statement of a wish to die under [specified] circumstances be legally sufficient?"

As our 1988 opinion pointed out, patients may make decisions about life-sustaining treatment in discussions with their physicians. A writing reflecting the patient's decisions, prepared by either the patient or the physician and embodied in the patient's medical records, would be legally sufficient. However, other kinds of written statements, not executed with the formalities of a living will or a durable power of attorney for health care, are of uncertain legal status and not likely to be viewed by health care providers as sufficient. Such statements undoubtedly would be regarded as significant and perhaps dispositive evidence of the person's intent should the question be litigated, but they may well not avoid litigation, as more formal documents would.

7. If a person has not executed a living will, who has final decisionmaking power should a question of life-sustaining treatment be raised?

(i) If the person has executed a durable power of attorney for health care, the agent named in that document would have decisionmaking authority, guided by whatever decisions were set out by the now-disabled person in the durable power itself. (ii) If the person is terminally ill and not under guardianship, close family members may decide to forgo life-sustaining treatment on behalf of the person, under the circumstances identified in our 1988 opinion. (iii) In other situations, specified in more detail in response to the next question, the court must approve decision to forgo life-sustaining treatment.

8. Under *Cruzan*, in what circumstances may the State "substitute [its] values for the individual's?"

As we read *Cruzan*, a majority of the Supreme Court has accorded constitutionally protected status to a competent individual's decision to decline life-sustaining treatment when the individual is terminally ill or permanently unconscious, whether made at the time or previously in a formal writing. A majority of the Justices also would recognize the constitutional right of an individual to delegate decisionmaking power to an agent by means of a durable power of attorney for health care. In these cases, a state may not substitute its decision for that of the individual or the agent. Maryland law, as construed in our 1988 opinion, is fully consistent with this aspect of *Cruzan*.

If a person has neither decided the question personally in an advance directive nor designated an agent with authority to do so, a state has extensive power to weight the decision toward the maintenance of life-sustaining treatment. *Cruzan* holds that a state may require the decision to be made by a court, instead of the patient's family, and may require treatment to be maintained unless clear and convincing evidence of the patient's wish to forgo treatment is available.

In Maryland as elsewhere, most people have not prepared an advance directive of any kind. When a person without an advance directive becomes disabled, our 1988 opinion advised, court approval of a decision to forgo life-sustaining treatment is required in the following situations: if the person is under guardianship; if the person is not terminally ill; if no close family member is available to act as surrogate decisionmaker for a terminally ill patient; or if participants in the decisionmaking about life-sustaining treatment for a terminally ill patient disagree about the proper course. This advice is consistent with *Cruzan* and we reaffirm it.

As indicated in our answer to the second question above, a court will likely require clear and convincing evidence in support of a petition to forgo life-sustaining treatment. Although *Cruzan* does not require this standard of proof, it is the one that we believe is most likely to be adopted by the Maryland courts.

9. What role does a physician play in decisionmaking about life-sustaining treatment?

Decisionmaking about life-sustaining treatment, like other treatment choices, is collaborative. The physician's role is to identify the treatment alternatives, including forgoing treatment, that are

medically reasonable in light of the patient's condition; explain the consequences of each alternative; and offer a medically appropriate recommendation. The final decision, however, is to be made by the patient or the patient's surrogate, not by the physician.

I

Cruzan

A. Introduction

The *Cruzan* case involved a young woman who, as a result of an automobile accident, was left in a persistent vegetative state. Nancy Cruzan "is not dead. She is not terminally ill. Medical experts testified that she could live another 30 years." *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1989).

Less than a month after her accident, and therefore at a time when hope of recovery still existed, Nancy Cruzan's doctors, with family consent, implanted a gastrostomy feeding tube. Years later, after any possibility of recovery was ruled out, Nancy's co-guardians, her parents, sought to have the feeding tube removed.[1]

The trial court approved the request of Nancy's parents to withdraw the feeding tube. Pointing to a "somewhat serious conversation with a housemate friend that if she were sick or injured she would not wish to continue her life unless she could live at least halfway normally," together with other evidence of her views, the trial court found that "given her present condition she would not wish to continue on with her nutrition and hydration." *See* 760 S.W.2d at 433 (trial court judgment reprinted in dissenting opinion).

The Missouri Supreme Court reversed: "Given the fact that Nancy is alive and the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state

[1] Having been in a persistent vegetative state for seven years, Nancy Cruzan will never regain cognitive functioning. "The longest any person has ever been in a persistent vegetative state and recovered was 22 months." 110 S.Ct. at 2868 n.8 (Brennan, J., dissenting).

maintains a vital interest." 760 S.W.2d at 424. When a person is not able to make treatment decisions directly, no person may forgo life-sustaining treatment on the person's behalf without "clear and convincing, inherently reliable evidence" that the person would have made the same decision. 760 S.W.2d at 425.

The Missouri court held that the evidence offered at trial about Nancy's wishes was "inherently unreliable and thus insufficient to support the co-guardians [*sic*] claim to exercise substituted judgment on Nancy's behalf." 760 S.W.2d at 426. As the Missouri court observed:

> The state's interest is in the preservation of life, not only Nancy's life, but also the lives of persons similarly situated yet without the support of a loving family. This interest outweighs any rights invoked on Nancy's behalf to terminate treatment in the face of the uncertainty of Nancy's wishes and her own right to life.

