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MARYLAND'S 1993 HEALTH CARE DECISIONS ACT— IMPLICATIONS FOR HEALTH CARE PRACTITIONERS

STEVEN A. LEVENSON*

INTRODUCTION

Maryland's new Health Care Decisions Act (HCDA)¹ addresses many issues previously covered under various statutes, case law, ethics debates, and nonbinding attorney general's opinions. The new law has many potential benefits for patients and for health care providers, including physicians. It reinforces the roles of the various participants—patients, families, doctors, health care facilities—but also acknowledges their limitations and offers several checks and balances.

Health care practitioners (HCPs) have always had a prominent role in ethical decisionmaking in health care. However, for reasons such as fear, misunderstanding, and disinterest, this participation—especially by physicians—has been inconsistent and sometimes obstructive. The HCDA should ease physicians' fears and help improve their participation in ethical decisionmaking. This Article discusses this and other implications of the new law for HCPs—the possible problems of implementing the law while making the best possible decisions for patients, and ways in which health care providers, public policy makers, and attorneys can help ensure that the HCDA achieves its intended benefits.

I. UNDERLYING PRINCIPLES

The HCDA is based on many commonly accepted concepts. The HCPs involved in ethical decisionmaking, however, may not be familiar with those concepts, nor do they necessarily share a common understanding of them. Even when participants concede their differences, the sources of disagreement may not be adequately un-

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1. MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1994) [hereinafter HCDA].

derstood and reconciled. Consistent, systematic processes are essential in order to accommodate diverse values and desires effectively.²

In the past—when laymen were considered incapable of understanding complex medical information—physicians often made treatment decisions for their patients. Many physicians had trouble seeing medical care as a means to an end, rather than an end in itself. They followed the simple principle that an available treatment ought to be used.³ For example, most physicians would insist on treating a patient with surgery or antibiotics, regardless of any patient or family expressions to the contrary. Also, treatment options were often limited.

As medical technology has advanced, and possible treatment interventions have proliferated, the value of many medical treatment options has become questionable. After years of debate, attitudes about the role of medical care in people's lives and the role of physicians in selecting medical care for ill individuals have changed.

Now it is widely accepted that medical care is a means to an end, which should serve a useful purpose.⁴ Moreover, the decision to intervene and the degree of desirable intervention must be individualized, depending on a person's wishes, condition, and prognosis. The treatment itself may be based in science, but the choice of whether to have treatment is not a scientific matter.

The United States Supreme Court has affirmed that competent individuals have a constitutionally guaranteed liberty interest to reject any or all life-sustaining procedures.⁵ This involves decisions about medical care, including withholding or withdrawing such life-sustaining procedures as mechanical ventilation or artificial nutrition

2. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH: SUMMING UP (1983).

3. Darrel W. Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots*, HASTINGS CTR. REP., Aug. 1978, at 23, 27 ("The only duty common to probably all Greco-Roman physicians was 'to help,' or at least do no harm.").

4. See *id.* at 23 (asserting that the modern duty to prolong life does not have any origins in classical medicine); see also Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955 (1988); David Hilfiker, *Allowing the Debilitated to Die: Facing Our Ethical Choices*, 308 NEW ENG. J. MED. 716 (1983) (commenting on the myth of "maximum possible care" and reality of compromise in treating "the old, chronically ill, debilitated, or mentally impaired").

5. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."); see also Bernard Lo & Robert Steinbrook, *Beyond the Cruzan Case: The U.S. Supreme Court and Medical Practice*, 114 ANNALS INTERNAL MED. 895 (1991) (discussing the unresolved clinical questions and potentially harmful consequences of the *Cruzan* decision); George J. Annas, *Nancy Cruzan and the Right to Die*, 323 NEW ENG. J. MED. 670 (1991) (discussing *Cruzan* within the context of *Quinlan*).

and hydration. Health care providers, including physicians, must accommodate patients who request limitations on care. This, however, does not prevent the physician from discussing treatment options or from trying to influence patient choices.⁶

Selecting a treatment plan is the endpoint of a bi-directional process combining components of clinical and ethical decisionmaking.⁷ The "patient-centered" direction considers a person's current or previously expressed wishes or directives and their current capacity for considering information or reviewing those wishes. The "care-giver-centered" direction reviews the potential treatment options, their risks and benefits, and the relevance of those options to an individual's wishes, current condition, and prognosis.

II. HEALTH CARE PRACTITIONER RESPONSIBILITIES UNDER THE HCDA

The HCDA specifies a number of rights and responsibilities for physicians in implementing the law's provisions. Under the HCDA, health care providers—practitioners and facilities—must honor the valid instructions of patients and their appointed agents, court-appointed guardians, or appropriately selected surrogate decisionmakers. The law anticipates and addresses situations where the physician and the decisionmaker disagree on the appropriateness of the request.

This law establishes and expands guidelines that should help physicians be more constructive participants in the ethics decisionmaking process. Because physicians still have considerable authority to define reality and to guide treatment selection, they may help or hinder decisionmaking, depending on how they assert their rights and fulfill their responsibilities. The law should also help patients and other practitioners be more effective participants.

Health care practitioner responsibilities as a direct or indirect result of the HCDA include: (1) helping interpret existing advance directives; (2) informing others about known existing advance directives; (3) helping decide who is capable of making medical decisions and to what degree; (4) helping determine how current medical circumstances relate to a patient's wishes; (5) helping determine when patients meet qualifying criteria for limiting certain treatments;

6. See Lo & Steinbrook, *supra* note 5, at 899-900 (suggesting that physicians should provide alternatives and encourage the use of advance directives "to minimize" the potentially harmful effects of *Cruzan*).

7. See generally STEVEN A. LEVENSON, *MEDICAL DIRECTION IN LONG-TERM CARE: A GUIDEBOOK FOR THE FUTURE* (1993) (presenting a model that incorporates both clinical and ethical concerns in developing long-term care treatment plans).

(6) witnessing and documenting patient instructions; (7) honoring legally valid wishes; (8) interpreting the potential effectiveness of proposed treatments; (9) proposing patient transfers in cases of irreconcilable differences; and (10) guiding facility staffs, judges, and others in making competency determinations, in guardianship proceedings, and in decisions about whether to withhold or withdraw treatments.

The potential successes and problems of these components of the law are considered throughout the following discussion.

