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Dear Anita:

You have presented an issue about the scope of a surrogate's authority to consent to a DNR order when the patient has an advance directive giving certain instructions. The specific case is as follows: A nursing home resident has been certified to be in an end-stage condition resulting from advanced Alzheimer's disease. The resident has a "living will" type of instructional advance directive which stated that, if she were in a terminal condition, she wanted comfort measures to facilitate a "natural" death and did not want CPR attempts, ventilator support, or artificial feedings. Her advance directive did not contain instructions about the use of life-sustaining medical treatments in the event of end-stage condition. The question is whether the resident's surrogate may consent to a DNR order.

In my view, for the reasons explained below, the surrogate has authority under the Health Care Decisions Act to consent to the DNR order if the surrogate concludes that entry of a DNR order is what the patient would have wished or, if the surrogate is unable to base a decision on the patient's wishes, is in the patient's best interest.

I

Binding Effect of Directly Applicable Advance Directive

A surrogate is obliged to follow the wishes of the patient, if they are known. § 5-605(c)(1) of the Health-General Article. Thus, the Health Care Decisions Act incorporates,

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as the primary decision making model for surrogates, what is often called the “substituted judgment” approach. *See Mack v. Mack*, 329 Md. 188 (1993). Out of respect for the self-determination rights of the now-incapacitated patient, the surrogate seeks to discern the decision that the patient would make, were he or she able to do so. If the surrogate is unable to make a decision based on a sense of what the patient would do, then the decision making standard becomes “the patient’s best interest.”

In thinking about what the patient would want done under the circumstances, the surrogate is to consider a variety of factors identified in the Health Care Decisions Act, only one of which is the patient’s “expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments.” § 5-605(c)(2). Others include the patient’s beliefs, values, and past experiences. Nevertheless, in my view, not all “expressed preferences” are the same. There is an important difference between the weight to be given an informal expression of preferences, as in a conversation occasioned by a personal or public event, and the weight to be given the expression of preferences in an advance directive.

In the case of informal expressions, a surrogate should give them the weight that corresponds to their force and clarity, but a surrogate can rightly view such remarks in a broader context, as a piece of a mosaic that includes other important pieces, like the patient’s religious and moral beliefs. It is from the whole mosaic that the surrogate should seek to discern what the patient would want done.

In the case of an advance directive, however, the surrogate is not free to decide how much weight to give to the document’s instructions about life-sustaining medical treatment. If the prerequisites specified in the Health Care Decisions Act are satisfied, and if an instruction in an advance directive is applicable to the clinical situation, the instructions are conclusive. The Act’s grant of authority to make an advance directive (§ 5-602(a)), its signature and witness requirements (§ 5-602(c)), the wording of the optional forms (§ 5-603), its detailed provisions on revocation (§ 5-604), its requirements for physician certification (§ 5-606), its criminal penalties for certain acts that sabotage the proper carrying out of an advance directive (§ 5-610) – all of these would be drained of their import if a surrogate were free to disregard an advance directive or deem it to be of no more weight than a conversational remark. Consequently, a properly executed advance directive giving contingent care instructions (for example, “If I’m in a terminal condition, then I want ... and don’t want ...”) is binding on a surrogate when the contingency is certified to have occurred.

Hence, if the patient in the case you presented were certified to be in terminal condition, rather than in end-stage condition, the surrogate would be obliged to consent to a DNR order, in furtherance of the advance directive. But in the actual case, as explained below, the surrogate is under no obligation arising from the advance directive and is free to consider it, along with other factors, in coming to a decision.

II

Surrogate Authority When an Advance Directive Is Inapplicable

A surrogate may authorize the withholding or withdrawal of life-sustaining procedures if the patient has been certified to be in terminal or end-stage condition or persistent vegetative state. § 5-606(b). If the patient is certified to be in one of these conditions but the patient's advance directive does not address the use of life-sustaining procedures in this condition, the surrogate may decide on the basis of the inferred wishes of the patient. In making that inference, the surrogate is free to give whatever weight to the advance directive the surrogate considers appropriate.

In the case that you present, the patient has a living will type of advance directive, drafted so that it only contains a refusal of CPR (and other life-sustaining procedures) in the event of terminal condition. The patient is certified to be in end-stage, not terminal, condition. Plainly, the living will is not directly applicable. It does not control the decision nor supplant the surrogate's discretion, including discretion to decide how the advance directive should figure in the decision, if at all. That is, the surrogate has discretion to consider that the living will, although framed in terms of terminal condition, reflects values that apply in the current clinical context. Or perhaps the patient's decision not to address end-stage condition meant that she was more cautious and would want CPR attempted. Or perhaps the patient simply wanted to leave decisions about CPR in the event of end-stage condition to the discretion of the surrogate. Any of these interpretations is plausible, and the surrogate may adopt whichever one the surrogate considers to fit best with the overall values and preferences of the patient. If the surrogate is unable to decide whether the patient would have wanted CPR attempted under these clinical circumstances, then the surrogate should decide whether attempted CPR is in the best interest of the patient.

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I hope that this letter of advice, although not to be considered an opinion of the Attorney General, is fully responsive to your request. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development