767 S.W.2d at 426.

B. The Supreme Court's Decision

The United States Supreme Court, by a five-to-four vote, affirmed the decision of the Missouri Supreme Court. Writing for himself and Justices White, O'Connor, Scalia, and Kennedy, Chief Justice Rehnquist stated that the question before the Court "is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did." 110 S.Ct. at 2851. The Constitution did not do so, the Court held: "In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state." 110 S.Ct. at 2854.

As is true in many constitutional controversies, the Court invoked a balancing test–the individual's interest against the state's interest. The Court acknowledged that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment ...." 110 S.Ct. at 2851. The Court further "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." 110 S.Ct. at 2852.

On the other side of the balance, a state may "assert an unqualified interest in the preservation of human life ...." 110 S.Ct. at 2853. More particularly, because "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality," a state "may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements." 110 S.Ct. at 2852-53. Missouri's clear and convincing evidence standard of proof guards against potential abuse by surrogate decisionmakers and, given the finality of a decision to forgo life-sustaining treatment, "may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment." 110 S.Ct. at 2854. The Court recognized that "Missouri's requirement of proof in this case may have frustrated the effectuation of the not-fully-expressed desires of Nancy Cruzan. But the Constitution does not require general rules to work faultlessly; no general rule can." *Id*.

The Court declined to rule on whether the Constitution would forbid a state from overriding the decisions of a surrogate designated by the disabled person while competent: "We are not faced in this case with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual." 110 S.Ct. at 2856.

C. Justice O'Connor's Concurrence

Justice O'Connor wrote a significant concurring opinion focused on the point not decided by the Court – the constitutional status of a person's designation of a surrogate decisionmaker.

Justice O'Connor began by pointing out why "state incursions into the body [are] repugnant to the interests protected by the Due Process Clause":

> The State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions.

> Such forced treatment may burden that individual's liberty interest as much as any state coercion.

110 S.Ct. at 2856. Moreover, Justice O'Connor continued, "[t]he State's artificial provision of nutrition and hydration implicates identical concerns. Artificial feeding cannot readily be distinguished from other forms of medical treatment." 110 S.Ct. at 2857. "Accordingly," Justice O'Connor wrote, "the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.*

Justice O'Connor then went on to express her view that, although "the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker, ... such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment." Observing that "[f]ew individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent," she wrote that "[s]tates which decline to consider any evidence other than such instructions may frequently fail to honor a patient's intent." *Id.*

"Delegating the authority to make medical decisions to a family member or friend," Justice O'Connor pointed out, "is becoming a common method of planning for the future." *Id.* Justice O'Connor lauded the states that "have recognized the practical wisdom of such a procedure by enacting durable power of attorney statutes that specifically authorize an individual to appoint a surrogate to make medical treatment decisions." *Id.* She also pointed to those states, including Maryland, whose general durable power of attorney statutes have been construed to authorize durable powers of attorney for health care. 110 S.Ct. at 2858.[2] The Court's decision in *Cruzan*, "holding only that the Constitution permits a state to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate." *Id.*

[2] In this passage, Justice O'Connor cited with approval our 1988 opinion.

D. Justice Scalia's Concurrence

Justice Scalia also wrote a separate concurrence, spelling out his preference that the Court "announce clearly and promptly, that the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide–including suicide by refusing to take appropriate measures necessary to preserve one's life; ... and hence, that even when it *is* demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve her life, it is up to the citizens of Missouri to decide through their elected representatives whether that wish will be honored." 110 S.Ct. at 2859 (emphasis in original).

E. Dissenting Opinions

Justice Brennan, writing in dissent for himself and Justices Marshall and Blackman, would have held "that Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interest of the State, and ... that the improperly biased procedural obstacles imposed by the Missouri Supreme Court impermissibly burden that right ...." 110 S.Ct. at 2864. Although the right to reject medical treatment may not be absolute, Justice Brennan wrote, "no state interest could outweigh the rights of an individual in Nancy Cruzan's position. Whatever a State's possible interests in mandating life-support treatment in other circumstances, there is no good to be obtained here by Missouri's insistence that Nancy Cruzan remain on life-support systems if it is indeed her wish not to do so." 110 S.Ct. at 2869.

In his view, Missouri may constitutionally impose "only those procedural requirements that serve to enhance the accuracy of a determination of Nancy Cruzan's wishes or are at least consistent with an accurate determination .... Just as a state may not override Nancy's choice directly, it may not do so indirectly through the imposition of a procedural rule." 110 S.Ct. at 2871-72. Missouri's clear and convincing evidence standard is so stringent, Justice Brennan thought, "that only a living will or equivalent formal directive from the patient when competent would meet this standard." 110 S.Ct. at 2875.

Moreover, Justice Brennan would have held that a state is constitutionally required to honor the decisions of a surrogate decisionmaker:

> A State may ensure that a person who makes the decision on the patient's behalf is the one whom the patient himself would have selected to make that choice for him. And a State may exclude from consideration anyone having improper motives. But a State generally must either repose the choice with the person whom the patient himself would most likely have chosen as proxy or leave the decision to the patient's family.