A. *Help Those Drafting Advance Directives*

Advance directives are written or oral statements made by individuals capable of stating their general or specific wishes about their medical care in advance of situations in which they are unable to make decisions or express those wishes.⁸ The HCDA supports the right of competent adults to make an advance directive and gives equal weight to both written⁹ and oral¹⁰ advance directives. An advance directive may give instructions about future health care, appoint an agent, or both.¹¹

An "agent" is someone that a person making an advance directive specifically appoints to make health-care decisions if that person becomes incapacitated.¹² An individual does not have to appoint an agent in an advance directive. A "surrogate" decisionmaker is someone permitted to act for an incapacitated individual under the conditions described in the law, even in the absence of an advance directive or when an individual fails to appoint an agent.¹³

A patient's currently expressed wishes should be considered pertinent unless the person is adjudicated as incompetent or certified by physicians in accordance with the HCDA to be incapable of making health care decisions.¹⁴ Advance directives should be considered credible substitutes for such instructions. Although the HCDA offers

8. MD. CODE ANN., HEALTH-GEN. § 5-602 (1994).

9. *Id.* § 5-602(a).

10. *Id.* § 5-602(d).

11. *See generally id.* §§ 5-602 to -603.

12. *See id.* § 5-602(b)(1) (stating that "[a]ny competent individual may, at any time, make a written advance directive appointing an agent to make health care decisions for the individual under the circumstances stated in the advance directive.").

13. *Id.* § 5-605(a)(2).

14. *Id.* § 5-602(e).

immunity for good faith adherence to directives,¹⁵ some practitioners may be unwilling to resist badgering or threats from family members wishing to overturn these instructions. Since advance directives would be less valuable if they could be readily ignored once a person became incapacitated, those making them should be reassured that their requests will be respected at the appropriate time.

The HCDA provides a model living will and a two-part advance directive—appointment of health care agent and health care instructions¹⁶—but does not require that any particular format be followed. Advance directives made prior to October 1, 1993, when the HCDA took effect, remain valid and should not require rewriting.¹⁷ The inclusion of these suggested forms within the Act may create several potential problems that should be addressed. First, the living will form is redundant, since the advance directive form can be used to cover terminal illness. Second, the living will form alone does not cover all possible situations. Third, some people may not understand that these formats provided in the statute are not required and that others may be used. Finally, it may not be clear that the “advance directive” form is comparable to a durable power of attorney form containing both a treatment and a proxy directive component. Health care providers and attorneys should explain these points to people contemplating making directives.

The HCDA reinforces the need for both HCPs and other advisors, such as attorneys, to help patients prepare advance directives. In doing so, they should consider several important principles. Patients often ask what their advance directive should contain. Providers should emphasize the directive’s content and scope more than its form. Any wishes about health care choices could be stated in several ways, either by treatment categories, or by situation. For example, a treatment-specific directive might say, “I do not want to be placed on a ventilator under any circumstances.” A situation-specific directive might say,

If my condition is such that aggressive medical intervention, including life-sustaining procedures, no longer are likely to make a difference in outcome or improve my quality of life, I would not want them to be used. However, if a treatment

15. See *id.* § 5-609(d) (providing that “[a]uthorization for the provision, withholding, or withdrawal of life-sustaining procedures in accordance with this subtitle shall be presumed to have been made in good faith.”).

16. *Id.* § 5-603.

17. *Id.* § 5-616.

may help reverse my condition, I would request that it be given.

The forms provided with the HCDA are primarily situation-specific directives with the option to add treatment-specific directives.

Some physicians are concerned about the limitations of treatment-specific directives, which may exclude a treatment even when it may do some good. While there is some merit to this argument, some people may also not want a treatment under any circumstances or may want it under some conditions but not others.

HCPs should advise those drafting directives, and consider the time spent discussing them with patients as preventive health care. Helping a patient understand their options and the reasons why some treatment choices are more consistent with their wishes and values than others, can prevent confusion and anguish when crises arise.

HCPs and other advisors, including attorneys, should encourage balanced directives that are as explicit as the individual desires, but flexible enough to accommodate the ambiguities of clinical decision-making. They should also encourage directives that appoint an agent who can make decisions about specific treatments when the need arises, based on those instructions.

B. Witnessing and Documenting Patient Instructions

The HCDA contains some explicit requirements for HCPs. For example, they must witness and document oral patient instructions.¹⁸ This is a critical role for physicians because they are considered credible witnesses who can understand the subtleties and implications of a patient's statements.

Physicians also must inform appropriate parties if they know that an advance directive exists and make it part of the declarant's medical record.¹⁹ Many physicians care for their patients at more than one care site; for example, both in the nursing home and the hospital. Their duty to ensure that others are aware of the advance directive is not facility specific. In other words, physicians should help facilities become aware of existing directives even if they are not going to follow the patient in a facility.

An advance directive recorded in one facility should be honored subsequently by other facilities. The staff of transferring facilities

18. *See id.* § 5-602(d) (asserting that an "oral directive shall have the same effect as a written advance directive if made in the presence of the attending physician and one witness and documented as part of the individual's medical record.").

19. *Id.* § 5-602.

should ensure that information about a written or oral advance directive is sent to a receiving facility. A facility or practitioner questioning an advance directive's legitimacy should refer the matter for discussion—for example, to a facility-based patient care advisory committee—rather than just refuse to honor it.

An oral advance directive made after October 1, 1993, must be made in the presence of the attending physician and another witness.²⁰ Of the two witnesses required, the physician should document in the greatest detail.²¹ She should either quote or precisely paraphrase what the patient has said in enough detail to avoid subsequent misunderstanding. A progress note that states, "The patient told me she doesn't want any life-sustaining procedures except under some circumstances" is not nearly as useful as one that states:

On rounds today, the patient told me that she had thought about her current situation since being in the hospital. She still wants me to work up and treat her condition, but told me that she does not want to be resuscitated. She approves being placed on a ventilator, if it is for a limited time and could help reverse an acute problem. However, if she becomes ventilator dependent, and it is unlikely that she can be weaned from the ventilator in a few days to two weeks or so, she does not want to be ventilator-dependent indefinitely. Under such circumstances, she would want the ventilator discontinued.

The other witness, who most likely will be a nurse or other HCP familiar with the case, should document the conversation more briefly, but still better than, "I agree with the above." For example, in the above case, "I witnessed this conversation and agree that the patient wants limits placed on ventilator use and does not want to be resuscitated," would be appropriate.

