December 27, 2025

Report of the Working Group on Alternatives to Guardianship for Unrepresented Hospital Patients in Need of Treatment and Discharge Decisions

Submitted as Background in Support of

House Bills 1062 and 1323

By the

Maryland Healthcare Ethics Committee Network

And the

Alternatives to Guardianship Working Group

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Executive Summary

Maryland hospitals face persistent and harmful delays when caring for **unrepresented patients**—individuals who lack decision-making capacity and have no legally authorized surrogate to consent to treatment or discharge. Under current Maryland law, hospitals must obtain a **court-appointed guardian** before providing non-emergency treatment or arranging discharge. These guardianships routinely take **weeks or months**, during which patients experience avoidable harm and hospitals lose critical capacity. As the report documents, one hospital "*waited 225 days for a guardian to be appointed*," and others face "*delays of 50 to 70 days*" before a hearing is held.

These delays lead to **overtreatment, undertreatment, prolonged suffering, increased clinical risk, and extended hospital stays**, disproportionately affecting older adults, individuals experiencing homelessness, and people with serious mental illness. Providers report moral distress, and hospitals experience operational strain. Maryland has attempted to address the issue before—most notably in a 2011 workgroup—but the situation has not improved and, in many cases, has worsened.

Following the failure of HB 698 in 2024, which sought to expedite guardianship hearings but raised concerns about overuse of guardianship, Del. Sandy Bartlett asked faculty at the University of Maryland Carey School of Law's Maryland Healthcare Ethics Committee Network o convene a **Working Group** of stakeholders to address the problem. The group's charge was to identify **less restrictive, more efficient alternatives** to guardianship for both treatment and discharge decisions.

Key Findings

- Guardianship is **too slow** and **too restrictive** for the narrow, time-sensitive decisions hospitals must make.
- Delays cause **clinical harm**, including increased risk of complications when procedures such as tracheostomy or ventilator withdrawal are postponed.
- Maryland law provides **no mechanism** for treatment or discharge decisions for unrepresented patients outside guardianship and emergencies.
- Discharge delays are often driven by the inability to access financial records or complete Medicaid applications without a guardian of the property.

Major Recommendations

1. Establish a Surrogate Decision-Making Committee for Treatment Decisions

Amend the **Health Care Decisions Act** to authorize a **hospital-based committee**, supplemented by external community members, to make treatment decisions when no surrogate exists.

Committee composition:

- Four hospital members (physician, nurse, social worker or clergy, ethics committee member)
- Three community members (e.g., former patient/caregiver, disability or aging advocate)
- Decisions require support from **at least two hospital members and two community members**.

Safeguards:

- Apply existing substituted-judgment and best-interest standards.
- Require capacity determinations by two clinicians.
- Prohibit decisions on sterilization or mental health treatment.
- Require training, documentation, and annual reporting.
- Provide liability protections similar to existing advisory committees.

2. Limit Committee Authority to Treatment Decisions

The committee may authorize treatment, withholding, or withdrawal of treatment, but **may not authorize discharge**. Transfers for medical reasons remain permissible.

3. Create a Less Restrictive Alternative for Discharge Decisions

Amend **Estates & Trusts §13-204** to allow courts to authorize **specific transactions** that include accessing financial records, applying for Medicaid, or demonstrating ability to pay—**without appointing a guardian of the property**. This targeted authority would enable timely discharge planning while preserving patient rights.

4. Address the Shortage of Guardians of the Property

The Working Group concurs with the state's Elder Abuse Task Force that Maryland must develop a sustainable mechanism to **compensate court-appointed guardians of the property**, though fiscal constraints prevented a specific proposal.

Conclusion

Maryland's guardianship-dependent system leaves unrepresented patients without timely, appropriate care and places hospitals in untenable legal and ethical positions. The Working Group recommends a **dual-track reform**: (1) a surrogate committee to make treatment decisions, and (2) a court-authorized transaction process to expedite discharge without unnecessary guardianship. Together, these reforms would protect patient rights, reduce harm, and improve hospital efficiency for some of Maryland's most vulnerable individuals.

Background

The Working Group (WG) on Alternatives to Guardianship for Unrepresented Hospital Patients was convened in August 2024 to address a critical issue in patient care across Maryland. The group focused on unrepresented patients in Maryland hospitals. These are individuals who have been certified by two physicians as lacking decision-making capacity and who have no legally authorized surrogate—such as a family member or designated proxy—to consent to or decline medical treatment or discharge on their behalf.

Under current Maryland law, unless the situation qualifies as a medical emergency involving imminent risk of death or serious bodily harm,[1] hospitals must petition a court for guardianship before proceeding with non-emergency treatment. This legal requirement often results in significant delays. Hospitals report that court-appointed guardianships can take weeks or even months, during which patients may receive substandard care and face avoidable harm. In other circumstances, this substandard care could lead to malpractice.

Data from Maryland courts in FY 2024 illustrate the severity of these delays:

- In Anne Arundel County, one hospital waited 225 days for a guardian to be appointed; another case took 114 days.
- In Baltimore City, hospitals routinely experienced delays of 50 to 70 days before a guardianship hearing was held.

Similar delays occur when hospitals want to discharge an unrepresented patient who no longer needs acute level care. These delays can lead to both overtreatment and undertreatment—ranging from unnecessary procedures to the withholding of beneficial interventions. Additional harms include delayed care that worsens clinical outcomes, prolonged suffering, and extended hospital stays. Health care providers also experience moral distress as they witness patients receiving inadequate care. Moreover, treatment and discharge delays strain hospital efficiency and reduce available capacity.

Vulnerable populations—including older adults, individuals experiencing homelessness, and those with serious mental illness—are disproportionately affected. Implicit bias may further influence the quality and type of care these patients receive.

Although Maryland does not publish a formal count of unrepresented patients, available data offer insight into the scope of the problem. National estimates suggest that between

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[1] Maryland Health Gen. §5–607.

70,000 and 330,000 patients in the U.S. may be unrepresented—a figure expected to rise due to demographic shifts such as aging and increasing rates of dementia.[2] In Maryland, court filings indicate that hospitals initiate at least 200 guardianship petitions annually in connection with medical treatment.[3]

This is not a new problem for Maryland hospitals. In 2011, the Department of Human Resources issued a "Report of the Workgroup on Hospitalized Adult Disabled Persons—Appointment of Temporary Limited Guardian."[4] The Report was prepared for the Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee, in response to a request that the Department of Human Resources "convene a workgroup to develop a uniform statewide policy relating to the appointment of temporary limited guardians for hospitalized adult disabled persons and to make recommendations for improving the guardianship process generally." At the time, according to the report, appointment of a guardian of a person could take between "seven and 180 days" depending on the jurisdiction. These numbers referred to all guardianship cases, not just cases from hospitals. While the focus of the Report was difficulty discharging, rather than making treatment decisions for, unrepresented patients, the issues share common features of unnecessary and prolonged stays in the hospital while not receiving the appropriate level of care.