110 S.Ct. at 2877.

Justice Stevens, in a separate dissent, objected to the majority's allowing Missouri's "abstract, undifferentiated interest in the preservation of life to overwhelm the best interests of Nancy Beth Cruzan, interests which would, according to an undisputed finding, be served by allowing her guardians to exercise her constitutional right to discontinue medical treatment." 110 S.Ct. at 2879. Although he did not discuss the point in detail, Justice Stevens, like the other dissenters, suggested that he likewise views a state as constitutionally required to recognize surrogate decisionmaking on behalf of a disabled person. *See* 110 S.Ct. at 2892.

II

Effect Of *Cruzan* On 1988 Attorney General's Opinion–Underlying Principles

In 1988 we concluded that a competent person "has a constitutional and common law right" to instruct that artificially administered sustenance not be used when the person is terminally ill or permanently unconscious. 73 *Opinions of the Attorney General* at 163 (1988). We believe that this conclusion is strengthened by the Supreme Court's decision in *Cruzan*.

The opinion of the Court recognized the common law basis of the doctrine of informed consent and its corollary, the right to refuse unwanted treatment: "The informed consent doctrine has become firmly entrenched in American tort law.... The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." 110 S.Ct. at 2847.

Moreover, the Court held, this right has constitutional stature. 110 S.Ct. at 2851. In our 1988 opinion, we cited several courts that had identified the right to refuse medical treatment within the constitutional right to privacy. 73 *Opinions of the Attorney General* at 172. The Court in *Cruzan* declined to so hold, concluding instead that "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." 110 S.Ct. at 2851 n.7. Nevertheless, the Court's constitutional holding was clear: Competent persons have "a general liberty interest in refusing medical treatment." 110 S.Ct. at 2851.

Although the Court stopped short of so holding, it implied that the right to refuse medical treatment generally encompasses the right to refuse artificially administered food and water. 110 S.Ct. at 2852. Justice O'Connor, in her concurrence, stated explicitly her view "that the refusal of artificially delivered food and water is encompassed within that liberty interest." 110 S.Ct. at 2856. And all four dissenting Justices took that view. Hence, at least five, and possibly as many as eight, Justices accept the proposition that a competent person has a constitutional right to forgo the medical intervention necessary to supply food and water through tubes.

The Court pointed out, as we did in our 1988 opinion, that the right to refuse treatment is not an absolute one and must be balanced against "the relevant" state interests. 110 S.Ct. at 2852. In our 1988 opinion, we identified four such interests: "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." 73 *Opinions of the Attorney General* at 173.

Given the facts of the case before it, the Supreme Court did not have occasion to consider the circumstances under which any of these state interests might outweigh the competent individual's right.[3] Nothing in the Court's opinion or that of Justice O'Connor, however, calls into question our conclusion that "[t]he right of a competent, terminally ill patient to refuse life-sustaining treatment outweighs these state interests, individually and cumulatively." 73 *Opinions of the Attorney General* 174. We continued: "The only state interest that conceivably might be given controlling weight in a particular case is the protection of dependents." 73 *Opinions of the Attorney General* at 175. *Accord, State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651 (1989).

Our 1988 opinion also discussed the ways in which a competent person might act to assure that future decisions about life-sustaining treatment would reflect the person's own views, should the person later become unable to make those decisions. In the next part of this opinion, we shall consider the current status of these methods of advance decisionmaking about life-sustaining treatment.

III

Direct, Advance Decisionmaking

A. Living Wills

In our 1988 opinion, we construed the Living Will Law, Subtitle 6 of Title 5 of the Health-General Article ("HG" Article), to allow a person to state explicitly in a living will the person's decision about the artificial administration of food and water: "If a declaration

[3] In his concurrence, Justice Scalia alone suggested that the state's interest in preventing suicide left it entirely free to negate a competent individual's choice to refuse life-sustaining treatment. 110 S.Ct. at 2860-61. No other Justice expressed this view, and the overwhelming majority of courts agree with the Connecticut Supreme Court that "[i]n exercising her right of self-determination, [the patient] merely seeks to be free of extraordinary mechanical devices and to allow nature to take its course. Thus, death will be by natural causes underlying the disease, not by self-inflicted injury." *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596, 605 (1989) (citing cases).

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." 73 *Opinions of the Attorney General* at 182.

Part of our reasoning in construing the statute in this way was to avoid a potential constitutional problem: "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." *Id*. As discussed in Part II above, at least five Justices of the Supreme Court hold the view that a competent person has a constitutional right to refuse artificially administered sustenance. *Cruzan* thus strengthens our construction of the Living Will Law. *See also McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989) (Connecticut's Removal of Life Support Systems Act reflects legislative policy allowing terminally ill patient to forgo tube feeding).

However, the Living Will Law addresses only a narrowly defined–albeit very important–medical circumstance: when a patient is in "terminal condition," defined as "an incurable condition" that "makes death imminent ...." HG §§5-601(f) and (g).[4] Because of this statutory limit on its scope, a living will cannot itself be an instrument of advance decisionmaking about life-sustaining treatment in any other circumstance–for example, a case of persistent vegetative state, as in *Cruzan. But see In re Greenspan*, 558 N. E. 2d 1194 1990 (Ill. 1990).[5]

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[4] "Terminal condition" is defined in full as "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." HG §5-601(g). *See also* HG §5-601(e) (definition of "life-sustaining procedure").