Since many patients do not make explicit directives, someone familiar with their wishes may have to advocate for them if others try to deny those wishes. Because the directives may not take effect for many years, physicians should familiarize themselves with their patients' advance directives, e.g., annotate conversations, make summaries of discussions, or record reminders about specific wishes of the patient for subsequent reference.

20. *Id.* § 5-602(d).

21. The attending physician is responsible for documenting the patient's statements in the medical record. *Id.* § 5-602(f)(2)(ii).

C. *Triggering an Advance Directive*

An advance directive may be triggered either by a competent patient or by circumstances that incapacitate a patient for purposes of making health care decisions. Before an advance directive can be triggered by incapacity, two physicians—one of them the attending physician—must certify the patient's incapacity in accordance with statutory requirements.²² At least one of the physicians must make the certification within two hours of actually examining the patient, to ensure that there is not a significant condition change in the interim.²³ A second physician is not required if the patient is unconscious or unable to communicate by any means.²⁴ The HCDA requires physician certification to clarify when decisionmaking by substitute decisionmakers becomes appropriate. This should help restrain attempts to circumvent the wishes of a patient who still has some decisionmaking capacity.

D. *Determining Decisionmaking Capacity*

The HCDA reflects the reality that physicians and other health care providers must deal with *de facto* competence regardless of any judicial proceedings. While courts may adjudicate someone's competence, legal determinations of competence generally do not consider the subtleties and partial capabilities relevant to health care decisionmaking. Thus, the term "decisionmaking capacity" is preferred to the term "competence" with regard to health care decisions.

Determination of decisionmaking capacity has other important implications, including possible loss of freedom of choice. In the case of health care decisions, it may trigger an advance directive and signal that another person should be consulted to make decisions for that individual.

The HCDA defines incapacity, but does not explain how it is determined.²⁵ Traditionally, various criteria have been used. Primarily, physicians have been utilized to determine competency and to certify incompetence. However, while the HCDA requires physician certification of someone's decisionmaking capacity, it does not affirmatively exclude participation of others in making such determinations. This is important because responsibility for documenting decisionmaking capacity is not the same as the exclusive right to define it.

22. *Id.* § 5-602(e)(1).

23. *Id.* § 5-606(a).

24. *Id.* § 5-602(e)(2).

25. *Id.* § 5-601(l).

Competence is not a medical attribute; it is a collection of abilities and skills based partially on biological function and partially on actual performance in the context of the setting in which that person lives. Many physically unimpaired people have poor judgment, insight, problem-solving ability, attention, and comprehension. Conversely, some people with medical illnesses (such as Alzheimer's Disease) may still function effectively depending on the setting. Decisionmaking capacity may be partial, it may fluctuate, or it may be sufficient for some situations or choices but not for others.²⁶

Given these consequences, all HCPs should try to evaluate and document decisionmaking capacity carefully and thoroughly. Sometimes a person's incapacity is readily apparent, while at other times the assessment should be "three-dimensional"—done over time and in various situations. While a standard short mental status examination is useful for measuring cognitive function if attention span is adequate,²⁷ physicians must also recognize that mental status is not equivalent to decisionmaking capacity and mental status examinations do not measure "competency."²⁸

A more consistent approach to decisionmaking capacity determinations among HCPs requires additional education. A joint effort among policy makers, health care providers, attorneys, and others will be needed to improve this situation. The model suggested by Applebaum and Roth provides an excellent starting point for establishing a model framework for assessing decisionmaking capacity. They advance a scheme based on four performance levels relevant to determinations of decisionmaking capacity.²⁹ Each of the four performance levels is discussed below.

1. *Evidencing a Choice.*—Someone who demonstrates an ability to make a choice by responding to questions, cooperating with a procedure, or expressing an interest in taking part in decisionmaking evi-

26. See Morris Freedman et al., *Assessment of Competency: The Role of Neurobehavioral Deficits*, 115 ANNALS INTERNAL MED. 203 (1991) (offering a "practical set of guidelines for assessing competency in patients," including the neurological mechanisms underlying competent decisions).

27. See JOSEPH J. GALLO ET AL., HANDBOOK OF GERIATRIC ASSESSMENT 17 (1988) ("Assessing attentiveness is important because a patient who is easily distracted and unable to attend to the examiner will have poor performance on mental status solely because of inattention.").

28. Carol H. Winograd, *Mental Status Tests and the Capacity for Self-Care*, 32 J. AM. GERIATRICS SOC'Y 49 (1984) (arguing that the Short Portable Mental Status Questionnaire is not an adequate predictor in assessing self-care).

29. Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCHIVES GEN. PSYCH. 951 (1992).

dences some decisionmaking capacity. For example, a demented individual who cannot rationally discuss whether they want to be tube fed, may still push the tube away, pull out an indwelling tube, or answer repeatedly, "I don't want it," in response to being advised about its possible placement. Often such communication can be useful in determining whether to perform a high-risk, uncomfortable, or life-sustaining procedure on someone who did not prepare a directive and for whom the procedure is of questionable value. The preferences of even a memory-impaired patient should weigh heavily in the final decision.

2. *Factual Understanding of the Issues.*—Factual understanding implies that a person is aware of the nature of the procedure or treatment, its risks and benefits, and facts about other alternatives.³⁰ For example, a person may be able to understand that she is being sent for an MRI scan because she fell and hit her head, but she may not be able to understand why an MRI scan is the appropriate test or the possible consequences of not doing one. Similarly, a partially capable person may be able to recall in general terms information presented about cataract surgery and may even be able to understand what it is for and what it would mean for their vision. That person, however, may not be able to recall the discussion subsequently or to understand the explanations about risk or the details of the procedure itself.

3. *Rational Manipulation of Information.*—Rational manipulation of information, including the ability to consider the alternatives and their potential consequences, involves the capacity for reality testing and judgment.³¹ For example, a person who is asked about a feeding tube would be able not only to explain what is involved in the procedure, but also the likelihood of progressive nutritional deficiency if a tube is not used, leading to further decline and eventual death.

4. *Appreciation of the Nature of the Situation.*—Finally, someone who demonstrates appreciation of a situation realizes they have a choice, understands what that choice is, comprehends the options and the consequences of those options, and can explain why they have chosen a certain option.³²

The standard of decisionmaking capacity should also relate to the expected risks and benefits of the decision. A low-risk procedure,

30. *Id.* at 953.

31. *Id.* at 954.

32. *Id.* at 954-55.

such as an X-ray test, will not demand as much thought or discussion as major surgery or hospitalization in an intensive care unit.