The 2011 Workgroup (WG) members ultimately rejected the idea of implementing a "temporary limited" guardianship policy as they concluded it "would not be the best solution to address the needs of this population at this time." The WG further concluded that the appointment of a guardian "substantially and often times permanently restricts the rights of individuals and requires costly and lengthy processes when essentially what is needed is 'consent for placement' in the least restrictive setting . . . upon discharge from a hospital." Instead, the WG proposed that a committee inside the hospital, such as an Ethics Committee (or Patient Care Advisory Committee),[5] make decisions for unrepresented patients regarding discharge. The workgroup saw this as a "less restrictive alternative" to guardianship.

The Recommendations were not acted upon and according to reports from many hospitals the situation has not improved and, in fact, seems to have become worse. Hospitals are concerned about situations in which an unrepresented patient requires treatment,

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[2] Scott J. Schweikart, Who Makes Decisions for Incapacitated Patients Who Have No Surrogate or Advance Directive? AMA J Ethics. 2019;21(7):E587-593. doi: 10.1001/amajethics.2019.587

[3] See Appendix A for source of data.

[4] See https://mgaleg.maryland.gov/cmte_testimony/2021/hgo/1ivsqy_g5w197DmAWJ_EV9148rfYA6jch.pdf

[5] See Patient Care Advisory Committee Act, Health-General Sec. 19-370, which enables a hospital-based committee to offer advice I cases involving individuals with life-threatening conditions.

withdrawal from treatment, or discharge, yet no one is authorized to make those decisions absent a court-appointed guardian. [6]

In late 2023, the Maryland Healthcare Ethics Committee Network, a membership organization established by the Law & Healthcare Program at the University of Maryland Carey School of Law, to "facilitate and enhance ethical reflection in all aspects of decision making in health care settings. . ."[7] identified the issue of unrepresented patients in need of treatment decisions as a pressing ethical issue facing hospitals in the state. The Network leadership established a subcommittee to better understand the issue and develop recommendations as to how to address it.

Shortly thereafter, in early 2024, a bill (HB 698) was introduced into the Maryland House of Representatives (along with a companion bill in the Senate) to amend the Guardianship statute by mandating that courts hold a hearing on guardianship submissions within 10 days when it involves an individual who needs to be discharged from the hospital. The bill, initiated by the Maryland Hospital Association, focused primarily on individuals who are awaiting discharge, but have no family or surrogates to consent to discharge. Advocates from the disability and aging communities were uniformly opposed, concerned about the appointment of too many guardians and the restrictions guardianship places on the rights of individuals. Several members of the judiciary also opposed the legislation stating, among other things, that it did not allow sufficient time for preparation of a jury hearing if one was needed. The bill did not pass. (Excerpts from testimony provided to the Judiciary Committee at a hearing on the bill are provided in Appendix B.)

Establishment of Working Group and Working Group Process

After the failure of HB 698, Del. Sandy Bartlett, Vice Chair of the House Judiciary Committee, reached out to Prof. Diane Hoffmann, Director of the Law & Health Care Program and the Maryland Healthcare Ethics Committee Network, at the University of Maryland Carey School of Law, to ask if she would be willing to convene a working group of stakeholders to make recommendations to improve the process for treatment and discharge decisions for "unrepresented patients" in Maryland hospitals. The goals of the

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[6] The one exception to this is when treatment is emergently necessary to save the patient's life or spare them from serious bodily harm. See Maryland Health Gen. §5–607.

[7] The Network accomplishes these goals by: "Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution acting consistently with its mission statement; Fostering communication and information sharing among network members; Providing educational programs for ethics committee members, other health care providers, and members of the general public on ethical issues in health care; [and] Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland." *See* The University of Maryland Fracis King Carey School of Law, Maryland Heathcare Ethics Committee Network, https://www.law.umaryland.edu/academics/programs--centers/law--health-care-program/mhecn/

Working Group were to make the process more efficient and, if possible, to avoid guardianship and develop less restrictive alternatives. (See letter at Appendix C)

The Working Group included representatives from the Maryland Healthcare Ethics Committee Network committee, Maryland hospitals and long-term care institutions, government agencies, the Department of Legislative Services and judiciary, as well as aging and disability rights advocates and experts, representatives of the Departments of Aging, Human Services and Disability, and attorneys who serve as court appointed counsel for alleged disabled persons and/or as guardians of the property. (See list of Working Group members at Appendix D)

The Working Group met initially in person on August 30, 2024 at the University of Maryland Carey School of Law and then met via Zoom three times in October and in person in November 2024, and then in person or a hybrid format in December, 2024, May 2025, and October, 2025. A full account of the process and meetings is provided in Appendix E.

This report provides the Working Group's recommendations for legislative changes to allow alternatives to guardianship for both decisions regarding treatment and discharge for unrepresented patients. Part I (p. 7) addresses alternatives for treatment decisions and Part II (p. 16) presents recommendations for cases involving hospital discharge.

PART I. Summary of Proposed Legislation and Rationale for Key Provisions of Decision-making for Treatment Decisions

The complete legislative proposal is provided in Appendix F. This section sets forth the principles that guided the WG's decision-making as well as key provisions and reasons for their inclusion.

Guiding Principles

The Working Group was guided by the following core principles as it evaluated options and formulated its recommendations. Our goal was to develop a process that:

1. **Ensures fairness**. Fairness entails recognizing the due process rights appropriate to this patient population. To uphold this principle, we emphasized adequate representation of any decision-making body, objective decision-making, and the use of less restrictive alternatives to guardianship.

2. **Is efficient**. Efficiency requires a process that enables hospital staff to initiate timely treatment—more promptly than is typically possible under the guardianship framework.

3. **Treats the patient with dignity and respect**. This includes ensuring that, after confirming that the patient lacks decision-making capacity for the healthcare decision in question, the patient's known wishes are honored. Recognizing that such wishes are often unknown, we aimed to design a process that promotes supported decision-making when feasible, considers patients' values even if their explicit wishes are unknown, and safeguards vulnerable individuals and protects them from discrimination based on disability, age, race, or sex.

4. **Avoids harm to the patient's health**. Delays in treatment—or in the withdrawal of treatment—can be detrimental to a patient's wellbeing by causing harm or preventing therapeutic benefits. For example, prolonged mechanical ventilation beyond two weeks increases the risk of ventilator-associated pneumonia, airway trauma, and lung injury. Many intensive care units consider tracheostomy between days 7 and 14 to mitigate these risks and improve patient comfort. However, both ventilator withdrawal and tracheostomy require appropriate consent. Thus, a patient needing a guardianship to consent to these procedures may wait weeks or months for a tracheostomy. The Working Group recognized the critical need for a process that supports timely, medically appropriate decisions in such cases.

