View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by The Catholic University of America Columbus School of Law

Journal of Contemporary Health Law & Policy (1985-2015)

Volume 5 | Issue 1 Article 19

1989

Euthanasia in Maryland: The Right to Die With Dignity?

Michael L. Dailey

Follow this and additional works at: https://scholarship.law.edu/jchlp

Recommended Citation

Michael L. Dailey, *Euthanasia in Maryland: The Right to Die With Dignity?*, 5 J. Contemp. Health L. & Pol'y 297 (1989).
Available at: https://scholarship.law.edu/jchlp/vol5/iss1/19

This Comment is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

ADMINISTRATIVE COMMENT

EUTHANASIA IN MARYLAND: THE RIGHT TO DIE WITH DIGNITY?

I. INTRODUCTION

The State of Maryland, generally known for conservative health law legislation, recently has interpreted its laws governing medical care of the terminally ill and permanently unconscious in a manner that places it among the most liberal states in the area of medical treatment decisionmaking. On October 17, 1988, the Maryland Attorney General's office released an analysis of the effect of the Maryland "Living Will"[1] and substituted judgment laws[2] upon the administering of artificial sustenance ("AAS"), *i.e.*, tubal or intravenous feeding of nutrition and hydration,[3] to terminally ill and permanently unconscious patients.[4] The Attorney General's opinion is intended to guide terminally ill patients, and surrogate decisionmakers of terminally ill and permanently unconscious patients with respect to the legal implications and requirements of a decision to withhold artificial sustenance.

---

1. MD. HEALTH-GEN CODE ANN. §§ 5-601-614 (1987).

2. *See* MD. EST. & TRUSTS CODE ANN. § 13-601 (1973), which allows a person to execute a document naming an attorney-in-fact to make substituted decisions in the event the grantor becomes incapable of making legally binding decisions. *See also* 73 Op. Att'y Gen. 88-046 (Oct. 17, 1988) [hereinafter Att'y Gen. Op.] where the Maryland Attorney general interpreted MD. HEALTH-GEN CODE ANN. § 20-107(d) (1987) as implicitly granting one the right to use a durable power of attorney for medical treatment decisions in the event he becomes incapacitated.

3. Both the Maryland laws discussed herein and the Attorney General's opinion pertain to patients who require artificially administered sustenance (hereinafter AAS) for physical or psychological reasons. The pertinent artificial sustenance includes "enteral" (*i.e.*, tubal) and "parenteral" (*i.e.*, intravenous) feeding. *See* Att'y Gen. Op., *supra* note 2, at 6 (citing THE HASTINGS CENTER, *Guidelines On The Termination Of Life-Sustaining Treatment And The Care Of The Dying*, 140 (1987)) [hereinafter HASTINGS CENTER GUIDELINES]. These statutes also govern the withholding of other types of medical procedures, such as orders to withhold cardio pulmonary resuscitation from a patient. *See also* MD. HEALTH-GEN. CODE ANN. § 5-601(e) (1987) (governing do not resuscitate orders) [hereinafter DNR orders]; MD. HEALTH-GEN. CODE ANN. § 20-107 (1987) (DNR orders can be requested by a family member on behalf of a patient in the same manner that an AAS withholding or withdrawing request is made). For a general discussion of do not resuscitate orders, see Legislative Comment, *Do Not Resuscitate Orders: A Matter of Life and Death In New York*, 4 J. CONTEMP. HEALTH L. & POL'Y 449 (1988).

4. Att'y Gen. Op., *supra* note 2, at 1.

This Comment begins with a summary of the Maryland Attorney General's opinion. Next, the Comment analyzes the Attorney General's opinion in terms of its impact upon euthanasic decisionmaking[5] and addresses inherent quandaries in the Maryland statutory and common law and the Attorney General's interpretation of the law. Finally, the Comment concludes that there are procedural safeguards which may need to be implemented to protect both terminally ill and permanently unconscious patients in Maryland from abusive medical treatment decisionmaking.

II. SUMMARY OF THE MARYLAND ATTORNEY GENERAL'S OPINION

As of February 1, 1987, two states had enacted "Living Will" laws,[6] and ten states had enacted both "Living Will" and Durable Power of Attorney laws.[7] In 1987, Maryland joined these twelve states by adding a "Living Will" law to its existing Durable Power of Attorney law. Thereafter, the Maryland Office on Aging requested a clarification of these two laws as they relate to AAS refusal decisions. The result was the Attorney General's October 17, 1988 opinion, which was directed at clarifying the legal ambiguities surrounding euthanasic decisionmaking by or on behalf of all patient groups in Maryland.[8]

The specific Maryland statutory and common law analyzed by the Attorney General govern euthanasic decisionmaking by or on behalf of three types of patients: 1) the terminally ill patient who is conscious and competent to make medical treatment decisions; 2) the terminally ill patient who is conscious but incapable of making legally competent medical treatment decisions; and 3) the permanently unconscious patient.[9] The Attorney General

5. Euthanasia is defined as "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 497 (5th ed. 1979).

6. *See* ALA. CODE §§ 22-8A-1 to 10 (1987 & Supp. 1988); NEV. REV. STAT. §§ 449.540-.690 (1987).

7. *See* CAL. HEALTH & SAFETY §§ 7185-7195 (Deering Supp. 1988); CAL. CIV. §§ 2412.5, 2430-44 (Deering 1985 & Supp. 1989); IDAHO CODE §§ 39-4501-4509 (1985 & Supp. 1988); IDAHO CODE §§ 15-5-501 to -507 (1985 & Supp. 1988); KAN. STAT. ANN. § 65-28, 101 (1983 & Supp. 1988); KAN. STAT. ANN. §§ 58-6 10-617 (1983 & Supp. 1988); MISS. CODE ANN. § 41-41-101 to -121 (Supp. 1988); MISS. CODE ANN. §§ 87-3-13, 87-3-15 (1972 & Supp. 1988); N.M. STAT. ANN. § 24-7-1 to -10 (1987); N.M. STAT. ANN. §§ 45-5-501 to -502 (1987); N.C. GEN. STAT. §§ 90-320-323 (1985); N.C. GEN. STAT. § 32A-8 to -14 (1985); OR. REV. STAT. §§ 97.050-.090 (Supp. 1987); OR. REV. STAT. § 126.407 (Supp. 1987); TEX. REV. STAT. ANN. § 4590h (Vernons 1982 & Supp. 1988); TEX. REV. STAT. ANN. § 36A (Vernons 1980); VA. CODE ANN. §§ 54.1-2981-2982 (1988); VA. CODE ANN. §§ 11-9.1-.2 (1985 & Supp 1988); WASH. REV. CODE ANN. §§ 70.122.010 to .100, .900, .905 (West Supp. 1989); WASH. REV. CODE ANN. § 11.94.010 to .020 (1987).