Medical illnesses may affect decisionmaking capacity temporarily or permanently. HCPs—especially nurses and physicians—should consider possible reversible causes of delirium, which invariably affect decisionmaking capacity, especially in anyone with abrupt changes in mental status or fluctuating consciousness. Common physical causes of altered mental status include infections, fluid and electrolyte imbalances, and drug toxicity. Such causes are especially common in the frail elderly and others of any age who have major chronic illnesses or who take many medications. If necessary, decisionmaking capacity should be reevaluated after delirium is resolved. Occasionally, those considered “incompetent” become more capable of making decisions after their problem is treated.

Also, HCPs should not confuse communication deficits with impaired decisionmaking capacity. The HCDA reflects the fact that some individuals may have effective nonverbal communication capabilities.³³ It may be necessary to try different ways to communicate with these individuals. In such cases, information from those familiar with the person may be especially important in helping evaluate their capacity.

HCPs should document specifically the degree and nature of a person’s decisionmaking capacity and its relevance to the required decisionmaking. For example, an appropriate note would be “This patient can understand some information, but cannot explain the basis for decisions. She cannot remember our discussions from the previous day. Nevertheless, I believe she understood our discussions about undergoing a biopsy.” When a patient’s decisionmaking capacity is unclear, appropriate consultants or the patient care advisory committee may help.

E. Defining the Patient’s Situation Accurately

The HCDA requires HCPs to respect patients’ wishes as stated in their advance directives. But some situations are not discussed explicitly in advance directives or it may otherwise be unclear. It is then necessary to decide whether and how the patient’s instructions apply. For example, a patient may say, “I decline life-sustaining procedures if my condition is hopeless and there is no possibility that the treatments

33. See MD. CODE ANN., HEALTH-GEN. § 5-601(1)(2) (1994) (“[A] competent individual who is able to communicate by means other than speech may not be considered incapable of making an informed decision.”).

would improve or restore a desirable quality of life." Several years later, that person may suffer a head injury, stroke, or pneumonia. Then or subsequently, several vital questions must be answered: What is the prognosis? Is the situation hopeless? Are life-sustaining procedures indicated? To what extent could treatment be successful? If treatment could potentially reverse the acute condition, would it have a significant impact on the overall prognosis and quality of life?

HCPs must jointly define such situations properly and determine the potential for treatment to be consistent with a patient's wishes and values. Some practitioners are uncomfortable with decisions that require additional explanations, discussion, and interpretation. HCP deficiencies in both these areas could undermine the effectiveness of these provisions of the HCDA.

All HCPs, but especially physicians, must try not to confuse the issues. Directives limiting treatment options may or may not limit evaluations to make a diagnosis or the use of unspecified treatments. Directives limiting cardiopulmonary resuscitation may not be extended to other treatments for specific medical conditions. These distinctions are especially important in the care of the frail elderly. Some physicians mistake potentially treatable acute situations, such as medication side effects, for exacerbations of irreversible chronic problems or even for a terminal condition. They may hesitate to investigate the cause of a problem because of a "Do Not Resuscitate" order or a premature conclusion that nothing should be done regardless of the cause. The law by itself cannot correct such misunderstandings.

F. Working Effectively with Substitute Decisionmakers

The HCDA defines categories of *substitute decisionmakers*, which may be defined as agents, guardians, or surrogates, who may make health care decisions for another individual. It requires HCPs to select and communicate with appropriately authorized substitute decisionmakers, and it guides the choice.³⁴ The HCDA also addresses some potential complications of dealing with substitute decisionmakers. For example, surrogates of the same class may disagree about the proper treatment options, or the HCP may feel that the substitute decisionmaker is not being "responsible." If there is no appointed agent and no one to fill the surrogate role, then health care providers may need a guardian.

34. *Id.* § 5-605.

HCPs, including physicians, should help substitute decisionmakers make decisions that reflect the patient's wishes and interests. Substitute decisionmakers may not fully understand the complex issues, or may be confused by the various treatment options; they may want to abide by the patient's wishes, but may not understand the relevance of various choices. The HCP must effectively present and interpret medical information for substitute decisionmakers.

The substitute decisionmaker must follow the patient's explicit or implicit wishes (substituted judgment). If these wishes are unknown or unclear, the substitute decisionmaker should act in the patient's "best interest"; that is, the decision should seek the best thing that could be done for the patient, or for a reasonable and prudent person in the same situation.³⁵

In applying the best interest standard, the law lists seven criteria which substitute decisionmakers should weigh when making decisions. These include the likely outcome of the treatment; whether benefits of treatment outweigh the burdens and risks; the treatment's impact on emotional, physical, and cognitive function; the associated pain; and the patient's religious beliefs and values.³⁶

HCPs must understand the implications of the "best interest" standard so they can guide substitute decisionmakers. Many physicians have held that if a condition can be treated, it is in someone's best interest to do so. But defining best interest is not strictly a medical issue. Considering medical care as a means to an end implies the need to assess more than the impact of a treatment upon the medical condition.

HCPs should also recognize the HCDA's emphasis on considering the benefits and burdens of specific treatments³⁷ rather than whether the individual should get any treatment at all. Any treatment may be withheld or withdrawn if it is *not* in the person's best interest to offer it. If no treatments are in that person's best interest, then none need be offered or continued. The HCDA's approach here should help HCPs focus primarily on medical benefit rather than on the value of someone's continued existence.

The HCDA requires physicians to refer cases to the facility patient care advisory committee or petition a court if they believe that a substitute decisionmaker is making a medically inappropriate decision.³⁸ If the patient is not in a health care facility, the physician *must* refer

35. *Id.* § 5-605(c).

36. *Id.* § 5-605(c)(2).

37. *Id.*

38. *Id.* § 5-605(b)(1).

such cases to court.³⁹ Practically speaking, few physicians will wish or need to use the judicial route. But even before simply using the ethics committee, HCPs should try to clarify the reasons for a particular decision. Sometimes, some additional discussion can resolve a misunderstanding.

