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Mr. Gary D. Raffel
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Dear Mr. Raffel:

I am writing in belated response to your letter of June 17, 2003, in which you pose several questions about surrogate decision making under the Health Care Decisions Act ("HCDA"). I apologize for the delay. Your questions and my responses are as follows:

1. "Does the HCDA permit a surrogate to make general health care decisions for a resident (i.e., those decisions that *do not* involve significant issues such as the withholding or withdrawing of life-sustaining procedures), if there are no physician certifications?" The question refers to the physician certification as to the resident's incapacity. You point out that, when an individual is admitted to a long-term care facility and is patently unable to make decisions personally, a surrogate is commonly asked to make certain decisions related to the resident's health care (for example, choosing a physician and indicating a preferred hospital). Yet, as you put it, "residents are not routinely subject to a competency examination upon admission."

The HCDA's provision on surrogate decision making grants authority to a surrogate to "make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent ...." § 5-605(a)(2) of the Health-General Article. The next section, on certifications, provides as follows: "Prior to providing, withholding or withdrawing treatment for which authorization has been obtained or will be sought under [the HCDA], the attending physician and a second physician ... shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination

of the patient." § 5-606(a)(1).[1] The term "incapable of making an informed decision" is defined in relevant part as "the inability of an adult patient to make an informed decision about the provision, withholding, or withdrawal of *a specific medical treatment or course of treatment* ...." § 5-601(l)(1) (emphasis added).

Reading these provisions as an integrated whole, I conclude that the HCDA's surrogate decision making process comes into play only when a decision is needed about a specific treatment or specific course of treatment (whether or not involving life-sustaining procedures).[2] In these circumstances, the question is whether the resident has the capacity to make an informed consent decision about the specific treatment. If not, the resident's incapacity should be documented in the physicians' certification of incapacity. Other preferences at admission, like choice of providers, are not the kind of specific treatment decisions that invoke the procedures for HCDA surrogate decision making.

2. "Should nursing homes conduct competency reviews on every resident at the time of admission, so as to avoid disputes regarding a surrogate's right to make health care decisions?" You express the concern that such a practice would not take into account improvements in cognitive capacity. "An example is a resident who is transferred from an acute care hospital to a nursing home and who may be disoriented at the time of admission, but who adjusts within a short time. In this type of case it would seem unfair for a physician to certify that a resident is incapable of making his own decisions."

As my response to your first question implies, I see no legal requirement for formal capacity assessments for all incoming residents.[3] The point that you make about fluctuations in capacity is valid. Indeed, the HCDA's emphasis on capacity as related to a specific treatment decision not only accommodates this concern but also recognizes the possibility that, at any given time, a resident may have capacity to make a relatively straightforward treatment decision but not another, more complicated one.

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[1] If a patient is unconscious or unable to communicate, the certification of a single physician suffices. § 5-606(a)(2).

[2] The phrase "course of treatment" refers to a specific, planned series of treatments (for example, rounds of chemotherapy). For brevity's sake, I shall henceforth refer only to a treatment, not to a course of treatment, but the analysis is the same.

[3] Given the HCDA's focus on a patient's ability to make informed consent decisions about specific treatment options, the preferable terminology is the more medically oriented "capacity" assessment, rather than the legally oriented "competency" assessment.

3. "Can a surrogate complete an advance directive for a resident prior to obtaining physician certifications regarding incapacity?" Your specific example is whether a surrogate could decide about attempted cardiopulmonary resuscitation before the resident's incapacity was certified.

My answer must begin with a clarification about terminology. "Advance directive" is defined in the HCDA as a written document or oral statement *made by the patient* before loss of capacity. § 5-601(b). Consequently, a surrogate may never, under any circumstances, complete an advance directive for a resident. I take your question, as rephrased, to be whether, prior to certification of a resident's incapacity, a surrogate may agree to a plan of care that includes withholding or withdrawal of life-sustaining procedures, such as CPR.

In my view, whether CPR is to be attempted in the event of an arrest is the kind of specific treatment decision that, if made by a surrogate under the HCDA, requires two certifications: of the resident's incapacity to make the decision personally and of the resident's end-stage or terminal condition in the event of arrest. *See* 79 *Opinions of the Attorney General* 218 (1994). A nursing home should have procedures in place to obtain these certifications promptly.[4] However, if a newly admitted resident has an EMS/DNR order, the facility is free to honor the order without certifications. § 5-608(a)(3).

I hope that this letter of advice is fully responsive to your questions. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development

[4] In a recent letter of advice, I concluded that, if the physicians have in fact determined that a patient is in one of the qualifying conditions but have not yet documented their findings in a signed certification, an interim certification suffices for HCDA purposes. Letter to Patricia Younger (January 15, 2003), available at http://www.oag.state.md.us/Healthpol/surrogates.pdf. The same is true of determinations about a patient's incapacity.