Treatment Decisions

Key Decisions and Provisions and their Rationale

Establishment of a Surrogate Committee

In exploring alternatives for how decisions should be made for unrepresented patients without the appointment of a guardian, the group considered three options:

1. A multidisciplinary committee composed of hospital staff and individuals external to the hospital, including a patient advocate and representatives of a patient population or their caregivers.
2. A state-employed "public surrogate," functioning much like a public guardian but limited to medical decision-making. These surrogates would undergo training comparable to that of guardians or ombudspersons and report to a designated state agency. Based on current estimates, approximately four full-time positions would be necessary across the state to travel to hospitals as needed.
3. An external, county-level committee modeled after Public Guardianship Review Boards.

After extensive deliberation, the Working Group concluded that the most practical and ethically sound approach, consistent with its guiding principles, would be the hospital-based committee structure, supplemented by several external members to ensure balance and accountability.

While assigning decision-making authority to a single public surrogate might offer efficiency, the Working Group emphasized that this benefit must be balanced against the broader perspectives a committee can provide. The group concluded that it is ethically essential to incorporate multiple viewpoints, thereby reducing the risk that the values or biases of any one individual could disproportionately shape critical treatment decisions.

Beyond ethical considerations, feasibility also weighed heavily in the Working Group's recommendation. Establishing a public surrogate system would require significant budgetary resources—an unlikely prospect in the current fiscal climate. Moreover, members familiar with Public Guardianship Review Boards noted persistent challenges in staffing these bodies, as volunteer positions often remain vacant for extended periods. These practical obstacles reinforced the group's determination that a hospital-based committee, supplemented by external members, represents the most workable and sustainable approach.

The idea of a committee making treatment decisions for an unrepresented patient is not without precedent or support. Legislatures in other states have passed laws allowing hospital ethics committees or other designated bodies to make health care treatment decisions for unrepresented patients. They include Alabama,[8] Arkansas,[9] Arizona,[10] North Dakota[11] and Tennessee[12]. Similarly, the Department of Veterans Affairs authorizes hospital committees to make health care decisions for unrepresented patients when life-sustaining treatments are at issue, but relies on a physician-centered process for other clinical

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[8] The Alabama law provides: "If the patient has no relatives known to the attending physician or to an administrator of the facility where the patient is being treated and none can be found after a reasonable inquiry, a committee composed of the patient's primary treating physician and the ethics committee of the facility where the patient is undergoing treatment or receiving care, acting unanimously; or if there is no ethics committee, by unanimous consent of a committee appointed by the chief of medical staff or chief executive officer of the facility and consisting of at least the following: (i) The primary treating physician; (ii) the chief of medical staff or his or her designee; (iii) the patient's clergyman, if known and available, or a member of the clergy who is associated with, but not employed by or an independent contractor of the facility, or a social worker associated with but neither employed by nor an independent contractor of the facility. In the event a surrogate decision is being made by an ethics committee or appointed committee of the facility where the patient is undergoing treatment or receiving care, the facility shall notify the Alabama Department of Human Resources for the purpose of allowing the department to participate in the review of the matter pursuant to its responsibilities under the Adult Protective Services Act, Chapter 9 of Title 38." AL Code § 22-8A-11 (2024).

[9] Arkansas Code § 20-6-102(19), https://law.justia.com/codes/arkansas/title-20/subtitle-2/chapter-6/subchapter-1/section-20-6-102/

[10] AZ Rev Stat § 36-3208 (2024) https://law.justia.com/codes/arizona/title-36/section-36-3231/

[11] North Dakota SB 2297 (2025) https://ndlegis.gov/assembly/69-2025/regular/bill-overview/bo2297.html

[12] TN Code § 68-11-1806 (c)(5) (2021)

treatments and procedures.[13] Other states (Colorado, Florida, Montana and New York), allow physicians to make "routine" decisions but require consultation with an ethics committee or other clinicians for major decisions. (See Appendix G for list of states that have implemented, and medical organizations that have endorsed, committee decision-making for hospitalized unrepresented patients.)

Amendment to the Health Care Decisions Act

The Working Group concluded that the Maryland Health Care Decisions Act offers the most appropriate statutory framework for incorporating a surrogate decision-making committee. This could be achieved by amending the Act to include a designated committee authorized to make medical treatment decisions on behalf of unrepresented patients as a surrogate decisionmaker when no other surrogates are available.

Key advantages of using this statutory approach include:

1. Capacity Determination: The statute provides that the patient must be formally determined to be incapable of making an informed decision[14] regarding their treatment, by both the attending physician and a second physician or nurse practitioner.[15]

2. Exhaustion of Surrogate Options: The "surrogate committee" may only act after reasonable efforts have been made to identify and contact all other potential surrogates, and a finding that none are willing or available to assume the role.[16]

3. Decision-Making Standards: The committee would be required to apply the same standards as other surrogates—namely, the substituted judgment standard, which includes consideration of any known advance directives such as a living will or durable

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[13] VHA DIRECTIVE 1004.01(3)(Dec. 2023).

[14] "Incapable of making an informed decision" means the inability of an adult patient to make an informed decision about the provision, withholding, or withdrawal of a *specific* medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision." MD Health - General Code § 5-601(o)(1) (2024).

[15] Md. Health-Gen. Sec. 5-606(a)(1) and (2).

[16] The statute states that "unavailable" for the purposes of identifying a surrogate decision-maker means: "1. After reasonable inquiry, a health care provider is unaware of the existence of a health care agent or surrogate decision maker; 2. After reasonable inquiry, a health care provider cannot ascertain the whereabouts of a health care agent or surrogate decision maker; 3. A health care agent or surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider; 4. A health care agent or surrogate decision maker is incapacitated; or 5. A health care agent or surrogate decision maker is unwilling to make decisions concerning health care for the individual."

power of attorney, and if those are unavailable or inconclusive, the best interest standard.[17] Both standards are explicitly defined in the statute.

4. Limitations on Life-Sustaining Treatment Decisions: As with other surrogates, the committee would be prohibited from authorizing the withholding or withdrawal of life-sustaining treatment unless two physicians, or one physician and one nurse practitioner, have certified that the patient is terminally ill, in a persistent vegetative state, or has an end-stage condition.[18]

Committee Composition and voting structure

The Committee's composition was designed to balance specialized expertise with representation from the patient population most likely to engage with this process. The Working Group also sought to ensure that the process remained both efficient—minimizing delays in scheduling meetings—and fair, by avoiding the inclusion of individuals with potential conflicts of interest.

In shaping the committee's composition, the Working Group focused on the nature of the decisions the committee would be required to make. When an unrepresented patient is admitted to the hospital, there is often little—if any—information about their preferences. Such patients typically lack an advance directive, and health care providers are unable to identify or reach a legal surrogate or others familiar with the patient's wishes. In these circumstances, the surrogate committee must assume responsibility for making treatment decisions guided by the patient's best interests.[19]

Most of the factors to be considered in the best interest test involve knowledge/expertise about the medical condition/prognosis of the individual however, when surrogates make the decision, the health care providers who are treating and caring for the patient generally

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[17] Md. Health-Gen. Sec. 5-605(c)(2).