In other cases, HCPs must deal with disagreements among surrogates. The HCDA creates a specific line of "succession."⁴⁰ If surrogates of the highest available class agree, then those of a lower class have no authority.⁴¹ A surrogate in a lower class cannot override one of a higher class. If surrogates of the same class cannot agree about withholding or withdrawing a life-sustaining procedure, the case should be referred to the patient care advisory committee.⁴² If the patient is not in an institution, and surrogates in the same class disagree, the physician cannot withhold or withdraw a life-sustaining procedure.⁴³ If a surrogate in one class is not available or is incapable of making decisions or chooses not to make them, the physician should consult someone in the next class.⁴⁴ A surrogate in a lower class who disagrees with the decisions of an appropriate surrogate of a higher class may petition for a court order, but has the burden to prove that those decisions are not consistent with the patient's wishes or in their best interest.⁴⁵

A potential problem is the HCDA's definition of "unavailable," which includes incapacity to make decisions.⁴⁶ If a potential surrogate is unavailable, a HCP may consult with those in the next lower class.⁴⁷ Therefore, as with the patient, the issue of determining a surrogate's capacity for medical decisionmaking may arise. As with patients, HCPs should use some objective criteria to assess a surrogate's decisionmaking capacity or "reasonableness."

G. *Interpreting the Medical Effectiveness of Treatments*

The HCDA codifies the ethical obligation to avoid giving medically ineffective treatment,⁴⁸ defined as treatment that, to a reasonable

39. *Id.* § 5-612(a).

40. *Id.* § 5-605(a)(2).

41. *Id.*

42. *Id.* § 5-605(b)(1).

43. *Id.* § 5-605(b)(2).

44. *Id.* § 5-605(a)(2).

45. *See id.* § 5-612(b).

46. *Id.* § 5-605(a).

47. *See id.* § 5-605(a)(1)(iv) (stating that "unavailable" includes when a "surrogate decision maker is incapacitated").

48. *Id.* § 5-611.

degree of medical certainty, will not prevent or reduce deterioration of an individual's health or prevent the individual's impending death.⁴⁹ While this is a good definition, it does not help practitioners determine whether a treatment meets these criteria.

Again, physicians have a critical role. They must certify medical ineffectiveness, but not alone define "best interests." The substitute decisionmaker should decide if a treatment is of value to the patient, if the physician determines it could potentially help the patient's medical condition.

Physicians must help explain the difference between treating a condition and solving a problem or improving overall status. They must be responsible for defining effectiveness and ineffectiveness carefully and recognize that "best interest" must relate to the overall objective of treatment in general, while medical effectiveness relates to a specific disease or condition.⁵⁰ This is particularly pertinent for the terminally ill, those in a persistent vegetative state (PVS) and those with advanced, progressive, irreversible conditions.

Thus, for instance, surgery may potentially correct acute abdominal distension with fever by removing a section of infarcted small intestine in someone with mesenteric artery blockage. But the broader consequences of the procedure for further improvement, or for sustaining a desirable quality of life, may be marginal. Therefore, the treatment may be medically "effective" but not in the patient's best interests.

Conversely, a substitute decisionmaker may request a treatment that the physician feels is medically ineffective. For example, a surrogate may request that a patient be placed on a ventilator, but the physician may believe that ventilatory support is futile (that is, to a reasonable degree of medical certainty the respiratory failure is not reversible and using the ventilator will not prevent or reduce the patient's deterioration or prevent impending death). In this case, the HCDA permits the physician to elect not to provide the treatment.⁵¹

However, if "generally accepted medical practice" considers a treatment to be potentially life-sustaining, two physicians must certify

49. *Id.* § 5-601(n).

50. See Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 950 (1990) (asserting that "the goal of medical treatment is not merely to cause an effect on some portion of the patient's anatomy, physiology, or chemistry, but to benefit the patient as a whole").

51. MD. CODE ANN., HEALTH-GEN. § 5-605(b) (1994). In case of a disagreement, however, the physician must first refer the case to the institution's patient care advisory committee. *Id.*

and document that the treatment is medically ineffective before it can be withheld or withdrawn.⁵² The attending physician must inform the patient, or an individual acting for the patient, of this conclusion.⁵³ The patient, agent, or surrogate has the right to seek transfer to another provider.⁵⁴ If transfer is desired, the request for the treatment must be honored pending the transfer if the failure to honor the request would likely result in the patient's death.⁵⁵

For example, if a spouse requests CPR for a patient and two physicians document that CPR would be medically ineffective, the attending physician is not obliged to order CPR. The physician may issue a "do not resuscitate" (DNR) order (with certification from a second physician) without an instruction from a patient, agent, surrogate, or guardian, but must give notice of such action. If the spouse does not wish a transfer, no further action is needed. However, if the spouse chooses to transfer the patient, then CPR must be provided if needed while the transfer is being arranged.

Again, the HCDA does not offer criteria for determining which procedures should be considered "medically ineffective." For example, while CPR is considered potentially medically effective in the general adult population, studies on CPR involving nursing facility patients strongly suggest that CPR is rarely effective and is never advisable in unwitnessed arrests.⁵⁶ Thus, although CPR could be viewed as a "medically ineffective" procedure in this specific population, there is no provision in the law for allowing the attending physician to declare CPR of a nursing home patient medically ineffective without getting a second physician's documentation. This may create problems in those nursing facilities with limited physician coverage, especially if an acute event such as a stroke or cardiac arrest has made prompt physician assessment necessary.

A major benefit of the HCDA is its support for the idea that treatment is reversible if it is not accomplishing its intended purpose. Prior to the HCDA, many physicians were reluctant to reverse treat-

52. *Id.* § 5-611(b)(2)(i).

53. *Id.*

54. *Id.* § 5-613(a)(1)(ii).

55. *Id.* § 5-613(a)(3).

56. See Gary E. Applebaum et al., *The Outcome of CPR Initiated in Nursing Homes*, 38 J. AM. GERIATRICS SOC'Y 197 (1990); Sissay Awoke et al., *Outcomes of Skilled Cardiopulmonary Resuscitation in a Long-Term-Care Facility: Futile Therapy?* 40 J. AM. GERIATRICS SOC'Y 593 (1992); R. S. Gulati et al., *Cardiopulmonary Resuscitation of Old People*, 1 LANCET 267 (1983); Steven H. Miles et al., *CPR in Nursing Homes: Policy and Clinical Realities*, 74 MINNESOTA MED. 31 (1991); Steven H. Miles, *Resuscitating the Nursing Home Resident: Futility and Pseudofutility*, 38 J. AM. GERIATRICS SOC'Y 1037 (1990).

ment decisions and withdraw existing treatments. As the potential effectiveness of a treatment is sometimes unclear at first, HCPs should consider offering a therapeutic trial or "time-limited treatment." Subsequently, the HCPs and substitute decisionmakers should consider whether to extend or to discontinue the treatment.