8. Att'y Gen. Op., *supra* note 2.

9. MD. HEALTH-GEN. CODE ANN. § 5-601(g) (1987) defines a terminal condition as "an

concludes that all three types of patients have a right to forgo artificial sustenance. The Attorney General asserts that this right is grounded in both the United States and Maryland Constitutions, as well as Maryland common law.[10]

No formalities are required for one to make an advanced decision to direct the withholding or withdrawing of certain medical treatment in the event he becomes disabled.[11] To ensure that such a prior decision is honored, one may express his desire to forgo AAS in a living will,[12] or a "medical" dura-

---

incurable condition caused by injury, disease, or illness, which to a reasonable degree of medical certainty makes death imminent, and from which, despite the application of life-sustaining procedures, there may be no recovery."

In defining "imminent," the Maryland General Assembly warned against statutory line drawing and noted that "inevitable" and "imminent" death can only be determined on a case-by-case basis. For guidance, the Attorney General cites neighboring jurisdictions' definitions of imminent death. *See* Att'y Gen. Op., *supra* note 2, at 7-8 (citing State Dep't of Human Serv. v. Northern, 563 S.W.2d 197 (Tenn. App. 1978) (imminent refers to closeness in point of time, and that closeness is a term of many degrees, requiring one to look at each individual case, and the surrounding circumstances); Hazelton v. Powhatan Nursing Home, Inc., 6 Va. Cir. 414, 417 (1986) (imminent death is not limited to death likely to occur within a few hours, but may include a condition likely to lead to death within a few months)).

Maryland law defines "permanently unconscious" as a condition where "all possible components of mental life, . . . including thought, feeling, sensation, desire, emotion and awareness of self or environment [are absent]." Att'y Gen. Op., *supra* note 2, at 8 (citing PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL BEHAVIORAL RESEARCH, *Deciding to Forego Life-Sustaining Treatment* 174, 174-75 (1983)) [hereinafter *President's Commission Report*]. Under this definition, "only vegetative functions and reflexes persist." *President's Commission Report* at 174-75. Consequently, the patient is "alive only in that their basic metabolic functions continue." *Id.* "Permanent unconsciousness," as used in the attorney general's opinion, however, is not the " 'irreversible cessation of all functions of the entire brain, including the brain stem,' " which is the definition for death under MD. HEALTH-GEN. CODE ANN. § 5-202(a)(2) (1987). Att'y Gen. Op., *supra* note 2, at 9 n.6.

The Maryland laws regulating substituted judgment do not allow artificial sustenance decisions to be made on behalf of nonterminal, conscious patients who are legally incompetent to make medical treatment decisions due to disease or conditions such as mental retardation or emotional handicaps. Furthermore, the laws do not cover the ending of life-sustaining treatment for infants. *Id.* at 4.

10. Att'y Gen. Op., *supra* note 2, at 9-19. The Constitutional guarantee stems from U.S. Constitution's "penumbra" based right to privacy which applies to all States via the fourteenth amendment. *See infra* note 28 and accompanying text. Although the first amendment does not expressly provide for a privacy right, many Supreme Court decisions have held that the first amendment does implicitly guarantee such a right. *See* Griswold v. Connecticut, 381 U.S. 479 (1965) (holding that the "penumbra" privacy right flows from several amendments to the United States Constitution, including the First, Fourth, Fifth, Ninth, and Fourteenth, which protect ones right to use contraception); Roe v. Wade, 410 U.S. 113 (1973) (holding that a woman may have the privacy right to abort a fetus, provided the state's interest in protecting life does not outweigh the woman's right to privacy).

11. Att'y Gen. Op, *supra* note 2, at 24-25.

12. MD. HEALTH-GEN. CODE ANN. § 5-602(c) (1987) requires that if one uses a living

ble power of attorney.[13] According to the Attorney General, even if a patient has not documented the decision to forgo AAS, he still retains the constitutional and common law right to self determination in the event he becomes terminally ill or permanently unconscious. Under Maryland law, if a patient is terminally ill and is disabled[14] (*i.e.*, legally unable to make treatment decisions), then a surrogate (court appointed or determined by statute) may be empowered to make an AAS refusal decision on the patient's behalf.[15] Similarly, the decision to withhold or end AAS for a permanently unconscious patient, even if he is not terminally ill, may also be made by a surrogate.[16]

In general, all surrogate decisions to withhold or withdraw AAS made on behalf of permanently unconscious patients require court approval.[17] Decisions by or on behalf of terminally ill patients, however, are subject to a different analysis. Maryland law does not require a competent, terminally ill patient to seek court approval before he can refuse AAS.[18] Court approval is usually required when the decision to withhold or withdraw AAS is made by a surrogate of a terminally ill, disabled patient. The legal status of the surrogate and the factual context in which the decision is made are analyzed to determine if the court must be petitioned.[19]

For example, under Maryland law legal guardians have superior decision-making power over all other surrogates, including family members of the

---

will to direct the refusal of AAS, he must specifically reference his wish to forgo artificially administered sustenance such as nutrition and hydration, to legally ensure that such treatment will not be administered if he eventually becomes incompetent to make his own medical treatment decisions.

13. MD. EST. & TRUSTS CODE ANN. § 13-601 (1974) allows one to execute a legal instrument to authorize a designated individual to act on his behalf in the event he becomes disabled. According to the Attorney General, MD. HEALTH-GEN CODE ANN. § 20-107(d) (1987) specifically refers to the use of a durable power of attorney relating to medical care, implying that the instrument may be used for medical treatment decisions. Att'y Gen. Op., *supra* note 2, at 23.

14. MD. HEALTH-GEN. CODE ANN. § 20-107(a)(2) (1987) states that a patient is a "disabled individual. . . when . . .[he] lacks sufficient understanding or capacity to make or communicate a responsible decision on health care . . . because of: (i) A physical disability; (ii) Chronic alcoholism; (iii) Drug addiction; (iv) A disease; or (v) A mental disability, including senility."

15. Att'y Gen. Op., *supra* note 2, at 3, 15-17.

16. *Id.*

17. *Id.* at 31, 38 (discussing decisions by family members and decisions by guardians, respectively). Under the Attorney General's analysis, it is unclear whether the analysis applied to surrogate decisions made on behalf of nonterminal, permanently unconscious patients is equally applicable to surrogate decisions made on behalf of terminal, permanently unconscious patients.

18. *Id.* at 9-15.