[18] Md. Health-Gen. Sec. 5-606(2)

[19] E.g., "Best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment, taking into account:
(1) The effect of the treatment on the physical, emotional, and cognitive functions of the individual;
(2) The degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment;
(3) The degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and dependency;
(4) The effect of the treatment on the life expectancy of the individual;
(5) The prognosis of the individual for recovery, with and without the treatment;
(6) The risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and
(7) The religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest. Md. Health Gen. § 5-601.

provide this expertise. The final decision is made by the surrogate(s) and requires weighing these factors and determining whether the benefits of the proposed treatment outweigh the burdens of the treatment. Absent a willing and available surrogate, another approach is required to make this determination.

Our proposal contemplates a committee composed of four members internal to the hospital (a physician, nurse, social worker or member of the clergy, and a member of the hospital's ethics committee), much like what is required under the Maryland Patient Care Advisory Committee Act,[20] AND three representatives of the "community" from outside of the hospital. This combination allows for both health care expertise and the type of lived experience that comes from being a former patient, a care-taker, or a representative of an aging or disability advocacy committee. Each perspective can complement the others and also provide a check on undesirable considerations such as conflicts of interest,[21] bias by any of the parties, deficits and misunderstanding of complex clinical features or the patient's prognosis. To reflect the importance of both inputs, the Working Group recommends that to grant consent for treatment or the withholding or withdrawal of treatment, those voting in favor must include at least two of the hospital members and two of the community members.

Medical Treatment Decisions

The proposal permits a surrogate committee to provide "informed consent" for the treatment or withholding or withdrawal of treatment for an unrepresented patient. The gathering of a committee of busy individuals, both within the hospital and without, to make these decisions spurred the question of whether such a committee would need to meet to provide consent for routine, low risk procedures. The Maryland HCDA does not provide a definition of "medical treatment" or "treatment" and deals primarily with life sustaining procedures. However, Maryland case law provides that a health care provider has a duty to

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[20] MD Health - General § 19-373 (2024)

[21] The WG discussed the issue of conflicts of interest by hospital staff at great length. While we were not presented with evidence of the problem in Maryland, the literature has reflected this concern stating that "financial interests of the clinician and/or institution could affect treatment decisions. For example, potential conflict could lead to overtreatment of patients in fee-for-service reimbursement models and to undertreatment in capitated models. Pressure to make scarce ICU beds available could also lead to undertreatment." Association of American Medical Colleges. In the Interest of Patients: Recommendations for Physician Financial Relationships and Clinical Decision Making. Washington, DC: AAMC, 2010. See page 11. See also American Medical Association, Code of Medical Ethics, Chapter 11: Opinions on Financing & Delivery of Health Care, Opinion 11.2.2 (Conflicts of Interest in Patient Care).
You can access the full text in the AMA's official PDF here. Financial incentives for over and undertreatment is more likely to be an issue in outpatient treatment, as in Maryland, all hospitals are reimbursed the same amount regardless of source of payor. "Pressure to make scarce ICU beds available," however, could be a conflict for health care providers.

obtain informed consent from a patient prior to any medical intervention that has a material risk. Sard v. Hardy, 281 Md. 432 (1977). In the Sard opinion, a material risk is defined as one that a reasonable patient would want to know as it could change their decision as to whether to consent to the intervention.[22] Failure to obtain informed consent, if it leads to harm, may result in a lawsuit for medical negligence. Additionally, a lawsuit for battery may be brought by a patient when there is no consent (explicit or implied[23]) at all, not just inadequate disclosure of risks.[24] Thus, under current law hospitals could be subject to lawsuits (based on either negligence or battery) for failure to obtain a guardian who can provide consent or informed consent for an unrepresented patient.

The only exceptions to such a requirement are when failure to treat the individual is life-threatening or could lead to serious bodily harm and time is of the essence. Sometimes clinicians will wait until the patient's condition evolves to meet those criteria and act under the implied consent doctrine thereby avoiding the need for a guardian to authorize treatment. However, medical ethicists have written that waiting for an emergency may result in longer periods of suffering and indignity, increasing the chance of morbidity or even mortality.[25] According to a report by the American Thoracic Society and American Geriatrics Society,

> The absence of a surrogate can "stymie decision-making and possibly leave . . . patients to linger in pain and discomfort." The Institute of Medicine found it ethically "troublesome" to wait "until the patient's medical condition worsens into an emergency so consent to treat is implied." Such an approach "compromises patient care and prevents any thorough and thoughtful consideration of patient preferences or best interest."[26]

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[22] Id. stating "A risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."

[23] Implied Consent is typically inferred from a patient's actions or behavior. For example: extending an arm for a blood draw or showing up at a clinic and cooperating with routine examination. The law also recognizes implied consent in emergency situations when a patient is unconscious or unable to communicate, and immediate treatment is necessary to preserve life or prevent serious bodily harm.

[24] In the Maryland case of Moore v. Johns Hopkins Hospital, 301 Md. 580 (1984), Mrs. Moore underwent a tubal ligation during a cesarean section. She claimed that she had not consented to the sterilization and was unaware it would be performed during her delivery. The Maryland Court of Appeals (now Supreme Court), held that the tubal ligation was performed without any consent, constituting unauthorized touching or battery.

[25] Institute of Medicine, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions (Washington, DC: National Academy Press, 1991). Pp. 61-62.

[26] American Thoracic Society and American Geriatrics Society.
Making Medical Treatment Decisions for Unrepresented Patients in the ICU: An Official American Thoracic Society/American Geriatrics Society Policy Statement.

Although neither courts nor the General Assembly in Maryland have addressed the issue of whether there are interventions that are so low risk or routine that they do not require consent or informed consent, several US states have enacted laws or policies that allow such decisions to be made by hospital staff. (See Appendix G for list of states).

Some states allow attending physicians or a hospital appointed individual to make decisions without requiring ethics committee involvement, e.g., North Carolina[27] and Oregon.[28] As stated above, Colorado,[29] Florida,[30] Montana[31] and New York,[32] allow physicians to make "routine" decisions, but require consultation with an ethics committee or other clinicians for decisions that are non-routine or for serious conditions.

In contrast to these statutes, the Working Group recommends, consistent with the current surrogate decision-making framework in the Health Care Decisions Act and Maryland common law, that hospitals convene the surrogate committee when they would otherwise seek consent from a surrogate. This should lead to continuity in the types of decisions that are already made by hospitals on a regular basis. Health care providers who are uncertain when to convene a surrogate committee should be encouraged to consult with their legal counsel.

Training

The Working Group further recommends that all members of the surrogate decision-making committee complete comprehensive training in core bioethical principles and the relevant provisions of the Health Care Decisions Act. This training should cover surrogate decision-making standards, informed consent and emergency exceptions, decision-

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American Journal of Respiratory and Critical Care Medicine 2020; 201(10):1182–1192.

[27] N.C.G.S. § 90-21.13 (8).

