Written Testimony in Support of HB 1323

Treatment Decisions for Unrepresented Hospital Patients
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Madams Chair and Vice Chair, and Members of the Committee, thank you for the opportunity to submit written testimony in strong support of HB 1323.

My name is Diane Hoffmann. I am a professor at the University of Maryland Carey School of Law, where I direct the Law & Health Care Program and the Maryland Health Care Ethics Committee Network. At the request of Maryland Delegate Sandy Bartlett and urging of members of the Network, I convened the Working Group on Alternatives to Guardianship for Unrepresented Hospital Patients. Over the past eighteen months, our group—representing hospitals, clinicians, disability and aging advocates, long-term care providers, state agencies, and court-appointed counsel—studied a problem that has persisted in Maryland for over a decade and has grown more urgent.

The Problem: Maryland's Current Guardianship System Causes Harm

Under current Maryland law, when a patient lacks decision-making capacity and has no legally authorized surrogate, hospitals must petition the court for a guardian before providing any non-emergency treatment. As our report documents, one Maryland hospital "*waited 225 days for a guardian to be appointed*," and others routinely face "*delays of 50 to 70 days"* before a hearing is held. These delays are not benign. They can lead to prolonged suffering and preventable clinical harm.

The Working Group heard repeated accounts of clinicians forced to watch patients "*linger in pain and discomfort*" simply because no surrogate existed to authorize treatment. Delays in procedures such as tracheostomy or dialysis can worsen outcomes, increase infection risk, and prolong ICU stays. These harms fall disproportionately on older adults, individuals experiencing homelessness, and people with serious mental illness.

Maryland attempted to address this issue in 2011 and again in 2024, but the underlying problem remains: guardianship is too slow, too restrictive, and too resource-intensive for the narrow, time-sensitive decisions hospitals must make.

HB 1323: A Balanced, Less Restrictive Solution

HB 1323 amends the Health Care Decisions Act (HCDA) to authorize a hospital-based surrogate decision-making committee for treatment decisions only. The committee includes:

- Four hospital members: a physician, nurse, social worker or clergy member, and an ethics committee representative
- Three community members: a patient advocate, former patient or caregiver, and disability/aging advocate

Any decision to provide, withhold, or withdraw treatment must include at least two hospital members and two community members voting in favor. This structure ensures fairness, incorporates persons with lived experience, and guards against bias. It is also a less restrictive alternative to guardianship, consistent with the principles of dignity, due process, and patient rights that guided our Working Group.

The committee's authority is strictly limited to treatment decisions. It cannot authorize discharge. All existing safeguards in the HCDA remain in place, including:

- Capacity determinations by two clinicians
- Exhaustion of all surrogate options
- Substituted-judgment and best-interest standards
- Statutory limits on life-sustaining treatment decisions

Other states—including Alabama, Arkansas, Arizona, North Dakota, and Tennessee—already use similar models.

Case Studies Illustrating the Need for HB 1323

Case Study 1: The 200-Day Wait

A patient in Anne Arundel County requires a tracheostomy after prolonged ventilation. The hospital applies for a guardian of the person and may have to wait *200 days for a guardian to be appointed*. During this time, the patient remains intubated, sedated, and at risk for a myriad of complications well known to be associated with prolonged intubation and ICU stays including ventilator-associated pneumonia, airway damage, sepsis, decubitus ulcers, muscle weakness, blood clots, and delirium. A surrogate committee could have authorized a tracheostomy within days, reducing suffering and improving prognosis.

Case Study 2: Dialysis Delay and Preventable Harm

A Baltimore City hospital has a patient with acute kidney injury who needs dialysis. Because no surrogate can be located, the hospital must petition for guardianship. The "*delays of 50 to 70 days*" before a hearing means the patient receives only emergent, stop-gap dialysis under the emergency exception. A committee could have authorized a regular dialysis schedule, preventing repeated crises and stabilizing the patient's condition.