19. *Id.*

patient.[20] Even with this legal status, court approval is still required before the guardian's decision to withhold or withdraw AAS from a terminally ill, disabled patient is honored. If a family member[21] of a disabled, terminally ill patient made the same decision, however, it would not require court approval, as long as all immediate family members, the physician, and the hospital patient care advisory committee concurred with that decision.[22] Alternatively, if family members are not available, absent a prior request by the patient, a physician cannot make the decision to withhold AAS from a terminal and disabled patient, without first receiving court approval.[23] This may be particulary difficult for Maryland nursing homes which are precluded from acting as a surrogate to either direct the administration or withholding of artificial sustenance from a terminally ill, or permanently unconscious patient.[24]

Two standards guide all decisions by surrogates in Maryland to initiate or withhold medical treatment from a patient. The first is known as the substituted judgment standard. Application of this standard requires the surrogate to base this decision upon his actual knowledge of prior statements or actions by the disabled person which reasonably indicate his treatment philosophies including the course of action that the patient would have chosen under the same circumstances.[25] Alternatively, where the surrogate does not possess any reasonable indication as to the patient's wishes, the surrogate may then substitute his judgment for that of the patient's pursuant to the

---

20. *Id.* at 4.

21. MD. HEALTH-GEN. CODE ANN. § 20-107(d) (1987) states that a patient's spouse has priority over all other family members in the ability to make surrogate decisions on his or her behalf. If the patient does not have a spouse, or the spouse is deemed legally incompetent to make a treatment decision, then the surrogate decision making authority flows as follows (in order of priority): 1) an adult child of the patient, 2) a parent 3) an adult sibling 4) a grandparent or 5) an adult grandchild. *Id.*

22. Att'y Gen. Op., *supra* note 2, at 37-38.

23. *See infra* notes 73-76 and accompanying text.

24. If the disabled, terminally ill or permanently unconscious patient is a resident of a nursing home, and a living will or medical power of attorney authorizes the nursing home to withhold or withdraw AAS, then the patient's request must, in most cases, be honored. Att'y Gen. Op., *supra* note 2, at 41-45. *See* MD. HEALTH-GEN. CODE ANN. § 19-344 (1987). Likewise, a nursing home in Maryland may not discharge or transfer a patient based solely upon the patient's or the surrogate's decision to refuse AAS. Att'y Gen. Op., *supra* note 2, at 43-45. The fact that such a decision conflicts with the nursing home's policies is irrelevant. *Id.* A Maryland hospital, however, may discharge or transfer a patient for such reasons, but only if to do so would not impose an undue burden upon the patient. *Id.* The reasoning behind the statutory distinction in Maryland between a nursing home and a hospital's ability to act in this context is unclear, although high demand for nursing home space in Maryland (which could lead to abusive behavior by the nursing homes) may be the determinative factor. *See generally infra* note 96 and accompanying text.

25. Att'y Gen. Op., *supra* note 2, at 25.

patient's best interest.[26] In making this judgment, the surrogate must weigh several factors listed by the Attorney General, including "the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained."[27]

III. ANALYSIS

This section begins with a discussion of the scope of an individual's right to self-determination in the State of Maryland. The discussion then focuses on the legal standards for a surrogate's decision to withhold or withdraw AAS for two types of patients: 1) the terminal, conscious, but incompetent patient; and 2) the permanently unconscious patient. Lastly, this section reviews the legal instruments available to Maryland residents which allow a patient to direct the course of medical treatment in the event he becomes legally disabled to make his own medical treatment decisions.

A. The Right to Die: Medical Choices

1. Rights of the Competent, Terminally Ill Patient

The Maryland courts recognize and protect the right of each resident "to safeguard the integrity of his or her own body."[28] This right to self-determination exists whether or not a formal document is executed. In theory, the right to self-determination is not an absolute. An individual's decision to refuse treatment may be limited by the State of Maryland's interests in: the preservation of life, the prevention of suicide, the protection of interests of innocent third parties, and the maintenance of ethical integrity of the medi-

26. *Id.*

27. *President's Commission Report*, *supra* note 9, at 135.

28. Att'y Gen. Op., *supra* note 2, at 9 (citing Mercy Hosp., 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)). The attorney general notes that although the Jackson case, cited in support of the proposition that each individual has the right "to safeguard the integrity of his or her own body," has been vacated, it is cited only for the value of its reasoning. *Id.* at 9 n.6. *See also* HASTINGS CENTER GUIDELINES, *supra* note 3, at 7 (stating that the terminally ill patient under the doctrine of self-determination has a "right . . . to determine the nature of his or her own medical care. . . . The Principle of autonomy is the moral basis for the legal doctrine of informed consent, which includes the right of informed refusal."). The Maryland Attorney General also explains that although the U.S. Supreme Court has yet to find that the U.S. Constitution guarantees the right to deny medical treatment, Courts in Delaware, New Jersey, and Florida have based the right of a competent individual to refuse "life-sustaining" treatment upon the Constitution's "penumbra" right to privacy. Att'y Gen. Op., *supra* note 2, at 11. Moreover, the Arizona Supreme Court has held that the Arizona State Constitution expressly protects a person's right to refuse treatment. Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (*cited in* Att'y Gen. Op., *supra* note 2, at 11). From these various state pronouncements, the Maryland Attorney General concludes that in Maryland one has a constitutional right to privacy which encompasses the right to refuse medical treatment. Att'y Gen. Op., *supra* note 2, at 9-15.

cal profession.[29] Yet, none of these four state interests has, to date, been found to be of sufficient weight by the Maryland courts to override the right of a competent, terminally ill patient to refuse life-sustaining treatment. Moreover, the Attorney General's opinion gives short shrift to these state interests. If the Attorney General's opinion reflects the prevailing view of the Maryland courts, the trend in that State will be the continued judicial support for decisions favoring euthanasia in most circumstances.[30]

Given this broad interpretation of the scope of the right to self determination, Maryland courts may at some point be called upon to resolve the inherent conflict with the Attorney General's opinion and the State's prohibition against aiding one in the exercise of suicide.[31] The Attorney General fails to adequately reconcile the conflict between legal self-determination[32] and prohibited suicide. According to the Attorney General, euthanasia through the withholding or withdrawing of artificial sustenance, as requested in a living will, medical durable power of attorney, or informally to a physician, are valid exercises of the common law right of self-determination.[33]

The Attorney General cites the case of *Tune v. Walter Reed Army Medical Hospital*[34] in support of the proposition that the refusal of AAS by a competent but terminally ill patient is not suicide. The *Tune* court held that such refusal is not the termination of a healthy life by self-induced means, but is,

29. Att'y Gen. Op., *supra* note 2, at 12.

30. Both the rights of third parties and the maintenance of the integrity of the medical profession are dealt with summarily by the Attorney General. He opines that no state interest would be furthered by prohibiting the competent, terminally ill patient from refusing artificially administered sustenance. *Id.* at 12-15. As for the ethical integrity of the medical profession, the Attorney General explains that refusal of artificially administered sustenance is in accordance with recognized medical views that "the dying are more often in need of comfort then treatment." *Id.* at 14 (quoting Satz v. Perlmuller, 362 So. 2d 160, 163-64 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (1980)). He also reasoned that the "control of one's fate . . . [is] superior to the institutional considerations" such as hospital policies. *Id.* (quoting *Satz*, 362 So. 2d at 164).