[28] OAR *411-390-0160 (4)(a) and (b) — Health Care Decisions*, https://secure.sos.state.or.us/oard/view.-action?ruleNumber=411-390-0160

[29] Colorado law, provides that for "routine treatments and procedures that are low-risk and within broadly accepted standards of medical practice, the attending physician may make health-care treatment decisions." C.R.S. § 15-18.5-103.

[30] Florida does not define the term routine medical care or treatment.

[31] Montana law provides that for "routine treatments and procedures that are low-risk and within broadly accepted standards of medical practice, the attending health care provider may make health care treatment decisions." MT Code § 50-5-1305 (2024)

[32] New York Public Health Law, Article 29-CC, § 2994-G ("Health care decisions for adult patients without surrogates")provides that "'routine medical treatment' means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition, such as the administration of medication, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic, for which health care providers ordinarily do not seek specific consent from the patient or authorized representative. It shall not include the long-term provision of treatment such as ventilator support or a nasogastric tube but shall include such treatment when provided as part of post-operative care or in response to an acute illness and recovery is reasonably expected within one month or less."

making capacity assessment, supported decision-making, substituted judgment, and the best-interest standard. In addition, the Working Group emphasized the importance of educating committee members on due process protections, patient rights, appropriate consultation with hospital ethics committees, confidentiality obligations, documentation protocols, conflicts of interest, and the impact of implicit bias. Particular attention was given to concerns about implicit bias among medical professionals, especially as it affects individuals with disabilities, but also bias based on race, gender, ethnicity, sex and socio-economic status.

Finally, external members may benefit from education about basic medical terminology, risks of overtreatment and undertreatment, and about common scenarios that arise for this patient population such as end-of-life care, ventilator withdrawal, tracheostomy, feeding tubes, and DNR orders.[33]

The Maryland Department of Human Services, along with the Office of Healthcare Quality,[34] would develop/conduct the training sessions or could outsource the training to an external entity, such as a university or non-profit entity that conducts similar training.[35]

Reporting

The proposed legislation also includes a provision requiring all hospitals in the state to prepare a report at the end of each year regarding their experience using the surrogate committee. This is to ensure transparency and accountability. The report will include the following information: whether its surrogate committee was convened and, if so, the number of times it was used; demographic information about the patients; a description of

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[33] Such training is not without precedent. Oregon regulations provide: A person who is willing and eligible to serve as an appointed health care advocate is required to complete Department-approved training prior to the appointment as a health care advocate and prior to making a health care decision for an individual. OAR *411-390-0160 (4)(g)) — Health Care Decisions*, https://secure.sos.state.or.us/oard/view.-action?ruleNumber=411-390-0160

[34] Both agencies have experience conducting training programs. For example, DHS provides training to local departments of social services staff and community partners on recognizing, reporting, and responding to abuse, neglect, and exploitation of vulnerable adults. DHS also DHS partners with local organizations to deliver workshops and informational sessions for caregivers, service providers, and sometimes the general public. OHCQ provides training and technical assistance to facility administrators and staff on compliance with state and federal regulations. This includes orientation for new providers and updates when regulations change. For example, OHCG personnel provided training for hospital staff on the implementation of the MOLST law, i.e., (Medical Orders for Life Sustaining Treatment).

[35] Resources currently exist that may be useful in developing a training program such as Maryland MOLST Guide for Authorized Decision Makers, available at: https://marylandmolst.org/docs/Guide_for_Authorized_Decision_Makers.pdf ; Making Healthcare Decisions, The Maryland People's Law Library, available at: https://peoples-law.org/making-healthcare-decisions; Maryland Judiciary, Guardians of the Person Training, available at: https://www.mdcourts.gov/sites/default/files/import/family/guardianship/pdfs/guardiansofthepersondisabledpersontraining.pdf

each patient's condition, the treatment decision considered; the decision of the committee and the reason for its decision. Additionally, the WG felt it important that hospitals describe their efforts to find a surrogate. Disability advocates and representatives of the Departments of Aging and Human Services indicated that some hospitals may not make sufficient efforts to find someone who knows the patient and can make decisions on their behalf. Additionally, we recommend the Report include, for each patient, whether the patient was able to leave the hospital and whether the hospital was required to file for guardianship of the person prior to the patient's discharge. Hospitals are required to place a link on their website to the report or information as to how members of the public may obtain a copy of the report. This information will not only serve to provide some accountability and transparency to the process but may also be used by the state and/or by researchers to evaluate whether the process is working satisfactorily.

PART II. Summary of Proposed Legislation and Rationale for Key Provisions of Decision-making for Discharge Decisions

The specific statutory provisions we are proposing appear in Appendix I. This section sets out our Guiding Principles and the rationale for each of the proposals.

Guiding Principles

Building on the principles established for treatment decisions, the Working Group affirms that discharge decisions for unrepresented patients must rest on the values of dignity, timeliness, and fairness. Care should prioritize patient well-being and timely transition to appropriate settings, using the least restrictive legal mechanisms necessary to address financial and care needs. Guardianship should be pursued only when all other alternatives have been exhausted, as it removes fundamental rights and risks unnecessary institutionalization. Preventing a "hospital-to-guardianship pipeline,"[36] is essential, as prolonged hospitalization can erode patient autonomy. Access to financial records must likewise be safeguarded and restricted to individuals who can be trusted to act solely in the patient's best interests.

To achieve these goals, courts must be equipped with flexible tools to authorize targeted actions that enable timely discharge while avoiding unnecessary guardianship. At the same

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[36] Anita Raymond, ABA Commission on Law and Aging, The Hospital to Guardianship Pipeline (July 16, 2023) https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bif-vol44-issue6/hospital-guardianship-pipeline/ See also, Maryland Judiciary, IDEAL: A Patient-Centered Approach to Adult Guardianship and Its Alternatives, https://www.courts.state.md.us/family/guardianship/healthcare .

time, compensation for guardians must be equitable and sustainable to ensure that a qualified pool of professionals is available when guardianship is required.

Current Situation

Most unrepresented hospital patients require discharge to long term care facilities. In Maryland, hospitals must secure a legally authorized surrogate or guardian to consent to the transfer, document that a comprehensive medical assessment has been done and a discharge plan of care is in place. Additionally, hospitals must comply with CMS discharge planning rules and Joint Commission standards. Discharge must be based on the patient's assessed needs, and the hospital must confirm that the nursing home can meet those needs.

Admission to a nursing home requires both consent by a surrogate or guardian and financial arrangements for payment. LTC facilities require proof that the cost of care will be covered, whether through insurance or private assets. Medicaid is the primary payer for most unrepresented patients. To qualify, patients must meet income and asset eligibility requirements. If the patient is not Medicaid-eligible and lacks insurance coverage, facilities require proof of ability to pay privately. Nursing homes often request financial disclosure (bank statements, proof of income, assets) before admission and may require a responsible party to sign a financial agreement covering costs until Medicaid approval. In practice, this means a family member, guardian, or representative must act as a financial guarantor, ensuring accountability if Medicaid or insurance does not cover the stay. If the patient has no surrogate with financial authority, a court-appointed guardian of the property may be needed to manage funds and apply for Medicaid.