Case Study 3: Moral Distress and Overtreatment

Clinicians report the moral distress of watching patients "*linger in pain and discomfort*" because no one is authorized to consent to withdrawal of burdensome treatment. At one hospital, a patient with an end-stage condition remains on aggressive interventions for weeks solely because no surrogate exists. A committee could have applied the statutory best-interest standard and allowed a humane, medically appropriate plan of care.

Case Study 4: The Patient with No Known History

Hospitals frequently admit patients with no identifying information—often individuals experiencing homelessness or severe mental illness. These patients may need urgent but non-emergency procedures, such as fracture repair or infection management. Without a surrogate, hospitals must wait weeks for guardianship. A committee could act promptly, preventing complications such as sepsis, loss of mobility, or chronic pain.

Addressing Possible Objections

Objection 1: "This gives hospitals too much power."

Response:
The committee is deliberately balanced: three community members must participate, and at least two must vote in favor of any decision. This is not a hospital-controlled process. It is a shared, accountable one.

Objection 2: "This could lead to withdrawal of life-sustaining treatment without adequate safeguards."

Response:
HB 1323 incorporates all existing statutory protections. The committee cannot withdraw life-sustaining treatment unless two clinicians certify that the patient is terminally ill, in a persistent vegetative state, or has an end-stage condition. These are the same limits that apply to all surrogates.

Objection 3: "Why not just improve guardianship?"

Response:
Guardianship is not designed for rapid clinical decisions. Even with reforms, it will remain slow, costly, and rights-restrictive. HB 1323 provides a targeted, efficient alternative for treatment decisions only.

Objection 4: "What about conflicts of interest?"

Response:
The committee's mixed composition, voting structure, documentation requirements, and annual reporting create more transparency and oversight than the status quo. Also, the literature shows that committees reduce—not increase—risk of bias.

Objection 5: "This will be too burdensome to the state agencies required to provide training to committee members."

Response:

The Department of Human Services regularly conducts training programs for persons who are appointed as public guardians. This training includes much of the same content required by HB 1323 of surrogate committee members and should not be a significantly burdensome task. Once the content is prepared it can be used repeatedly and in the future without requiring additional work from the agencies.

Objection 6: "The formation of a committee with external members will be too burdensome for hospitals to establish."

Maryland hospitals are already familiar with committee structures that include external, unaffiliated members. For example, every hospital that conducts human subjects research must maintain an Institutional Review Board (IRB), and federal regulations require each IRB to include at least one member who is not affiliated with the hospital and not part of its workforce. Additionally, many hospitals include one or more community members on their Patient Care Advisory Committees ("ethics committees"). These examples demonstrate that hospitals can successfully recruit external members when the goal is to protect vulnerable individuals and ensure balanced, accountable decision-making. HB 1323 follows this well-established approach by incorporating community members into the surrogate decision-making committee, ensuring that treatment decisions for unrepresented patients reflect both clinical expertise and independent perspectives. The bill does not dictate how hospitals are to recruit members for the committee but there are a number of options available including: 1) sharing external members across hospitals; 2) having the Maryland Hospital Association establish a pool of volunteers; or 3) for hospital systems, establishing one pool of external members for all the hospitals in the system.

Objection 7: "Hospitals will likely have to apply for a guardianship of the person, in any case, when the patient needs to be discharged."

While hospitals may ultimately need to seek a guardian of the person to authorize discharge, that reality does not eliminate the need for timely treatment decisions now. The duration of the patient's hospitalization is uncertain—often days or weeks—and without a decision-making mechanism in place, the patient will remain untreated during that period. That delay not only compromises the standard of care but also prolongs the hospitalization itself, because the patient cannot stabilize or improve without the necessary treatment. Waiting for a public guardian to be appointed before any care can proceed effectively extends the hospital stay and worsens the very discharge delays this objection assumes are inevitable.

Conclusion

Maryland's current system leaves unrepresented patients without timely, appropriate care and places hospitals in untenable legal and ethical positions. HB 1323 offers a narrow, balanced, and humane solution. It prevents unnecessary guardianships, reduces harm, and ensures that some of Maryland's most vulnerable individuals receive timely, medically appropriate treatment.

For these reasons, and on behalf of the Working Group, I respectfully urge a favorable report.