31. *See* O'Brien, *Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle Into That Good Night*, 31 ST. L. UNIV. L.J. 655 (1987) (reprinted in 10 SPECIALTY LAW DIGEST: HEALTH CARE 7 (1989)) [hereinafter *Facilitating Euthanatic Rational Suicide*] stating that "[i]n some states that do not specifically prohibit the assisting, soliciting or causing of a suicide, the state may prosecute a suicide abettor under the common law." Maryland is cited as one of these states.

32. The use of the term self-determination is arguably inappropriate in the context of certain surrogate decisions. When a surrogate bases a medical decision upon what he believes to be in the patient's best interest, or upon what he believes that the patient would want done, without a prior writing or statement by the patient, then the decision is really that of the surrogate, and not of the patient. Therefore, the patient is not exercising self-determination; rather, the surrogate is exercising substituted judgment.

33. *See* Att'y Gen. Op., *supra* note 2, at 10-19, 24.

34. 602 F. Supp. 1452 (D.D.C. 1985).

"nature . . . tak[ing] its course."[35] The Attorney General does not acknowledge, however, that often it is the withholding of nutrition, and not the disease, that eventually terminates the patient's life.[36] Therefore, the statement that the withholding of nutrition for the terminally ill patient is simply "nature running its course" is an insufficient basis for distinguishing between self-determination and prohibited suicide.

In short, the reasoning of the *Tune* case, as adopted by the Attorney General, makes an illogical distinction between the withholding of food and water from an unhealthy and a healthy individual. The withholding of nutrition will ultimately end both the healthy persons's life and, assuming the terminal disease has not yet run its course, the life of the terminally ill patient as well. In the case of the former, however, the act of withholding nutrition would be assisting in a suicide or the commission of a homicide. In the latter case, the withdrawal of artificial sustenance from the terminally ill patient would be a common law, and now statutorily supported, exercise of self-determination, regardless of whether the patient dies of dehydration and/or starvation, rather than another cause. Detractors of the Attorney General's position argue that the withdrawing of AAS from a terminally ill patient is not merely "allowing nature to take its course," but, rather approaches "active misfeasance."[37]

2. *Rights of the Terminally Ill and Disabled or Permanently Unconscious Patient*

Maryland law defines the disabled patient as one who lacks the capacity to make his own treatment decisions.[38] A patient that is permanently uncon-

35. *Id.* at 1455 n.8.

36. *See Facilitating Euthanatic, Rational Suicide, supra* note 31, at 662-63:

> Withholding nourishment severs the patient's life line and moves perilously close to grazing the fine line separating misfeasance or 'active' misconduct, from nonfeasance, 'passive' inaction or an omission to act. Some commentators urge that the withdrawal of artificial devices providing nourishment and hydration more nearly approximates active rather than passive euthanasia. The rationale for the distinction is that the patient's death results from starvation and dehydration, not from the culmination of the natural course of the immobilizing disease.

(citing D. WALTON, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS 233-37 (1983); Note, *I.V. Withdrawal: The Severance of Medicine's or Society's Umbilical Cord?*, 63 NEB. L. REV. 941, 956-57 (1984)).

37. *Id.*

38. MD HEALTH-GEN CODE ANN. § 20-107(a)(2) (1987). It is not enough that the patient disagrees with the doctors suggested treatment plan to label him "disabled." Therefore, the patient is protected from the doctor's substituting his own judgement for that of the competent patients. *Id.* (citing Sard v. Hardy, 281 Md. 432, 440, 379 A.2d 1014, 1020 (1977), holding 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.").

scious is disabled by definition because he is incapable of making his own treatment decisions. Once a patient is deemed to be disabled, decisionmaking on his behalf may be conducted by court appointed legal guardians, family members, or physicians.

The Attorney General cites the analysis of the New Jersey Supreme Court in the case of *In re* Quinlan[39] as the requisite starting point for all cases involving a surrogate's decision to withhold or terminate AAS, including decisions made on behalf of terminally ill, disabled patients. *Quinlan* involved the well-publicized decision by a permanently unconscious patient's father to remove his daughter's respiratory life support system. The New Jersey Supreme Court upheld the right of the father in *Quinlan* to make medical treatment decisions on behalf of his daughter. In *Quinlan*, the father petitioned the court for approval to remove the life-support systems as required under New Jersey law.[40] The doctors who had examined the patient and the hospital ethics committee concurred that there was no reasonable possibility that the patient would ever emerge from her comatose condition to a cognitive state.[41] In granting permission to remove the respirator, the court held that the patient, if competent, would have had the constitutional right in New Jersey to refuse medical treatment, even life-sustaining treatment.[42] Accordingly, because the patient was not competent, the court allowed the patient's father to make the decision on her behalf. The court explained that the unconscious patient's right to terminate a "noncognitive, vegetative existence . . . by natural forces . . . [which is] regarded as a valuable incident of her right of privacy . . . should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice."[43]

The Maryland Attorney General concludes that the refusal or withdrawal of artificial sustenance is equivalent to the withdrawal of artificial respiration. According to the Attorney General, the *Quinlan* court analysis, thus, provides legal support for the ability of a surrogate, with court approval, to decide to withhold or withdraw AAS from terminally ill and disabled, or permanently unconscious patients.[44] It should be noted, however, that

39. 70 N.J. 10, 355 A.2d 647 (1976).

40. *See id.* at 53-55, 355 A.2d at 670-71.

41. *Id.* at 54-55, 355 A.2d at 671.

42. *Id.* at 39, 355 A.2d at 663.

43. *Id.* at 41, 355 A.2d at 664.

44. Att'y Gen. Op., *supra* note 2, at 18. The attorney general states "[e]very 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. *See* Barber v. Superior Court, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983); *In re* Gardner, 534 A.2d 947, 954 (Me. 1987); *In re* Jobes, 108 N.J. 394, 413 n.9, 529 A.2d 434, 444

Karen Quinlan was not deprived of nutritional sustenance. Rather, the respirator that was theoretically providing her with life-sustaining oxygen was removed. Arguably the *Quinlan* analysis does not support the Attorney General's interpretation because the removal of a machine which, in effect, "breathes" for the patient is more an exercise of "nature taking its course" than is the deprivation of an individual's basic nutritional needs.[45] Indeed, the significance of this distinction becomes apparent after further examination of the *Quinlan* case. Once the respirator was removed, Ms. Quinlan continued to survive for nine years without the aid of the respirator.[46] The same certainty would not have been true had she also been deprived of food and water during this nine year period.