[5] In *Greenspan*, the Illinois Supreme Court concluded that the death of a person in a persistent vegetative state was "imminent," within the meaning of the Illinois Living Will Act, because the person's death would occur quickly if artificially administered sustenance were withdrawn: "Imminence must be judged as if the death-delaying procedures were absent ...." 558 N.E. 2d at 1204.

(continued...)

If a person modified a living will to expand its scope to conditions other than terminal illness as defined in the statute, those changes would surely be viewed as probative evidence of the person's intent. However, that portion of the living will would not be legally self-executing, as a living will otherwise is.

B. Durable Powers of Attorney For Health Care

In the 1988 opinion, we concluded that "a medical durable power of attorney is a legally effective instrument" for advance decisionmaking. 73 *Opinions of the Attorney General* at 184. The heart of a durable power of attorney for health care is the naming of an agent to make health care decisions on behalf of the principal, typically in the event of the principal's disability.[6]

A durable power of attorney for health care is a very flexible instrument and can be tailored to the individual's wishes. It can be used to empower the agent to make decisions in any medical circumstance covered by the durable power. That is, it is not necessarily limited to terminal illness or permanent unconsciousness. It can delegate authority about any treatment choice that the principal could make personally. *See In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1230-31 (1985).

Although a principal may choose simply to make a delegation of decisionmaking power to the agent, the principal can also assist the agent by including in the durable power instructions outlining the circumstances under which life-sustaining treatment is to be used or

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[5](...continued)
This reading of the Illinois law is at best questionable. *See* 1990 Ill. LEXIS 82, at 37-38 (Ward, J., dissenting). A comparable construction of Maryland's law would be untenable, for the law expressly limits the applicability of a living will to conditions that lead to imminent death "despite the application of life-sustaining procedures ...." HG §5-601(g).

[6] Although a durable power of attorney that immediately vests decisionmaking power in the agent is legally effective, most durable powers of attorney for health care are drafted so that the power becomes effective only upon the principal's disability (a so-called "springing" power of attorney). The durable power form drafted by the Health Law Section of the Maryland State Bar Association and available from this office is of this type.

forgone. If a durable power merely delegates decisionmaking authority, a leading commentator has pointed out, the agent "lacks any formal guidance from the [principal] as to the [principal's] actual wishes about treatment." If the principal includes instructions, however, the agent's "discretion can be guided in such a way that it is the [principal's] will that is being applied ...." A. Meisel, *The Right to Die* §10.5 at 322 (1989) ("*Right to Die*"). *See In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).

The concurring opinion of Justice O'Connor and the dissenting opinions in *Cruzan* together indicate the view of a majority of Justices that the use of a durable power of attorney for health care, either as a general delegation of authority to an agent alone or in combination with a statement of the principal's decisions, is constitutionally protected. *See* Part IC and E above.

C. Prior Instructions to Physician

In the 1988 opinion, we advised that "[t]he 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." 73 *Opinions of the Attorney General* at 185. Apart from the *Cruzan* decision's recognition of the constitutional right to refuse life-sustaining treatment, *Cruzan* does not affect our conclusion in this regard.

In our prior discussion of this method of decisionmaking, we supposed that it would ordinarily occur in a discussion between doctor and patient, with the patient's oral decisions recorded by the doctor in the patient's chart. Nothing in the 1988 opinion was meant to suggest that the patient might not state his or her decisions about future treatment options in a writing that the doctor would incorporate into the medical records.[7]

[7] Persons who execute a living will or durable power of attorney for health care should consider forwarding a copy of that document for inclusion in their medical records.

D. Informal Writings

Delegate Pitkin asked whether a simple written statement of a person's decision to forgo life-sustaining treatment is the legal equivalent of a statutory living will or durable power of attorney for health care. We are doubtful whether an informal writing (apart from those incorporated into the patient's medical record, discussed in Part IIIC above) would achieve the same result as these more formal documents.

One out-of-state case has held that an individually drafted "mercy will and last testament" could be given effect without court approval to permit the removal of a respirator from a comatose and terminally ill patient. *John F. Kennedy Hospital v. Bludworth*, 452 So. 2d 921, 922 (Fla. 1984). The *Bludworth* case has little bearing on the present situation in Maryland, however, for the Maryland General Assembly has specifically addressed the matter of written advance decisionmaking, by enacting the Living Will Law and by giving express recognition to the validity of durable powers of attorney for health care. *See* 73 *Opinions of the Attorney General* at 180-85. Under these circumstances, we doubt whether a writing not executed with the formalities of these documents would be given equivalent legal effect. *See Saunders v. State*, 492 N.Y.S.2d 510, 516 (Sup. Ct. 1985).