H. *Withholding or Withdrawing Life-Sustaining Procedures*

The HCDA contains penalties for giving health care contrary to an advance directive, and for withholding life-sustaining care against an individual's wishes.⁵⁷ The law does not penalize withholding or withdrawing non-life-sustaining care against someone's wishes, but doing so may potentially create civil liability.

The HCDA prescribes a process to decide whether a surrogate decisionmaker may authorize withholding or withdrawal of life-sustaining procedures. An advance directive that does not appoint an agent cannot be used to withhold or to withdraw life-sustaining procedures unless the attending physician and a second physician certify that the resident is terminal or in an end-stage condition,⁵⁸ or two physicians certify that the resident is in a PVS.⁵⁹

1. *Qualifying Conditions.*—The HCDA defines PVS as a state in which a person has lost consciousness and exhibits no awareness of self or surroundings other than reflexively.⁶⁰ Some physicians may be reluctant to declare any vegetative state as persistent or irreversible because of rare instances in which patients in prolonged vegetative states have regained consciousness. Thus, it is significant that the HCDA's definition of PVS focuses on the awareness of self and surroundings and does not specify any duration of unconsciousness as a marker of persistence.

The medical literature provides some guidelines for considering the permanence of a vegetative state.⁶¹ Medical criteria for defining PVS include: history of extensive brain injury from any cause; abnor-

57. MD. CODE ANN., HEALTH-GEN. § 5-610(b) (1994).

58. *Id.* § 5-606(b)(1).

59. *Id.* § 5-606(b)(2) (one of the two physicians is to be a neurologist, neurosurgeon, or other physician with special expertise in cognitive functioning, such as a geriatrician).

60. *Id.* § 5-601(o)(1).

61. See, e.g., D. Bates et al., *A Prospective Study of Nontraumatic Coma: Methods and Results in 310 Patients*, 2 ANNALS NEUROLOGY 211 (1977); Henry K. Beecher et al., *A Definition of Irreversible Coma*, 205 JAMA 85 (1968); Ronald E. Cranford & Harman L. Smith, *Some Critical Distinctions Between Brain Death and the Persistent Vegetative State*, 6 ETHICS SCI. MED. 199 (1979); David E. Levy et al., *Prognosis in Nontraumatic Coma*, 94 ANNALS INTERNAL MED. 293 (1981); Daniel Silverman et al., *Cerebral Death and the Electroencephalogram: Report of the Ad Hoc Committee of EEG Criteria for Determination of Cerebral Death*, 209 JAMA 1505 (1969); A.

mal CT scan showing loss of brain substance; lack of awareness of environment and self; inability to communicate; and presence of only reflex or random motor activity to stimulus.⁶² These findings should be made in the absence of sedative, toxic, or systemic complications that alter the level of awareness. An experienced physician should perform a careful neurologic examination to establish that pertinent physical findings exist. As needed, the CT scan may be supplemented by angiography or other radiographic tests.

The extent to which it is desirable to continue aggressive treatments depends on the overall condition, prognosis, and reason for the unconsciousness.⁶³ No significant neurological recovery after one month is a poor prognostic sign, and no significant recovery after six months is an almost certain indicator of permanence.⁶⁴ In non-traumatic coma, signs suggesting a poor prognosis include absent motor responses at admission,⁶⁵ poor motor responses at three days despite awakening at day one, persistent roving conjugate eye movements at one week, and persistent coma at one week.⁶⁶ In all cases, a physician should perform serial neurologic examinations to document lack of progress.

Thus, the physician should be flexible in defining persistence. Making predictions in younger individuals with isolated acute conditions, such as a head injury from an auto accident, may differ from doing so for the already compromised individual who becomes comatose from a second major stroke. In the latter case, it is probably futile to continue care for months in anticipation of an expected recovery. In the former case, it may be appropriate to continue supportive treatments for some months before concluding that there is no hope for recovery (unless there are clear signs of extensive brain damage).

A terminal condition is considered to be one that, to a reasonable degree of medical certainty, will cause an imminent death and is incurable, and from which recovery is impossible even if life-sustaining procedures are used.⁶⁷ Life-sustaining procedure refers to any

Earl Walker et al., *The Neuropathological Findings in Irreversible Coma*, 34 J. NEUROPATHOLOGY EXPERIMENTAL NEUROLOGY 295 (1975).

62. See generally Bates et al., *supra* note 61 (documenting extensively the criteria and functioning of 310 patients for purposes of assessing useful indicators for prognosis).

63. *Id.* at 218.

64. *Id.* at 216.

65. *Id.* at 216-17.

66. *Id.* at 217.

67. MD. CODE ANN., HEALTH-GEN. § 5-601(q) (1994).

mechanical or artificial means, including artificial nutrition and hydration, for sustaining a person's life.⁶⁸

Physicians are often asked to quantify a person's remaining life expectancy or to declare that death is imminent so that a treatment could be withheld. It is difficult to precisely time an "imminent" death. In the past, when terminal illness was the only acceptable criterion for withholding treatment, the term "imminent" had been stretched to mean anywhere from days to months. Because of a physician's reluctance to agree that death was imminent, a lot of undesired or medically ineffective treatment was given.

Fortunately, the HCDA's additional categories of PVS and end-stage condition⁶⁹ allow physicians to consider a persistent vegetative state with no likely improvement, or progressive decline with no realistic hope of recovery, as circumstances for withholding or withdrawing care, even if death is not imminent. This enables physicians to focus primarily on the potential benefits of treatment for a person's overall condition and prognosis rather than on trying to predict when they will die.

2. *The Supportive Care Plan.*—A supportive care plan implies that a patient will receive only comfort measures and pain relief, but no aggressive medical interventions. This may be appropriate in a terminal condition, PVS, or end-stage condition when further treatment is undesired or is likely to be medically ineffective. Typically, this implies all of the following: do not resuscitate; do not hospitalize; do not intubate; do not use artificial means of nutrition or hydration; do not transfuse; do not use antibiotics; and do not use intravenous fluids.

When such an approach is selected, HCPs should ensure that adequate supportive measures are ordered and given. Doing so benefits the patient and reassures a family or other substitute decisionmaker that comfort measures are humane alternatives to aggressive medical intervention. Various HCPs, including physicians, should reinforce this message, so substitute decisionmakers can overcome reservations and authorize appropriate limitations. HCPs should not equate supportive care with "doing nothing." Unless they understand the value of comfort measures, substitute decisionmakers may authorize unne-

68. *Id.* § 5-601(m)(1)(i)-(ii).