Another problem with allowing a surrogate to make a decision to withhold AAS from a disabled patient, terminal or otherwise, is the irreconcilable conflict between such a course of action and the state's interest in preserving life, including the prevention of suicide. If, as discussed above, the Attorney General could not provide a sound basis for distinguishing between a legally assisted suicide and the refusal of AAS by a competent but terminal patient, there is even less of a legal basis for finding that a *surrogate's* decision on the behalf of another to terminate or refuse AAS is not legally assisted suicide. Unlike a decision by a competent terminal patient, who is able to balance his own personal reasons for deciding to remove or refuse AAS, the same decision on behalf of an unconscious or mentally incompetent (and terminally ill) patient necessarily involves active participation by at least one other individual. This means that the exercise is no longer one of self-determination. Rather, it requires the surrogate to substitute his judgment for that of the patient.

Finally, the amount of pain involved in death by dehydration is especially

---

n.9 (1987); *In re* Peter, 108 N.J. 365, 380-82, 529 A.2d 419, 427 (1987); *In re* Conroy, 98 N.J. 321, 372-74, 486 A.2d 1209, 1236 (1985); Delio v. Westchester County Medical Center, 129 A.D. 2d 1, 16-19, 516 N.Y.S.2d 677, 688-89 (1987); *In re* Grant, 109 Wash. 2d 545, 561-63, 747 P.2d 445, 454 (1987); *Accord In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1140-42, 225 Cal. Rptr. 297, 302-03 (1986); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 430-38, 497 N.E.2d 626, 637 (1986).

45. *See* Att'y Gen. Op., *supra* note 2, at 9 (stating that the permanently unconscious patient "may stay alive for an indefinite period of time because their basic metabolic functions continue."). *See also* Barry, *The Ethics of Providing Life-Sustaining Nutrition and Hydration to Incompetent Patients*, 1 J. FAM. & CULTURE 23, 27 (1985) (stating that the withholding of nutrition and hydration differs from the withholding of medical treatment in that unlike medical treatment, nutrition and hydration are not used to remedy a clinical condition; rather, they supply "the means of fulfilling a basic human need and . . . support[ ] the body's natural defenses.").

46. *See* Note, *Removal of a Nutrient Feeding Tube and the Need for a Living Will*, 3 J. CONT. HEALTH L. & POL'Y 253, 253 n.5 (1987).

pertinent to decisions made on behalf of terminal and disabled patients. The Attorney General, however, fails to adequately address this issue. In the case of the terminal and disabled patient, it is the surrogate, and not the patient, who must determine that the patient would rather die than continue living in his current condition. Accordingly, before the surrogate may make a fully informed surrogate decision, he must consider the amount of pain that the starvation and dehydration will cause to the patient. Although this issue is disputed within the medical community, one expert has concluded that, "[d]eath by dehydration is almost always accompanied by very painful conditions: soreness and burning of the lips, lacrimation, lesions and large fissures on the lips, ulcerations, crusting, dermatitis on the skin, hard sebaceous plugs in the nose, fissures on the tongue and swelling associated with edema."[47]

B. Legal Standards Applied to Surrogate Decisionmaking

1. A Surrogate's Decision on Behalf of a Terminal and Disabled Patient

There are two common law standards—the substituted judgment and the best interest standards—which delineate the scope and limitations of the surrogate's power and define the decisionmaking process to be exercised by the surrogate on behalf of a terminal and disabled patient. The Maryland courts also rely on these standards to determine the validity of the surrogate's decision. The specifics of these common law standards, as well as the Maryland statutory scheme, and the requirement of prior court approval are discussed below.

a. Common Law Standards

Under the common law substituted judgment standard, "if the 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."[48] If the surrogate is not able to ascertain the patient's treatment philosophies under the substituted judgment standard, then the surrogate decisionmaker must base his decision upon the "best interest" standard. Under the "best interest" standard, the surrogate decisionmaker uses an objective, cost/benefit analysis to determine the course of treatment in terms of the "patient's

47. Barry, *supra* note 45, at 25; *but see* Billings, *Comfort Measures for the Terminally Ill: Is Dehydration Painful?*, 33 J. AM. GERIATRICS SOC. 741, 808-10 (1985) (stating that terminally ill patients experience relatively benign symptoms from dehydration which are easily relieved).

48. Att'y Gen. Op., *supra* note 2, at 25.

best interest."[49] In either event, the substituted judgment standard or the best interest standard must guide every surrogate decision, whether this decision is made by a guardian, family member, or by the court.[50] If the substituted judgment standard is employed, then the surrogate must attempt to reach the same decision that the patient would have made, based solely upon the surrogate's evaluation of the person's prior statements or actions which indicate the patient's beliefs and medical treatment philosophies.[51] In conducting this analysis, the surrogate necessarily must exercise a certain degree of subjectivity in ascertaining the patient's decision. Whenever subjectivity is involved in a standard, the exercise becomes inexact. When there is no objective evidence of the patient's medical treatment philosophies upon which the surrogate can base a treatment decision, then the best interest standard is more appropriately applied.

When applying the best interest standard, the Attorney General explains that several factors employed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research should be evaluated.[52] Of these factors, the one which is the most predisposed to conflicting interpretation is the "quality and extent of life" as weighed by a third party on the patient's behalf.[53] Quality of life is to be measured in terms of value to the patient and not the value that others may find in the continuation of the patient's life.[54] Consequently, the surrogate decisionmaker must consider two questions. First, whether forgoing AAS will allow the patient to avoid the burden of prolonged dying with accompanying pain and suffering; and second, whether the patient "has the potential benefit of achieving some satisfaction" if he survives for a longer period.[55]

The definition of "some satisfaction" requires a case-by-case analysis, and is heavily dependent upon the patient's condition and current physical

---

49. *Id.*

50. *Id.*

51. *See Brophy*, 398 Mass. at 427, 497 N.E.2d at 631, holding that the factors used to determine whether the patient in a "persistent vegetative state" would refuse artificial sustenance include:

> (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; and (5) the prognosis both with and without treatment. The judge also considered present and future incompetency as an element which . . . [the patient] would consider in his decision-making process.

