## *C* *ACTION ITEMS FOR REVIEW OF EXISTING LEGISLATION SUBCOMMITTEE*

## I. Reforming Portions of the Health Care Decisions Act

### *Confusing Forms*

Members of the subcommittee discussed both their own impression and empirical evidence (a study conducted some years ago by Professor Diane Hoffmann) that the two optional forms now in the Health Care Decisions Act (HCDA), the advance directive and living will, are difficult for many to use. With their overlapping scope and sometimes unclear language, the current documents may hinder the expression of an individual's wishes. The Council should consider combining the statutory advance directives into one user-friendly form. This new, optional form should be present in the HCDA because we agree with the legislature's intent of including a legally acceptable form to allow people to document their end of life care wishes without a lawyer's assistance.

While this subcommittee acknowledges a degree of uncertainty in the terms "terminal condition" and "persistent vegetative state," we believe the definitions present in the HCDA are adequate and should not be amended. These inexactly defined terms reflect inevitable clinical grey areas and necessarily rely on physicians using their best judgment.

### *Two Physician Requirement*

Section 5-606 of the HCDA states that "prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician ...shall certify in writing that the patient is incapable or making an informed decision regarding the treatment. " The Council should revisit and reevaluate this two physician requirement because there are some settings, such as nursing homes, where it is rare to have more than one physician making regular rounds.

### *Health Care Agents and Surrogates*

The Council should look at whether the HCDA provides sufficient and appropriate guidance about the scope of a health care agent's decision-making authority when the patient has also executed an instructional advance directive.

Under the law, disputes among surrogates with equal decision making priority are resolved by an institution's patient care advisory committee, commonly referred to as an ethics committee. It is not uncommon, however, for these committees to convene infrequently (especially in long-term care settings) and to have many items on their agenda. Also, assembling the committee members in a timely way may be difficult. The Council should explore a more efficient and timely mediation mechanism for resolving disputes among surrogates of the same priority order.

## II. Guardianship Laws

Although the HCDA greatly reduced the need to use guardianship as a means of designating a proxy decision maker, some end-of-life cases still are decided by the courts. To ensure that judges are informed about the proper clinical considerations and legal standards they should consider when adjudicating these cases, the Council should advocate for a judicial education program on end of life issues.

## III. Medicaid Hospice Benefit

The Medicare hospice benefit requires a physician's certification that a patient's life expectancy is six months or less. This eligibility requirement has traditionally been incorporated into the Medicaid program's comparable benefit. We recognize, however, that often doctors are reluctant to predict so specifically about a patient's life expectancy and that in some cases patients should not have to forgo all curative treatments to avail themselves of palliative care. The Council should explore changes to Maryland's Medicaid program that would end reliance on a six-month prognosis requirement.

## IV. Educational Efforts

### *Modes of Education*

When the Council is ready, it should consider a media campaign using local radio and television media.  Outreach to underserved communities could also take place by contacting community leaders such as religious ministers and popular role models.

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