Alternatives to Guardianship

Authorized Representative

For unrepresented patients, the rules for hospital discharge and admission to nursing homes appear to require, at a minimum, the appointment of a guardian of the person, and in many cases, both a guardian of the person and property. However, there are some alternatives in current law that can reduce the length of time for the actual discharge by expediting the receipt of financial documents necessary to apply for Medicaid and completing the Medicaid application. The first is a provision in Maryland regulations[37] that allows an "authorized representative" to act on behalf of an applicant for, or recipient of, Medicaid, including helping the patient apply or establish eligibility for the benefit.

If the patient does not have capacity to designate an authorized representative, certain individuals or organizations can serve as an authorized representative if they declare under

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[37] COMAR 10.01.04.12 & 10.09.24.04

oath that they are acting in good faith, the patient lacks capacity, no other representative is available, and they have no conflicting financial interest.[38] This could include a hospital employee.

If the authorized representative needs access to financial or other records, they may need a court order, but appointment of an individual to carry out "specific transactions" for the patient is another option.

Specific Transactions

Current Maryland law provides that a court may appoint an individual to carry out a specific transaction on behalf of an individual lacking decision-making capacity, without appointing a guardian of the property. The law states:

(a) (1) If a basis exists as described in § 13–201 of this subtitle[39] for assuming jurisdiction over the property of a minor or disabled person, the circuit court, without appointing a guardian, may authorize or direct a transaction with respect to the property, service, or care arrangement of the minor or disabled person.

(2) The transactions described under paragraph (1) of this subsection include:

(i) Payment, delivery, deposit, or retention of funds or property;
(ii) Sale, mortgage, lease, or other transfer of property;
(iii) Purchase of contracts for an annuity, life care, training, or education;
(iv) Making the election to take an elective share of an estate subject to election under § 3–403 of this article; or
(v) Any other transaction described in:
  1. § 13–203(c)(2) of this subtitle;[40]
  2. Title 9, Subtitle 2 of this article;[41] or

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[38] The form for an "Applicant Without Representative Who Lacks Capacity to Appoint a Representative" is available at this link.

[39] Sec. 13-201 states: (a) On petition, and after any notice or hearing prescribed by law or the Maryland Rules, the court may appoint a guardian of the property of a minor or a disabled person. . . . (c) A guardian shall be appointed if the court determines that:

(1) The person is unable to manage effectively the person's property and affairs because of physical or mental disability, disease, habitual drunkenness, addiction to drugs, imprisonment, compulsory hospitalization, detention by a foreign power, or disappearance; and

(2) The person has or may be entitled to property or benefits which require proper management.

[40] Sec. 13-203 (c)(2) provides: "These powers include, but are not limited to, the power to convey or release the minor's or disabled person's present and contingent and expectant interests in real and personal property, including marital property rights and any right of survivorship incident to joint tenancy or tenancy by the entirety, and to exercise or release the minor's or disabled person's powers as trustee, personal representative, custodian for minors, or donee of a power of appointment."

[41] Subtitle 2 of Title 9 deals with Maryland Trust Law provisions, specifically focusing on the powers and duties of trustees. It includes sections such as: § 9-201 – General powers of trustees; § 9-202 – Specific powers (e.g.,

3. § 15–102 of this article.[42]

This provision provides a vehicle for our recommendation, described below.

Key Provisions of our Proposal and their Rationale

Amend the "specific transaction" provision in Estates & Trusts Sec. 13-204

While the WG believes the "authorized representative" provisions in the Maryland Code currently provide a way for hospitals to apply for Medicaid for unrepresented patients, they may need authorization to access a patient's financial records to complete the Medicaid application or, if the patient is not Medicaid eligible, to provide proof of ability to pay the nursing home out of personal finances. Thus, the primary proposal of the Working Group regarding ways to expedite discharge of unrepresented patients, is to amend the "specific transaction" provision in Estates & Trusts Sec. 13-204 to allow a court appointed individual (who is not a guardian) to take specific actions, described in a court order, that meet a demonstrated need of a disabled person and that serve as a less restrictive alternative to the appointment of a guardian of the property. These would include the following actions, which would be in addition to the currently listed actions:

> 1. Granting access to financial or other records related to a minor or disabled person 2. Establishing a minor or disabled person's eligibility for benefits, such as Medical Assistance.

Rationale for amendment

Hospitals not only face the challenge of identifying a decision-maker to guide treatment for unrepresented patients, but they also often endure weeks or even months waiting for the appointment of a guardian authorized to make discharge decisions. Even after a guardian is appointed, discharge may be delayed further while the guardian gathers financial records and, if necessary, applies for Medicaid to secure admission to a long-term care facility. Without a guardian to perform these functions, hospitals cannot arrange discharge, leaving patients in acute care beds for hospital care they no longer need—where they remain vulnerable to hospital-acquired infections and other complications and are deprived of a chance to live in a less restrictive environment. By contrast, discharge planners can typically transition patients with decision-making capacity or a surrogate into long-term

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investment, management, sale of property); § 9-203 – Duties of trustees (loyalty, prudence, impartiality); § 9-204 – Accounting and reporting obligations; § 9-205 – Court supervision and remedies for breach of trust.

[42] Section 15-102 is the central provision granting fiduciaries broad powers to manage estates and trusts in Maryland. It essentially equips trustees and personal representatives with the authority to handle property as if they were the owner, subject to fiduciary duties and any limitations in the governing instrument.

care by coordinating facility selection and payment documentation. When a patient lacks capacity and has no legally authorized surrogate, courts generally appoint a guardian of the person and, if financial management is required, a guardian of the property. The guardian of the person may decide on discharge and placement but cannot manage finances, while the guardian of the property is appointed only when financial oversight is necessary to secure or sustain placement. Courts tailor guardianship to the patient's circumstances; for example, if an unrepresented patient has no assets and qualifies for Medicaid, only a guardian of the person may be required.

In order to reduce the requirement for appointment of both a guardian of the person and property, the Working Group proposes the amendment described above to the current Maryland Estates and Trusts Art. Sec. 13-204.

After consulting with representatives from the Administrative Office of the Courts, an attorney representing financial institutions in Maryland, and several attorneys who have served as court-appointed guardians of property, the Working Group determined that these changes were essential. These guardians described persistent difficulties in obtaining patient financial records even after receiving formal court appointment. Other attorneys have noted that financial institutions frequently impose barriers to account access by demanding documentation inconsistent with Maryland law.[43]

The amendments are consistent with recently proposed amendments to Maryland Rules of Procedure. (Rule 10-304.2)

The Rules of Procedure change also includes a Committee Note, stating:

> Examples of an action or series of actions that the court may authorize as a specific transaction to establish an individual's eligibility for Medical Assistance include marshalling the individual's assets, accessing financial or other records that must be submitted with a Medical Assistance application, and effectuating a spend down of known income and resources to permit the individual to meet eligibility thresholds by creating a Medicaid eligible trust, making burial arrangements, establishing an ABLE account pursuant to 26 U.S.C. § 529A, or other appropriate action.[44]

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[43] Report of Elder Law Task Force ON PREVENTING AND COUNTERING ELDER ABUSE (April 30, 2025).