52. Att'y Gen. Op., *supra* note 2, at 28 (citing *President's Commission Report*, *supra* note 9, at 135). These factors include "the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained." *Id.*

53. *Id.*

54. *Id.*

55. *Id.* (citing HASTINGS CENTER GUIDELINES, *supra* note 3, at 28).

state.[56] For example, one court has based the decision to withhold AAS for the terminally ill and disabled patient on the surrogate's finding of the patient's "prior dislike for medication and medical procedures as well as her dislike for the medical staff."[57] Additionally, the Attorney General states that when a patient lacks capacity to make treatment decisions for himself, then his conduct, such as "forcible resistance to the insertion of a feeding tube, or continued efforts to remove a tube . . . should be considered in determining whether the continuation of [AAS] is in the patient's best interest."[58] Arguably, all of these factors are subject to various interpretations and may result in conflicting conclusions by those involved in the decision-making process depending upon the weight applied by the decisionmaker(s) to each factor. One may conclude, for example, that attempts to remove a feeding tube are merely "reflexive" and indicate only that the tube is uncomfortable; others may conclude that the removal effort is an indication by the patient that he wishes to have the sustenance withdrawn.[59] Therefore, even under the "objective" best interest standard, the reliance by the surrogate upon medical conclusions which are controverted may lead to inconsistent and potentially devastating results.

b. Statutory Standards and the Need for Court Approval Applicable to Surrogate Decision Makers

The Maryland Estates and Trust Code[60] authorizes the appointment of a guardian for a disabled person, as previously defined, and empowers the appointee to make medical treatment decisions for the person's benefit.[61] Although the Code does not expressly discuss medical treatment decisions, the Attorney General concludes that Section 13-708(8) of the Code implicitly authorizes the guardian to withhold or withdraw consent to medical treatment, including AAS.[62] Court approval is required, however, before

56. *In re* Grant, 109 Wash. 2d at 545, 747 P.2d at 457. The Washington Supreme Court allowed the patient's mother to decide on behalf of her daughter to withhold all life-sustaining treatment, including nutrition and hydration. *Id.* Her daughter was suffering from an incurable neurological disorder. *Id.* The court reasoned that the withholding of life-sustaining medical treatment was proper since the patient was in the end stages of a terminal illness with no hope of improvement, and she had to be physically restrained by tie-downs to avoid injury to herself because she was subject to frequent seizure attacks. *Id.*

57. Att'y Gen. Op., *supra* note 2, at 28 (citing *In re* Grant, 109 Wash. 2d at 550-52, 747 P.2d at 448).

58. *Id.* at 28 n.38.

59. *See id.* at 6-7 (noting that the insertion and maintenance of a feeding tube can be quite painful).

60. MD. EST. & TRUSTS CODE ANN. § 13-704 (1973).

61. MD. EST. & TRUSTS CODE ANN. § 13-708(8) (1988).

62. *Id.* If this section is read literally, it would not require court approval before the

the court appointed guardian's withdrawal decision is honored. If a guardian has been appointed by the court, then the guardian's decision takes priority over decisions by any other surrogate, including decisions made by physicians or family members.[63]

Surrogate decisions made by a family member are subject to a different set of rules and standards than those of a court appointed guardian. Decisions made by family members on behalf of the patient to continue the administration of artificial sustenance to the patient are governed by Section 20-107 of the Maryland Health General's Code.[64] Although Section 20-107 discusses the ability of the surrogate to make decisions concerning the furnishing of treatment, there is no mention in that section of the ability of the surrogate to make decisions involving the withholding or withdrawing of medical treatment.[65] Therefore, the surrogate's decision for withholding or withdrawing of sustenance must be analyzed under other legally recognized surrogate decisionmaking procedures, including those found under Maryland common law.

The ability of family members to make a life-*sustaining* medical decision on behalf of a terminally ill disabled relative is protected under Maryland law.[66] Life-*ending* decisions made by family members on the disabled patient's behalf also are valid provided certain procedures are followed. These procedures, as discussed below, are derived from the need to make expedient medical treatment decisions when the patient is terminally ill and unable to make his own medical treatment decisions. Moreover, in many of these cases no prior documentation expressing the patient's treatment wishes exists. Therefore, an informal case law parallel to Section 20-107 of the code has evolved.[67]

Under the common law surrogate decisionmaking rule, if the attending physician has concluded that life-sustaining treatment should be withheld or

---

guardian could authorize the withholding or withdrawing of life-sustaining treatment. The code speaks only of the court's "authorizing an affirmative medical treatment." *Id.* at § 13-704. The Attorney General, however, interprets the provision to require court approval for "negative" action decisions as well, such as withholding artificial sustenance. Att'y Gen. Op., *supra* note 2, at 31. The guardian should apply the substituted judgement or best interest standards in formulating their decision in the case of the permanently unconscious patient. *Id.* at 31.

63. Att'y Gen. Op., *supra* note 2, at 4.

64. *Id.* at 33-34.

65. *See* MD. HEALTH-GEN. CODE ANN. § 20-107 (1987).

66. *See, e.g., id*; Att'y Gen. Op., *supra* note 2, at 33 ("[MD. HEALTH-GEN. CODE ANN.] . . . § 20-107(d) grants decisionmaking authority to family members . . . . 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 (g) . . . .").

67. Att'y Gen. Op., *supra* note 2, at 35.

withdrawn, and this decision is consistent with proper standards of patient care, then the physician may recommend this decision to the family.[68] If the entire immediate family agrees with the decision, and the hospital patient care advisory committee concurs,[69] then the statutorily authorized family member can allow the physician to withhold or withdraw treatment without court approval.[70] Unlike the decision to furnish AAS made under Section 20-107 of the Estates and Trusts Code, if any members of the immediate family, or the hospital patient care advisory committee objects to withholding or withdrawing the AAS, then the decision may not stand without court approval. This is true even if the statutorily selected family member and decisionmaker contends that withdrawal of AAS from the patient is necessary. If the withdrawal decision is unanimously agreed upon by the immediate family, the physician is protected from liability for honoring the decision, provided that the recommendation has been made in accordance with accepted standards of medical practice.[71]

This common law rule appears to directly conflict with the statutory requirement of court approval for withholding or withdrawing life-sustaining treatment. According to the Maryland Attorney General, however, the common law rule is reconcilable with the statute because the decision is made by the terminal and disabled patient's family members, who are usually in a better position then the courts to make such a decision on behalf of the patient. Additionally, the Attorney General concludes that the patient is protected from any potential abuse of the family's decisionmaking power because if an immediate family member objects to the withdrawal decision, or there is disagreement with the decision by the hospital or the physician in charge, then court approval is mandated before the family members may act.[72]

A final type of surrogate decisionmaking enables a competent patient to instruct his physician not to administer artificial sustenance in the event that

---

68. *Id.*

69. MD. HEALTH-GEN CODE ANN. § 19-371 (1987) requires each hospital to establish a patient care advisory committee. *See* MD. HEALTH-GEN. CODE ANN. §§ 19-373-374 (this committee must advise the physician(s) and the family members concerning the options for medical care and treatment of an individual with a life threatening condition.); *see also* Md. Health-Gen. Code Ann. § 19-374 (b)(2) ("[a]ny information or document that indicates the wishes of the patient shall take precedence in the deliberations of the advisory committee.").