At the same time, an informal writing undoubtedly is "relevant evidence of the patient's intent." *In re Conroy*, 486 A.2d at 1229 n.5. The "existence of a writing suggests the author's seriousness of purpose." *In re O'Connor*, 72 N.Y.2d 517, 531 N.E. 2d 607, 613 (1988). Thus, when a court or the patient's family considers a decision about life-sustaining treatment, the decisionmaker would certainly take any writing into account in applying the "substituted judgment" standard for surrogate decisionmaking – that is, when the decisionmaker endeavors to make the decision that the disabled person would make if able to do so. *See* 73 *Opinions of the Attorney General* at 186-87.[8]

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[8] The two principles of surrogate decisionmaking discussed in our 1988 opinion were "substituted judgment" and "best interest," nicely summarized by a commentator as follows: "The essential distinction between the two is that

(continued...)

IV

Surrogate Decisionmaking

A. Family Decisionmaking

Our 1988 opinion considered the standards and procedures for decisionmaking when a person had not engaged in any form of direct decisionmaking (including the naming of an attorney in fact under a durable power of attorney for health care), was unable to make treatment decisions when a decision about life sustaining treatment needed to be made, and was terminally ill. In brief, we identified a form of family decisionmaking recognized in many cases from outside Maryland that we believed the courts of this State would also recognize.

We advised that "a close family member may decide that artificially administered sustenance [or any other form of life-sustaining treatment] 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;
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> (ii) The attending physicians agree that forgoing treatment is medically proper;
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> (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;
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> (iv) No other family member disagrees with the decision; and

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[8](...continued)
under the best interests standard the surrogate is to do what is best for the patient in the surrogate's own judgment, whereas under the substituted judgment standard the surrogate is to attempt to replicate what the patient would have decided if competent to do so." *Right to Die* §9-10, at 270.

> (v) When applicable, the hospital's patient care advisory committee has not advised against forgoing treatment.

73 *Opinions of the Attorney General* at 164, 165 and 196-99.

Because *Cruzan* did *not* involve a terminally ill person, neither the holding nor the reasoning of that case calls this conclusion into question. *Cruzan* held that the Constitution does not require a state to vest decisionmaking power in the family of a permanently unconscious patient who is not terminally ill. *Cruzan* is not inconsistent with our conclusion that, if treatment would merely prolong the dying process of a terminally ill patient, Maryland courts would recognize the common law right of family members to decline treatment on the patient's behalf. "Our common human experience teaches us that family members ... care most and best for a patient ... [and] have the best interests of the patient at heart. The importance of the family in medical treatment decisions is axiomatic." *In re Farrell*, 108 N.J. 335, 529 A.2d 404, 414 (1987).

At the same time, our 1988 opinion declined to extend this conclusion about family decisionmaking beyond those who were terminally ill. We expressed "serious reservations about the reasoning of decisions that allowed families to decide, without court approval, to end artificially administered sustenance for a patient whose death might otherwise be averted indefinitely." 73 *Opinions of the Attorney General* at 200.[9] At bottom, our concern was that the state's interest in the preservation of life mandated greater procedural safeguards when the patient was "neither on the verge of death nor suffering ...." 73 *Opinions of the Attorney General* at 201. As we put it, "[u]ndoubtedly, 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." 73 *Opinions of the Attorney General* at 200.

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[9] We were not referring "to a family member who is empowered to act under the patient's medical durable power of attorney." 73 *Opinions of the Attorney General at 200* n.59.

In *Cruzan*, the Supreme Court expressed a similar concern in rejecting the argument that the family had a constitutional right to assert its "`substituted judgment' ... even in the absence of substantial proof that their views reflect the views of the patient." 110 S.Ct. at 2855. The Court wrote: "Close family members may have a strong feeling–a feeling not at all ignoble or unworthy, but not entirely disinterested, either–that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." 110 S.Ct. at 2855-56.

Thus, we reaffirm our conclusion that, until the Court of Appeals or the General Assembly determines otherwise, "a family 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)." 73 *Opinions of the Attorney General* at 201.

B. Guardianship

One noteworthy change in the law regarding guardianship occurred not as a result of *Cruzan* but in recently enacted legislation. In our 1988 opinion, we concluded that a guardian of the person who sought to direct the withholding or withdrawal of artificially administered sustenance or any other life-sustaining treatment was required to petition the guardianship court for authorization. 73 *Opinions of the Attorney General* at 192. The opinion reflected the view that the court had the power, applying the "substituted judgment" and "best interest" decisional standards discussed at length in that opinion, to approve such a request.

This conclusion was called into question in litigation culminating in a decision by the Court of Appeals, *In re Riddlemoser*, 317 Md. 496, 564 A.2d 812 (1989). In this case, the guardianship court had declined to approve a guardian's request that a "do not resuscitate"

order be entered for an unconscious, terminally ill patient.[10] The trial judge "indicat[ed] his belief that he lacked authority to issue the order." 317 Md. at 501. Because the patient had died before the appeal could be heard, the Court of Appeals dismissed the appeal on mootness grounds. In so doing, the Court left open the question of whether §13-708(b)(8) of the Estates and Trust Article ("ET" Article) "should be interpreted to invest the [guardianship] court with authority to order the cessation of life-sustaining treatment ...." 317 Md. at 505. The Court described this question as "one of interpretation which, arguably, may not be free of conflicting views." 317 Md. at 504. The Court by implication, and Judge Adkins expressly, invited "the legislature to eliminate the ambiguity ...." 317 Md. at 506 (Adkins, J., concurring).