[44] The Rules of Procedure further provide that: (c) . . . A motion for specific transaction shall state:
(1) the specific transaction sought; (2) how the specific transaction meets a demonstrated need of the minor or alleged disabled person; (3) the inability of the minor or alleged disabled person or currently authorized individual to effectuate the requested specific transaction; (4) facts supporting whether the petitioner alleges that the requested specific transaction is sufficient to meet the demonstrated needs of the minor or alleged

While in most cases this process does not avoid the need for guardianship of the person, in some cases, a patient may have a surrogate who can and is willing to make health care decisions for the patient, but is not able or willing to make financial decisions for the patient. In such cases, the process for appointing someone to carry out specific transactions may expedite the discharge process as the proposed judicial rule includes a process for courts to hear requests for specific transactions on an expedited basis.

Provision to allow for payment of Court Appointed Guardians of the Property

Generally, court appointed guardians of the property in Maryland are paid out of the assets of the alleged disabled person. If that person has no assets, the guardian may not be paid at all. While a court may appoint a family member to serve in this capacity who is willing to serve without pay, in the context of unrepresented hospital patients, there is usually no family member available or willing to serve in this role. When the court has to appoint a guardian, who is a stranger to the patient, they most often appoint an attorney. Some hospitals may pay these attorneys out of their budgets, but others may not. Failure to pay these attorneys results in a very small number who are willing to serve in this capacity.

The Working Group agreed with a recommendation of the TASK FORCE ON PREVENTING AND COUNTERING ELDER ABUSE, that it is important to pay these attorneys. That report, transmitted to Governor Moore on April 30, 2025 states:

> Medical assistance planning is complex and attorneys skilled in this area are few and far between. The attorneys are expected to serve on a *low bono* or *pro bono* basis. There is no source of funding to pay them, and attorneys are not lined up at the courthouse to provide this service. Courts across the state are at crisis points because there are not enough attorney guardians to do this work. The reality is that if a guardian of property is needed, until someone is willing to serve in that role, the person who no longer requires acute care is forced to languish in a hospital. This financial piece is often the crux of the issues presented in guardianship matters. It is vital that it be addressed.

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disabled persons without appointing a guardian of the property; (5) information about any individual the petitioner believes is qualified to perform the requested transaction including that individual's:
(A) name, age, organization, if any, address, telephone, and email address, if available;
(B) relationship to the minor or alleged disabled person; (C) relationship to the petitioner;
(D) whether that individual (i) has been convicted of a crime listed in Code, Estates and Trusts Article, § 11-114 or any such charge is currently pending against the individual and (ii) if the individual has been convicted of such a crime, the charge for which the individual was convicted, the year of the conviction, the court in which the conviction occurred, and any good cause for the appointment, if applicable under § 11-114(b); and
(E) any relevant qualifications of the individual; and
(6) the level of intrusion the requested specific transaction would have on the rights or interests of the minor or alleged disabled person.

Although the Working Group agreed with the Task Force Report in this regard, given the current budget crisis in Maryland, and a lack of time to determine the best statutory and administrative vehicle to implement the recommendation, our Working Group decided to delay a more specific legislative suggestion.

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Appendix A

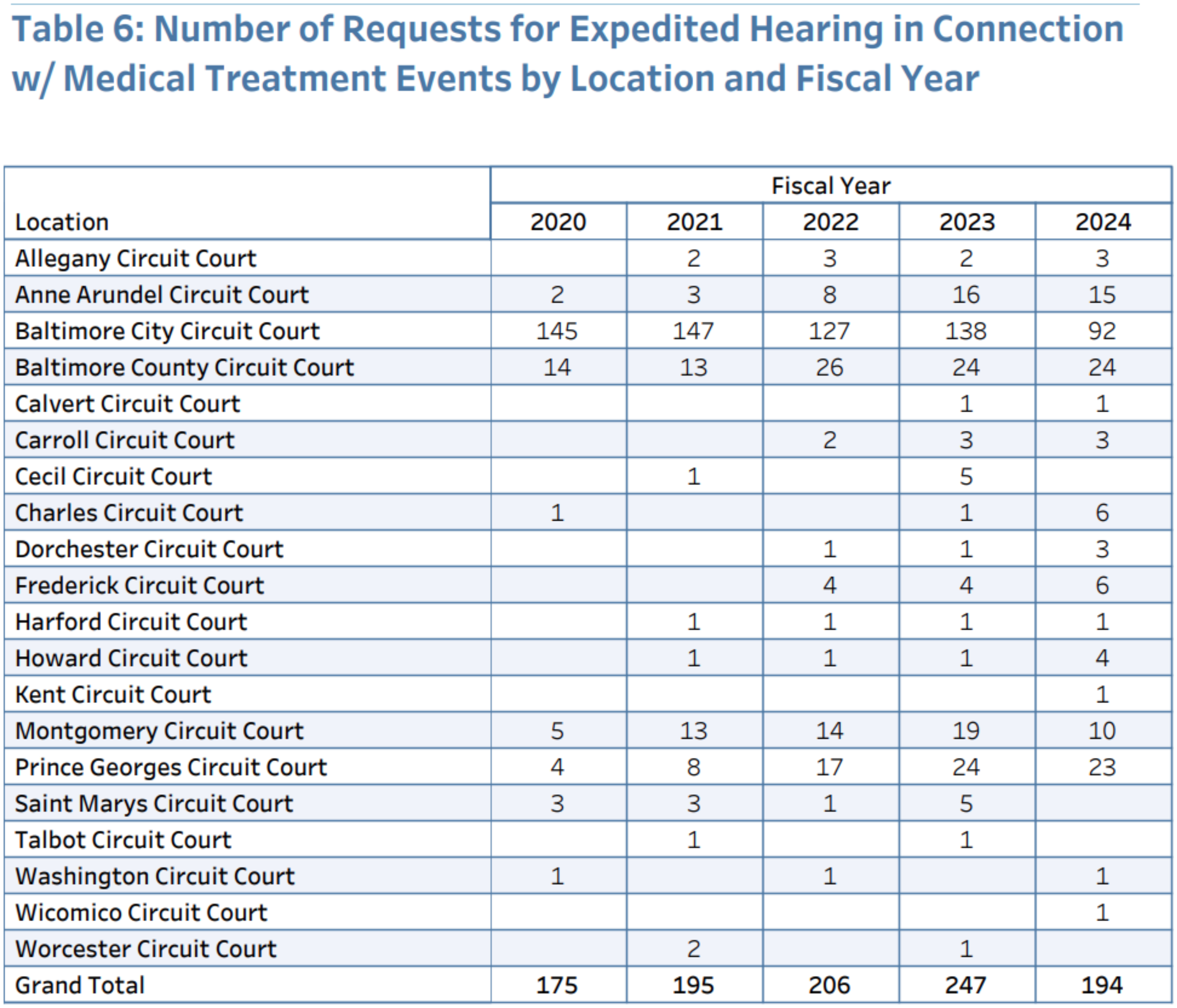

Table 6: Number of Requests for Expedited Hearing in Connection w/ Medical Treatment Events by Location and Fiscal Year