70. Att'y Gen. Op., *supra* note 2, at 35, 38 (citing *Rasmussen*, 154 Ariz. at 222-23, 741 P.2d at 691, *In re* Grant, 109 Wash. 2d at 545, 747 P.2d at 456).

71. *Id.* at 38 n.55. If no family members are available to make a surrogate decision on the disabled patient's behalf, then court approval is required before the physician may remove or withhold life-sustaining treatment. *Id.* at 38 n.56 (citing *In re* Hamlin, 102 Wash. 2d 810, 819-21, 689 P.2d 1372, 1378 (1985)).

72. *Id.* at 37-38. *See Rasmussen*, 154 Ariz. at 222-23, 741 P.2d at 691.

he becomes disabled. Prior physician instructions appear to be the least regulated area of surrogate decisionmaking under the current Maryland euthanasia laws.[73] In this context, AAS may be withdrawn, with court approval, if the physician sufficiently establishes that at some prior time, the patient expressed his desire not to receive such life-sustaining treatment.[74] No formal documentation or legal instrument is required to corroborate the physician's statement pertaining to the patient's medical treatment decision.[75] Moreover, neither the substituted judgment standard, nor the best interest standard appear to govern the physician's decision. In support of the physician's power of substitute judgment, the Attorney General stresses that such direct decisionmaking between doctors and patients should be honored,[76] and concludes that the patient is protected because the physician or family members or guardian must petition the court for approval before AAS is withheld or withdrawn.

2. *A Surrogate's Decision on Behalf of a Permanently Unconscious Patient*

For patients who are not terminally ill, but who are incapable of making legally competent medical treatment decisions because of permanent unconsciousness,[77] a living will, a medical durable power of attorney, or court approval is required before AAS is withheld or withdrawn.[78] Controversy within the medical and legal communities surrounds the ability of a surrogate to direct the withholding or withdrawing of AAS for a permanently unconscious patient absent a prior refusal decision by the patient. The more liberal authority granted under Maryland common law to certain family members to withhold AAS without court approval in the context of the terminal and disabled patient is not applicable to decisions to withhold or withdraw treatment made on behalf of the permanently unconscious patient.[79] Such decisionmaking requires court approval since, unlike the situation with terminally ill patients, there is no need for quick decisionmaking.[80]

---

73. *See* Att'y Gen. Op., *supra* note 2, at 24 ("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 . . . .").

74. *Id.*

75. *Id.*

76. *Id.*

77. *See President's Commission Report*, *supra* note 9, at 174-75.

78. Att'y Gen. Op., *supra* note 2, at 38.

79. *Id.*

80. *Id.* at 39-40.

As with all surrogate decisionmaking, the substituted judgment or the best interest standards must guide the surrogate in deciding the medical treatment plans on behalf of the permanently unconscious patient. These patients, however, pose a different set of problems in the application of the surrogate best interest standard than do terminal and disabled patients. Some experts conclude that a permanently unconscious patient does not experience physical or emotional suffering.[81] If this is true, one cannot justify the withholding or withdrawing of artificial sustenance from a permanently unconscious patient upon factors such as the pain and suffering the patient would experience if his life were prolonged by use of artificial sustenance. Similarly, the Attorney General holds that a factor which is not normally considered in the terminally ill patient context must be examined: the inability of the patient to experience any of life's satisfactions because of his permanently unconscious state.[82] The Attorney General takes the extreme view, *i.e.*, that the permanently unconscious patient receives no benefit from medical treatment, including AAS.[83] Experts have concluded, however, that there is a sufficient benefit to the patient if his death is prevented by continued treatment.[84] The Attorney General has left the ultimate say to the Maryland General Assembly and to the Maryland courts.[85]

C. Formal Euthanasic Decisionmaking

1. The Living Will and Medical Durable Power of Attorney

Two different instruments are available to Maryland residents to avoid the ambiguities and problems involved in surrogate decisionmaking. These instruments ensure that the patient's medical treatment philosophies are respected in the event he becomes disabled, either from illness or permanent unconsciousness. Under the Maryland Life-Sustaining Procedures Act, a competent person, who is at least eighteen years of age, may execute a declaration, commonly known as a living will, directing the withholding or withdrawing of life-sustaining treatment.[86] To declare the intent to decline

81. *Id.* at 29.

82. Att'y Gen. Op., *supra* note 2, at 29.

83. *Id.* at 29. The *President's Commission Report* emphasizes the tremendous emotional and financial burden imposed upon the family when treatment to maintain the person in a permanent state of unconsciousness is continued. *President's Commission Report*, *supra* note 9, at 185.

84. May, Barry, Griese, Grisez, Johnstone, Marzin, McHugh, Meilander, Siegler, Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES IN L. & MED. 203, 209 (1987).

85. Att'y Gen. Op., *supra* note 2, at 30.

86. MD. HEALTH-GEN. CODE ANN. § 5-602(a) (1987). The common reference to these laws are the "Living Will" laws. One who forges another's living will declaration, or willfully

nutrition and hydration, the person must directly specify in the living will that such treatment be withheld if circumstances warranted it. Therefore, a broadly worded living will which merely states that the person wishes not to be kept alive by artificial means is inadequate to allow the withholding of AAS.[87] A living will may also be used to express a person's desire to receive AAS.[88] The treating physician must honor such a declaration, regardless of the wishes of the family, guardian, or other surrogates.[89]

Alternatively, the Maryland Estates and Trusts Code allows one to execute a durable power of attorney to authorize another to act on the grantor's behalf in the event he becomes disabled.[90] Such authority includes the power of the grantee to make medical decisions on the grantor's behalf.[91] Although the Code does not expressly state that the durable power of attorney may be used for medical treatment decisionmaking, the Attorney General concludes that the Code provision implicitly allows such a use because it is not expressly prohibited by the Code.[92] Additionally, the Attorney General states that the durable power of attorney is referenced in the Health Attorney General Articles.[93] Therefore, he concludes that the General Assembly intended for the medical durable power of attorney to be used as a type of living will substitute.[94]

2. *Nursing Homes and Powers of Attorney*

The Maryland Estate and Trusts Code allows a nursing home to request a potential or present resident of the nursing home to execute a power of attorney naming the nursing home as his attorney-in-fact.[95] This provision provides the nursing home with an avenue of abuse, because a potential resident

---

conceals or withholds personal knowledge of a revocation by the patient is guilty of a misdemeanor and subject to a fine not to exceed $1000. *Id.* at § 5-614. Note that the punishment for forging a living will, or committing the other prohibited acts above is a misdemeanor, while the end result for the victim is fatal.