The General Assembly did so at its next session by enacting Chapter 709 (Senate Bill 735) of the Laws of Maryland 1990, "Guardians–Disabled Persons–Medical Treatment." As amended by this statute, ET §13-708(b)(8) now expressly empowers a guardian to approve the "withholding" or "withdrawing" of "medical or other professional care, counsel, treatment or service." However, "where a medical procedure involves, or would involve, a substantial risk to the life of disabled person," the guardianship court must itself "authorize a guardian's consent or approval for" a procedure, the withholding of a procedure, or the withdrawing of a procedure. ET §13-708(c).

The language "authorize a guardian's consent or approval for" the forgoing of life-sustaining treatment is somewhat ambiguous in one respect. Arguably it could be taken to mean that the court could in advance generally "authorize" a guardian to make this kind of decision without further court approval when the need for an actual decision later arose.

Given the background of the legislation, however, we do not believe that such a construction comports with the legislative objective. The General Assembly was seeking to confirm the guardianship court's authority as it had been previously construed, not to broaden the guardian's authority to decide about life-sustaining

[10] A "do not resuscitate" order or "no-code" is an instruction that cardipulmonary resuscitation not be undertaken if a patient suffers cardiac arrest. *See* 317 Md. at 501 n.2.

treatment independently. Hence, we conclude that the authorization called for by ET §13-708(c) is an authorization of a specific recommendation by the guardian, enabling the court to assess the circumstances at the time that the decision needs to be made.

V

Standard of Proof

A. Introduction

The "burden" or "standard of proof," in the sense relevant here, is "the burden of persuading the trier of fact that the alleged fact is true." Cleary, *McCormick on Evidence* §336, at 947 (3d ed. 1984). The "alleged fact" that a surrogate acting under the "substituted judgment" standard advances is that the now-disabled patient would choose to forgo life-sustaining treatment if he or she were able to make a decision. *See* 73 *Opinions of the Attorney General* at 186, 187.[11]

As the reference to "trier of fact" implies, the very concept of "burden of proof" applies only in a judicial or quasi-judicial forum, when a party is attempting to persuade a judge or juror to reach a desired decision. A formal standard of proof is not applicable to nonjudicial decisionmakers–an agent acting under a durable power of attorney for health care or a family member acting on behalf of a terminally ill patient, for whom a standard of proof would not be meaningful. Decisionmaking of this kind, although subject to the substantive standards of "substituted judgment" and (if applicable) "best interest," does not usually require identification of a standard of proof: "When [decisionmaking] occurs in the health care institution, [the standard of proof] is likely to be a latent issue because nonlegal decisionmakers are less accustomed to thinking in such terms." *Right to Die* §8.38, at 254. To be sure, the decisionmaker must be convinced that the decision is what the patient would want or, for a terminally ill

[11] Other facts – related to the patient's diagnosis and capacity, for example – are also decided in relation to a standard of proof. *See, e.g. In re Jobes*, 108 N.J. 394, 529 A.2d 434, 441 (1987) (requiring "clear and convincing medical evidence" of persistent vegetative state).

patient, is in the patient's best interest; but outside a judicial forum, there is no need for the decisionmaker to use the rubric of a standard of proof in coming to a decision. *See In re Peter*, 529 A.2d at 425.

B. Choice of Standard

"According to the customary formulas a party who has the burden of persuasion of a fact must prove it in criminal prosecutions `beyond a reasonable doubt," in certain exceptional controversies in civil cases, `by clear, strong and convincing evidence,' but on the general run of issues in civil cases `by a preponderance of the evidence.'" *McCormick on Evidence* §339, at 956 (citations omitted). These three levels of stringency are said to be "equivalent to statements that the trier must find that the fact is (a) almost certainly true, (b) highly probably true, and (c) probably true." *Id*. at 956 n.4.

The 1990 amendment to the guardianship statute did not set out any evidentiary standard for decisionmaking by the court. In our 1988 opinion, we observed that "[t]he best proof of a patient's wishes [is] the patient's own previous expressions." 73 *Opinions of the Attorney General* at 187. We then gave an example, drawn from the cases, of the factors to be considered, but we wrote that "[t]he caselaw does not permit us to generalize about an evidentiary standard." 73 *Opinions of the Attorney General* at 187 n.34.

In *Cruzan*, the determinative question involved the burden of proof. As discussed in Part I above, the Missouri Supreme Court required clear and convincing evidence of Nancy Cruzan's wish to forgo artificially supplied food and water and held that the conversations offered as evidence of her wishes failed to meet this standard. The Supreme Court, in turn, held that Missouri did not violate Nancy Cruzan's constitutional right by imposing this standard of proof, more stringent than that in most civil proceedings.