69. The HCDA defines an end-stage condition as an "advanced, progressive, irreversible condition" that has caused individuals severe, permanent deterioration and made them incompetent and completely dependent. *Id.* § 5-601(i)(1). Furthermore, it must be determined that to a reasonable degree of medical certainty the treatment would be medically ineffective. *Id.* § 5-601(i)(2).

essary or excessively aggressive treatment to satisfy themselves that they are not neglecting the patient. Often, they do this because the HCP has not clarified the options sufficiently.

I. Emergency Treatment

Highly aggressive medical intervention has become a traditional part of emergency medical care. Thus, prior to the HCDA, emergency practices sometimes contradicted existing limited treatment plans because hospital Emergency Room (ER) staffs and Emergency Medical Technician (EMT) teams would automatically provide aggressive care regardless of other wishes.

Under the HCDA, this practice should change. Pursuant to section 5-608 of the Act, an EMT can withhold CPR if DNR orders have been issued in accordance with Maryland Institute of Emergency Medical Services protocols or if oral DNR orders are issued by the EMT medical command or a physician on the scene.⁷⁰ This permits subsequent limitations on treatment for individuals who enter the emergency medical system because of a sudden illness or accident, or a panicked request for emergency intervention contrary to directives.

The HCDA authorizes health care providers to give emergency treatment without consent if the patient cannot make a decision, no authorized decisionmaker is available, and delay in treatment would, to a reasonable degree of medical certainty, adversely affect a person's life or health.⁷¹ HCPs should use this provision judiciously, and be prepared to reverse treatment which is later determined to be inconsistent with someone's wishes or if an appropriately authorized substitute decisionmaker requests such limits. Even such measures as placing a gastrostomy feeding tube, or intubation and mechanical ventilation, are reversible depending on the situation.

III. OTHER ISSUES RELEVANT TO THE PROCESS

A. Physician Withdrawal from Cases

The HCDA permits physicians to withdraw from cases where they have irreconcilable differences with decisionmaker(s).⁷² Physicians have different comfort levels in handling ethical issues, including requests for limiting the scope and duration of medical treatments. However, a physician's reluctance or refusal to deal with the issues

70. *Id.* § 5-608.

71. *Id.* § 5-607.

72. *See id.* § 5-613 (requiring that the HCP inform the decisionmaker and make every reasonable effort to transfer the patient to another HCP if requested to do so).

should be the exception, not the rule. A physician who wishes to withdraw cannot just ignore the patient's or substitute decisionmaker's wishes, but must follow certain procedures.⁷³

B. *Physicians and Court Proceedings*

The HCDA guides the judiciary in cases regarding the withholding or withdrawal of life-sustaining procedures.⁷⁴ Moreover, a judge may allow a guardian to request withholding or withdrawing of treatment without having to return to court.⁷⁵ Typically, however, there must be a reliable medical basis for making these decisions.

Physicians may be involved directly or indirectly in guardianship proceedings. Their roles may include assessing a patient's decision-making capacity, condition, and prognosis and informing a court about their findings and the basis for their opinions and recommendations.

Given the number and complexity of such proceedings, and the significant implications of related decisions, physicians could clearly have a major impact under the HCDA if they provide thoughtful, complete, and timely information. Most physicians, however, are reluctant to prepare reports or to go to court. Thus, considerable thought should be given to revamping the entire guardianship system, to streamlining related processes, and to facilitating the physician's role, for example, by allowing videotaped testimony or use of a videophone for remote testimony.⁷⁶

C. *Law, Ethics, and the Overall Problem-Solving Process*

Several factors influence how well health care providers manage these difficult problems. Paradoxically, the HCDA's greater complexity compared with past laws ultimately facilitates the decisionmaking process and allows greater latitude for both patients and health care providers, including physicians. The HCDA should help reduce much of the fear and confusion that now inhibit health care decisionmaking.

But, like any law, the HCDA cannot guarantee good judgment or effective decisionmaking processes. Facilities, patients, and HCPs, including physicians, all must help this new law serve its intended pur-

73. *Id.*

74. *Id.* § 5-612.

75. *See id.* § 5-605.

76. Another option might be to allow a nonphysician provider to present the views of a collection of HCPs who have assessed a person's decisionmaking capacity, as long as these have been discussed and documented appropriately.

pose. HCPs must understand and adhere to the law's prescribed processes. They also must collaborate with policy makers and attorneys to reduce the fear of consequences that could still continue to inhibit effective decisionmaking.

Effective handling of ethical issues requires adherence to a rational, systematic, truly interdisciplinary problem-solving process. Defining problems correctly must precede reaching conclusions about treatment. The varied assumptions and values involved from start (problem definition) to finish (treatment plan and medical orders) must be understood by all participants.

D. Improving Physician Participation

One reason for passing the HCDA was to help physicians do a better job, and to support patients and families in making decisions without being blocked by recalcitrant physicians. It is important to look beyond the law at how to achieve these goals better.

There are many reasons why physician participation—like that of other participants in the processes—may be less than effective. These reasons may be grouped into problems of knowledge, attitudes, communications, and interpretation. (See Table 1.) Various approaches can help improve the situation. (See Table 2.)

First, traditional medical education and training has heavily emphasized technical training and underemphasized vital issues such as communicating effectively and learning how to define problems precisely. Physicians may have trouble effectively communicating information, precisely defining and explaining a problem, or assessing their patients' understanding of their conditions. Those who train medical professionals must be adept at handling these problems and at communicating information, so that trainees can learn by example. Showing people how to do something correctly and providing them with positive feedback is more effective than just telling them they must do it.

Second, some health care facilities must improve their systems and processes for decisionmaking. Fortunately, Maryland's law requiring a patient care advisory committee in health care facilities has helped somewhat. But some facilities with policies and procedures on paper are nonetheless weak in implementation and quality improvement processes.

Third, practicing physicians have few incentives to improve their skills at handling ethical issues. Despite the importance of those skills, they are not needed to graduate from medical school, to complete residency programs, or to obtain licensing or certification. Answering

test questions about handling ethical issues does not adequately reflect practical skill in doing so.

Fourth, some physicians still do not take nonmedical issues seriously, but consider them to be "unscientific" matters for nurses, social workers, or administrators to handle. Physicians from some countries or cultural backgrounds appear to have difficulty sharing medical decisionmaking responsibility or discussing issues of limiting or withdrawing treatment. Medical societies and associations should strongly support greater, more constructive physician involvement in these issues. Also, physician malpractice insurers should cover ethical decisionmaking principles and practices in their risk management courses, which physicians often attend to get a reduction in their malpractice insurance premiums.