87. MD. HEALTH-GEN. CODE ANN. § 5-602 specifically addresses food and water. The Attorney General concludes that the act requires a competent patient to specify to the physician that food and water be withheld before the physician can remove such sustenance.

88. MD. HEALTH-GEN. CODE ANN. at § 5-611 (1987).

89. Att'y Gen. Op., *supra* note 2, at 21.

90. MD. EST. & TRUSTS CODE ANN. § 13-601 (1974).

91. *See* Att'y Gen. Op., *supra* note 2, at 23, stating that "although . . . [MD. EST. & TRUSTS CODE ANN.] § 13-601 does not expressly authorize the delegation of health care decisionmaking, nothing in the statute or other law prevents it."

92. *Id.*

93. *Id.*

94. *Id.*

95. *See* MD. HEALTH-GEN. CODE ANN. § 19-344(b)(3)(i) (1987). Under this provision, nursing homes can request, but cannot require prospective residents to execute medical durable powers of attorney. Att'y Gen. Op., *supra* note 2, at 23.

may be unduly influenced to sign such an instrument if to do so would increase his chances of admission into a home.[96] The Attorney General has requested that the Maryland General Assembly enact legislation specifically addressing safeguards to protect nursing home residents.[97] Otherwise, as the Attorney General correctly notes, the potential for abuse is great. For example, nursing homes in Maryland could begin to make decisions such as whether a terminally ill resident should continue to receive certain life-sustaining treatment purely upon the demand for nursing home space, or the ability of the patient to pay for such life-sustaining treatment.[98] With the aging of our population, this is a real concern.[99] Such decisionmaking would be based upon the benefit to the nursing home, rather than the benefit to the patient, and would directly conflict with the common law standards for surrogate decisionmaking (*i.e.*, in the patient's best interest or substituted judgment) that would otherwise apply if there were no direct power of attorney.

Finally, at the other end of the spectrum, the health care provider may have concerns over its liability in the event it honors an AAS refusal. The Attorney General opines that any Maryland nursing home or hospital which honors a sustenance refusal decision is protected from a charge of not providing adequate health care. While both federal and state law require hospitals and nursing homes to "meet the nutritional needs of their patients," the Attorney General concludes that these laws do not require the institution to administer artificial sustenance to the patient.[100] Accordingly, the Attorney General explains that a hospital or nursing home honoring the patient's or the surrogate's request to remove or withhold artificial sustenance would not

96. *See generally* McCormick, *Caring or Starving: The Case of Claire Conroy*, 1985 AMERICA 269, 273 stating that:

> [N]ursing homes are often afflicted with industry-wide problems that make them a very troubled and troublesome component of the health care system. And all of this at the very time when there are economic and social pressures on health care delivery. Together these factors may make it extremely difficult to keep patients' best interest at the heart of these [artificial sustenance removal] decisions. In other words, the potential for abuse is enormous.

97. Att'y Gen. Op., *supra* note 2, at 24, stating "[a]lthough 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 matters."

98. *See* McCormick, *supra* note 96, at 273.

99. *See* B. SPRING & E. LARSON, EUTHANASIA: SPIRITUAL, MEDICAL, & LEGAL ISSUES IN TERMINAL HEALTH CARE 22-23 (1987) (from 1950 to 1980 the number of Americans over the age of sixty-five jumped from 12.4 million to 25.7 million respectively. That group will grow to a projected 35 million by the year 2000, and may reach upwards to 64 million by the year 2030.).

100. Att'y Gen. Op., *supra* note 2, at 45 (citing 42 C.F.R. §§ 405.1125, 482.28 (1987); Code of Maryland Regulations (COMAR) §§ 10.07.02.13E, 10.07.03.11a(2) (1987)).

be in violation of such state and federal regulations.[101]

IV. CONCLUSION

The application of economic factors to medical decisionmaking is a relatively new concept, which has been spurred by the increased cost of advanced medical procedures, especially those procedures pertaining to life-saving and life-sustenance. For the terminally ill and permanently unconscious patient, forgoing medical treatment, specifically AAS, equates to forgoing life. Accordingly, granting power to a surrogate to make such a decision on behalf of the patient requires stringent governance. This is especially true for the elderly who are living in nursing homes, and who are potential targets for abusive economic decisionmaking by either the home or by the family.

This is not to say that economics is irrelevant to life-sustenance decisionmaking. A competent person using a living will or durable power of attorney in Maryland may have determined that in the event he becomes disabled and terminally ill, or permanently unconscious, that the benefit of sustaining life at that point would be outweighed by the burden upon himself, or the burdens, including financial, that would be place upon those who would be responsible for his care. It may be erroneous, however, to impose this same "financial burden" analysis upon the terminal and incompetent, or permanently unconscious patient who has not made a prior expression as to life-sustaining treatment. Absent any prior expression by such patients in regard to the withholding or withdrawing of AAS, granting the surrogate unbridled power to make "substituted judgments" or decisions that are disguised as "in the patient's best interest" may lead to abusive economic based medical treatment decisionmaking. Such a decision violates the common law standards which are to guide all medical treatment decisions made by surrogates in Maryland.

Similarly, economic considerations aside, the ability of a surrogate to make a life-ending decision on behalf of a terminal but disabled, or permanently unconscious patient arguably cannot be based upon the same grounds as a similar decision by a competent but terminally ill patient. The competent patient can weigh factors such as burdens upon his family, and the potential pain and suffering he would face if nutrition and hydration were withheld or withdrawn. Conversely, the ability of a surrogate, even a family member, to adequately access the desire of the patient who can neither legally speak for himself, nor weigh the burden and pain and suffering factors,

101. *Id.*

and who has not made a prior declaration of his medical treatment philosophies, is speculative at best.

In protecting the individual's right to "die with dignity," the Attorney General may have overlooked the terminally ill and permanently unconscious patient's right to fight for life. One method of equalizing the "imbalance" of rights is to require court approval prior to honoring all surrogate decisions to end AAS including decisions by family members, even when there are no objections by the either the hospital or other relatives. Such a requirement may reduce the use of economics by the surrogate as the determinative factor, while labeling the decision "in the patient's best interest." Finally, the factors upon which the surrogate bases an AAS withholding or withdrawing decision need to be clarified by the Maryland Courts and the Maryland General Assembly. Such clarification is necessary to adequately protect the patient and to guide the surrogate to ensure that the decision is one with which all involved can live.

Michael L. Dailey