To be sure, the Supreme Court did not *require* the clear and convincing evidence standard; the Court merely held that Missouri was constitutionally permitted to adopt that standard. Other states are free to choose this or a different standard, or indeed to fashion procedures

that do not invoke traditional legal formalities like an identified standard of proof.[12]

However, the Missouri court's choice of an evidentiary standard in *Cruzan* does reflect a growing body of caselaw recognizing clear and convincing evidence as the standard for determining what the now-disabled person would want done under the circumstances. In *In re O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607 (1988), for instance, the New York Court of Appeals approved an order to insert a feeding tube into a severely debilitated 77 year old stroke victim over the objection of the patient's family. Clear and convincing evidence of the patient's intent to decline treatment was required, the New York court wrote, "because if an error occurs it should be made on the side of life." 531 N.E.2d at 613. "Viewed in that light," the court continued, "the `clear and convincing' evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented." *Id*.[13] The New York court found the patient's statements to have been too general and casual to "demonstrate a seriousness of purpose necessary to satisfy the `clear and convincing evidence' standard." 531 N.E.2d at 614.

Two other recent cases, involving withdrawal of artificially administered sustenance from permanently unconscious patients, also

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[12] As Justice O'Connor observed, the Court's decision does not "prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment.... [N]o national consensus has emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the `laboratory' of the States ... in the first instance." 110 S.Ct. at 2858-59 (citation omitted).

[13] The court pointed out, however, that it did not mean to suggest "that, to be effective, a patient's expressed desire to decline treatment must specify a precise condition and a particular treatment. We recognize that human beings are not capable of foreseeing either their own medical condition or advances in medical technology." The relevant question is "whether the infirmities [that the patient] was concerned with and the procedures she eschewed are qualitatively different than those now presented." 531 N.E.2d at 614. *See also In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1230 (1985).

invoked the "clear and convincing evidence" standard. *In re Estate of Longeway*, 133 Ill. 2d 33, 549 N.E.2d 292, 300 (1989); *McConnell v. Beverly Enterprises*, 559 A.2d at 605. So have a number of earlier cases. *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 691 (1987); *In re Gardner*, 534 A.2d 947, 953 (Me. 1987); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809, 815 (1980); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 750 (1983). Professor Meisel concluded last year: "The predominant standard is clear and convincing evidence." *Right to Die* §8.38, at 254. *See also* N. Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 376 (1988) (clear and convincing evidence is "the typical legal requirement").

We think it likely that the Maryland Court of Appeals would also choose the clear and convincing evidence standard. As the Supreme Court observed, "An erroneous decision to withdraw life-sustaining treatment ... is not susceptible of correction." 100 S.Ct. at 2854. Moreover, the Court of Appeals' decision in *Riddlemoser*, while not directly on point, does reflect an overall cautiousness in this area. *See* J. C. Byrnes, *A "Macro" View of the Law of Life Support Withdrawal*, The Barrister, Summer 1990, at 9, 12. In short, we have no reason to think that the Court of Appeals would not adopt the predominant clear and convincing evidence test for judicial decisions approving the withholding or withdrawal of life-sustaining treatment.

C. Nature of "Clear and Convincing Evidence"

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

Applied to the question of substituted judgment when a decision about life-sustaining treatment must be made, this standard calls for a careful assessment of the quality of the evidence. "The probative value

of prior statements will vary, depending on the age and maturity of the incompetent patient, the context of the statements, and the connection of the statements to the debilitating event." *In re Grant*, 109 Wash. 2d 945, 747 P.2d 445, 457 (1987).

The clear and convincing evidence standard seeks to assure that a decision will not be made if "`the evidence is loose, equivocal or contradictory' ...." *In re Storar and Eichner*, 52 N.Y. 2d 363, 420 N.E.2d 64, 72 (1981). As the New Jersey Supreme Court wrote, "an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances." *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1230 (1985).

On the other hand, the clear and convincing evidence standard can be satisfied through testimony that a mature person had thought about the issue of life-sustaining treatment and had expressed his or her desires "forcefully and without wavering," corroborated by testimony that the decision to forgo treatment reflected that person's values. *McConnell v. Beverly Enterprises*, 553 A.2d at 604-05. *See also, e.g., In re Severns*, 425 A.2d 156, 158 (Del. Ch. 1980); *In re Gardner*, 534 A.2d at 953; *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626, 631-32 (1986); *In re Peter*, 108 N.J. 365, 529 A.2d 419, 426-27 (1987); *In re Conroy*, 486 A.2d at 1230; *In re Storar and Eichner*, 420 N.E.2d at 72.

A writing is not required. "Despite the obvious evidentiary advantages of written advance directives, courts have only infrequently been reluctant to enforce oral directives because to require `a written expression in every case would be unrealistic ... [and] would unfairly penalize those who lack the skills to place their feelings in writing.'" *Right to Die* §10.11, at 328-29 (quoting *In re O'Connor*, 531 N.E.2d at 614). As another commentator points out, "The best evidence available may consist of conversations with family, friends, and physicians." K. Rothenberg, *[Forgoing] Life-Sustaining Treatment: What Are the Legal Limits in an Aging Society?*, 33 St. Louis U. L.J. 575, 589 (1989).

VI

Physician's Role in Decisionmaking

Delegate Pitkin also asked about the decisionmaking role of physicians when a decision about life-sustaining treatment must be made.