Finally, effective decisionmaking may be inhibited by the fear of subsequent second guessing, penalties, or liability. For example, nursing facility staff contemplating removal of a feeding tube may fear second-guessing by surveyors during licensure surveys. Thus, consistent interpretation and clear guidance by agencies overseeing health care practitioners and facilities can support more effective decisionmaking by reducing fear.

Previously, many health care facilities have felt helpless in the face of physician resistance. Now, provider organizations, medical associations, facilities, and individual physicians with authority, such as hospital vice presidents for medical affairs and nursing facility medical directors, should collaborate on these issues. Physician managers must help educate physicians, improve processes, and clarify appropriate physician roles.

Other HCPs (nurses, social workers, etc.) must assume more of a decisionmaking role and not defer all decisionmaking to physicians. They should do as much fact-finding as possible to help physicians make better decisions. They should consider that *how* questions are asked largely determines the answers received. Asking physicians "targeted" or "guided" questions, like "The patient's best interest has been determined to be What treatment options are most consistent with those conclusions?", is more likely to get the answers needed than asking open-ended questions, such as, "We need your orders so we know what to do," or "What is in the patient's best interest?"

E. Problems in Dealing with Patients or Substitute Decisionmakers

Part of the HCDA's success depends on how well health care providers help laypeople be more responsible decisionmakers. There are a number of reasons for suboptimal or irresponsible ethical deci-

sionmaking by laypeople. (See Table 3.) While some problems are due to personal inadequacies of the patient or substitute decisionmaker, most are related to deficiencies in communication or in decisionmaking processes, as discussed above. HCPs must recognize their vital role in improving the communications process, eliciting the appropriate information, and guiding patients and families to ask the right questions.

Possible solutions to these challenges include stronger support by health care facilities and administrators for their practitioners' efforts to provide relevant information; more acquisition and use of alternative communications like written, video, and computer-based self-instruction to supplement discussions; and redoubled efforts to improve communication processes. Physicians should help improve these processes.

Moreover, the whole public education system must assume a greater role in incorporating discussions of these issues into the general curriculum. Laypeople must be trained to make informed, responsible health care decisions. That training should not await personal crises, but rather should be as much a part of their ongoing education as science courses or social studies.

CONCLUSION

Maryland's HCDA has many positive benefits for its citizens and health care providers. It is a potentially useful model for the rest of the country, because the benefits of the law—including the emphasis on rational decisionmaking, consistent processes, and shared responsibility—have broader implications for progress in overall health care reform. But no law by itself can resolve all the issues it addresses, and the HCDA has not addressed the technical aspects of how to apply its provisions better in real life. Thus, it demonstrates that health care should always be considered in the broader context of how it relates to all other aspects of our lives. Only then can health care decisionmaking be related most effectively to the purpose of health care: a means to an end, not an end in itself.

TABLE 1
 CAUSES OF SUBOPTIMAL PHYSICIAN PARTICIPATION IN
 ETHICAL DECISIONMAKING PROCESSES

CATEGORY	PROBLEM
KNOWLEDGE	<ul style="list-style-type: none"> • Inadequate understanding of the underlying issues • Inadequate understanding of risks/benefits of various treatment options • Insufficient knowledge of various options to manage different situations • Insufficient knowledge of pertinent laws and regulations • Failure to understand individual rights
ATTITUDES	<ul style="list-style-type: none"> • Personal discomfort in dealing with issues • Personal philosophies and perspectives considered to take precedence over those of patients • Perception of decisionmaking as a power struggle • Fear of personal legal or other consequences for the decisions that are made
COMMUNICATION	<ul style="list-style-type: none"> • Failure to listen to patient/family or staff • Insufficient explanation of facts, options to decisionmakers or other caregivers • Inadequate responses to patient/family or staff questions
INTERPRETATIONS	<ul style="list-style-type: none"> • Failure to correctly define the patient's problem • Premature conclusion about treatment before considering preliminary assumptions and relevant facts • Listening to family and ignoring legitimate wishes of patient • Misinterpretation of current prognosis or significance of condition change • Confusion of DNR with "Do Not Treat" or "Do Not Evaluate"

TABLE 2
POSSIBLE APPROACHES TO IMPROVING PHYSICIAN
PARTICIPATION IN ETHICAL DECISIONMAKING

EDUCATION	<ul style="list-style-type: none"> • Better training of physicians in communications skills • Better training in undergraduate and postgraduate medical education in understanding and handling ethical problems • More case-based guidance from faculty in education and training programs • Better training in the specific details of relevant laws, regulations • Requirements for faculty to demonstrate appropriate knowledge, attitudes, and skills regarding ethical decisionmaking
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SYSTEMS SUPPORT	<ul style="list-style-type: none"> • Better systems and processes in health care facilities for managing ethical issues • More and more effective feedback from physician leadership (department heads, medical directors, etc.) regarding individual performance in handling ethical issues • More readily available resources for information and expert guidance • Better support from health care facility administrations for handling issues without fear of legal entanglements
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REGULATORY	<ul style="list-style-type: none"> • Required basic proficiency in handling ethical issues as part of licensure and certification process • More explicit guidance and consistent interpretation of requirements by regulatory agencies
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PROFESSIONAL SUPPORT	<ul style="list-style-type: none"> • More attention paid by insurance carriers and by medical societies and associations • Professional associations emphasize greater receptivity by physicians to advice and input from other disciplines

TABLE 3
 POSSIBLE REASONS FOR SUBOPTIMAL ETHICAL
 DECISIONMAKING BY PATIENTS OR SUBSTITUTE
 DECISIONMAKERS

DECISIONMAKERS	<ul style="list-style-type: none"> • They think they understand, so they don't request more clarification • They have personal limitations in comprehending information generally • They don't want to make a decision • They are afraid they might do the wrong thing • They hold out until they hear what they want to hear • They misinterpret the information they receive • They do not admit that they do not understand
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HEALTH CARE PROVIDERS	<ul style="list-style-type: none"> • Providers fail to give decisionmakers all relevant facts about the condition, options, risks, prognosis, etc. • Providers give decisionmakers incorrect information • Providers erroneously interpret the facts for decisionmakers • Providers fail to respond adequately to their request for additional explanation or information • Providers fail to clarify or to understand the rationale behind the decisionmaker's conclusions
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