As in other situations invoking principles of informed consent, the physician's main responsibility is "to provide [the] patien[t] with sufficient information to permit the patient himself to make an informed and intelligent decision ...." W. Keeton, D. Cobbs, R. Keeton, & D. Owen, *Prosser & Keeton on the Law of Torts* §32, at 190 (1984). *See generally Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977). As a presidential commission summarized:

> The extent of the obligation of providers to inform patients so that they can make sound choices is no different for life-sustaining treatment than for any other .... [H]ealth professionals should ensure that patients understand (1) their current medical status, including its likely course if no treatment is pursued; (2) the interventions that might be helpful to the patient, including a description of the procedures involved and the likelihood and effect of associated risks and benefits; and (3) in most cases, a professional opinion as to the best alternative.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to [Forgo] Life-Sustaining Treatment* 51-52 (1983).

Except in an emergency, a physician may not impose unconsented treatment on a patient. *Sard v. Hardy*, 281 Md. at 439. Medical treatment imposed without any consent whatever traditionally has been viewed as battery. F. Rozovsky, *Consent to Treatment* §1.2, at 7 (2d ed. 1990). If treatment is performed with consent, but the consent was given on the basis of inadequate information, the cause of action is for negligence. D. Meyers, *Medico-Legal Implications of Death and Dying* §5:2, at 63 (1980).

Under the modern doctrine of informed consent, approved by the Court of Appeals in *Sard v. Hardy*, the physician explains the range of medically reasonable choices and usually provides a recommendation, but "[m]edical choice increasingly depends on factors that transcend professional training and knowledge. As medicine has become able to extend life [and] delay and redefine death, ... questions about values have come to the fore in medical decisionmaking. Health care choices involve profound questions that are not finally referable to professional expertise." M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L.J. 219, 222 (1985).

If a competent patient makes an informed and voluntary decision to forgo life-sustaining treatment, ordinarily the physician would have no legal basis on which to impose the treatment in the face of the patient's decision. *See In re Farrell*, 108 N.J. 335, 529 A.2d 404, 413 (1987); 73 *Opinions of the Attorney General* at 170.[14] *See also State v. McAfee*, 259 Ga. 579, 385 S.E.2d 652 (1989).

As a commentator summarized the point: "[W]ithin broad limits it is the patient's right to make `mistakes' about what is best. Indeed, what is best for a patient, both ethically and legally, is defined as what the patient subjectively believes is best and therefore, by definition, is not a `mistake.' Thus, ... physicians must tolerate patients' decisions that the physicians believe are not best for the patient from a medical perspective." *Right to Die* §2.3, at 20.

The physician's role is the same if the decision in question was made in advance by the patient in a living will or durable power of attorney for health care or is made by the agent whom the patient has designated in a durable power of attorney. Assuming that the decision about life-sustaining treatment falls within the range of medically reasonable alternatives, as determined by the physician, the decision of which alternative to choose is the patient's, as expressed in an advance directive or as delegated to the patient's agent. The Living Will Law provides that the physician is to "implement the declaration" of a qualified patient. *See* HG §5-604(a)(2). Even in other situations

[14] If the physician believes that a countervailing interest like the protection of dependents should cause the patient's choice to be overridden, the physician should take steps to bring the matter to court.

not so specifically addressed, we see no legal basis on which a physician may impose a decision contrary to that of the legally recognized decisionmaker.[15]

If a patient is disabled and has neither decided about the use of life-sustaining measures in an advance directive nor designated an agent to do so, a decision to forgo treatment may be made either by a guardian with court approval or by the patient's family if the patient is terminally ill. 73 *Opinions of the Attorney General at* 190-92 and 196-201. The physician's role is to identify the medically reasonable alternatives and the consequences of each and to offer a recommendation, but again final decisionmaking authority does not reside with the physician.

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[15] If the physician's own values preclude his or her carrying out the patient's (or agent's) decision, the physician must transfer the patient to another physician. HG §5-604(b). *See In re Grant*, 747 P.2d at 456 n.6. *Cf. Doe v. Mundy*, 378 F. Supp. 731, 736 (E.D. Wis. 1974).

We note that the General Assembly recently enacted a provision specifying that a hospital or nursing home may not be held liable for "failing to carry out the advice of [a patient care] advisory committee concerning a patient's medical care if the advice given is inconsistent with the [institution's] written policies ...." HG §19-374(f), enacted in Chapter 545 (House Bill 191) of the Laws of Maryland 1990. This provision eliminates the institution's risk of liability premised on the theory that failure to adhere to the advisory committee's recommendation manifests a lack of due care. *See Right to Die* §15.22, at 505. However, given the narrow language of the provision; the narrow wording of the pertinent portion of the bill's title; and the General Assembly's failure to amend HG §19-344(f)(1)(ii), which grants to each resident of a nursing home the right to "refuse medication or treatment," we do not regard this immunity provision as diminishing the informed consent rights of patients in hospitals and nursing homes. *See* 73 *Opinions of the Attorney General* at 202-06.

VII

Conclusion

In summary, the Supreme Court's decision in *Cruzan* has not changed the basic conclusions that we reached in our 1988 opinion about the forgoing of life-sustaining treatment, including artificially administered food and water.

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Editor's Note:

Maryland law on the topics addressed by this opinion has been clarified significantly in the Health Care Decisions Act, Chapter 372 (House Bill 1243) of the Laws of Maryland 1993.