	Fiscal Year				
Location	2020	2021	2022	2023	2024
Allegany Circuit Court		2	3	2	3
Anne Arundel Circuit Court	2	3	8	16	15
Baltimore City Circuit Court	145	147	127	138	92
Baltimore County Circuit Court	14	13	26	24	24
Calvert Circuit Court				1	1
Carroll Circuit Court			2	3	3
Cecil Circuit Court		1		5	
Charles Circuit Court	1			1	6
Dorchester Circuit Court			1	1	3
Frederick Circuit Court			4	4	6
Harford Circuit Court		1	1	1	1
Howard Circuit Court		1	1	1	4
Kent Circuit Court					1
Montgomery Circuit Court	5	13	14	19	10
Prince Georges Circuit Court	4	8	17	24	23
Saint Marys Circuit Court	3	3	1	5	
Talbot Circuit Court		1		1	
Washington Circuit Court	1		1		1
Wicomico Circuit Court					1
Worcester Circuit Court		2		1	
Grand Total	**175**	**195**	**206**	**247**	**194**

Please note: Attorney motions for expedited hearings in connection with medical treatment are submitted to circuit courts using non-specific docket events ("Motion to Expedite" and "Motion for expedited Trial Date") and the event specified for these motions ("Requests for Expedited Hearing in Connection w/Medical Treatment.") The specific event code for these motions is not consistently used by attorneys filing these motions.

For motions submitted with non-specific docket events, clerk comment data fields were reviewed to further identify motions specific to expedited hearings in connection with medical treatment. However, the data is likely undercounted due to incomplete data in the comments field.

Source: Administrative Office of the Courts

Appendix B

Excerpts from Written Testimony on HB 698

Testimony in favor:

Maryland Chapter, American College of Emergency Physicians

- "It has been well-documented that wait times in Maryland emergency departments are among the longest in the nation, which is often the result of the lack of either inpatient beds and/or the availability of community services, such as behavioral health placements. . . . If a patient no longer needs medical services in a hospital, the patient needs to be discharged or transferred as quickly as possible to make room for patients needing medical services."

Lifebridge Health

- "Hospital caregivers constantly work to balance the influx of patients, prioritizing those with life-threatening conditions while attending to less urgent cases as quickly as possible. One of the factors that we see often that [is] exacerbated by existing laws is the inability to transfer patients to appropriate skilled nursing and therapeutic environments in a timely manner. . . The data below shows on average how long a patient needing temporary guardianship waits for a hearing within our hospitals.
    - 78 days (2.5 months) in Carroll County,
    - 122 days (4 months) in Baltimore County . . .
    - 119 days . . . in Baltimore City"

Johns Hopkins University & Medicine

- "Too many patients in Maryland . . . experience delays in what should be a routine process, especially if there is no legally identified decision maker available, or willing, to support an individual who lacks capacity to make decisions about their next level of care. In these cases, Johns Hopkins health system employees work tirelessly to identify appropriate locations that will accept the patient and then must petition the courts for guardianship of the person in order to safely discharge the patient.
- "When the courts fail to act in a timely manner, the patients – who no longer need medical care – are stuck. They continue to occupy beds that are needed for patients who need medical treatment. This contributes to the backlog for care and long wait times in our emergency departments which is a matter of statewide concern."
- "On an individual level, these patients have a greater risk of decline. They are isolated from meaningful supportive social and emotional care available in other appropriate treatment settings. They risk acquiring additional infections."

Maryland Hospital Association

- "Maryland hospitals have expressed concerns with the declining health of patients who are unable to be discharged. Often patients' conditions deteriorate due to isolation and inability to be placed in the appropriate treatment setting. The risk of infection, sepsis, and the like are more prevalent when overstaying in hospitals."
- "For years, hospitals have taken preemptive steps like hiring private investigators and contacting potential relatives upon patient admission. At times, these patients arrive at hospitals without any information on or the identity of family members or potential surrogates or the means to contact family or potential surrogates."
- "In surveying Maryland hospitals, MHA found patients wait an average of 60 days for a hearing to be scheduled by the court, and in some instances, more than 100 days. Additionally, these patients wait on average 126 days to be appointed a guardian following an initial guardianship hearing request."

Del. J. Sandy Bartlett (Anne Arundel County)

- "Over the interim, a Workgroup was convened at the direction of the General assembly to investigate the underlying causes of [emergency department wait times in Maryland hospitals]."
- "The WG concluded there are multiple factors contributing to this problem, including insufficient care options outside a hospital, throughput inefficiencies inside the hospital, and the ability for the hospital to discharge individuals who no longer need acute care in a timely manner."
- "Regarding timely discharge of disabled individuals, the WG heard over and over there are significant delays in the appointment of a guardian and there are wide variations between jurisdictions on the time it takes for the court to appoint a guardian. Unfortunately, there are consequences associated with those delays. Most importantly, the patient is not in the right setting to meet their needs and often the patients' condition deteriorates due to isolation, a higher risk of infection, lack of rehab services, etc."
- "I intend to offer an amendment of Section 13-204 of the E&T Article to allow for the authorization of specific transactions, such as a petition for discharge, without appointment of a guardian."

Testimony opposed:

Maryland Dept. of Aging

- Maryland's 19 Area Agencies on Aging, which are overseen by the Dept. of Aging (MDOA) serve as public guardians in last resort situations for adults 65 and older where no other family member or suitable alternative guardian is available."
- Once notified of the need for a public guardian, AA personnel spend nearly half of their time researching family members and pursuing guardianship avoidance options. "Older adults in these guardianship petitions routinely are living alone, do not have organized finances, thus the marshaling of their assets depends on the guardians of the property, who are usually court appointed attorneys that operate on their own timelines. Once the older adult's financial picture has been determined, the AAA guardianship staff works to determine what post-acute care setting the older adult can afford, which sometimes requires a move and judicial transfer of the case to another jurisdiction with more affordable assisted living options."
- Hospitals should be applying the Maryland Health Care Decisions and Supported Decision-Making laws, the latter which only took effect in October, 2022. More education for hospitals and work implementing these two existing state laws would be prudent before jumping into this extreme proposed change.
- Maryland's AAAs had 626 total guardianship of person cases in 2022 and 706 in 2023, a 13% increase.

Maryland Judiciary

- Although well intentioned, this bill raises constitutional issues and would undermine rights and protections afforded to respondents to guardianship proceedings.
- The timeline of 10 days for a hearing is unworkable as it would not allow for scheduling of contested cases or a jury trial if needed. The timeline does not recognize the demands of other pending cases or the trial calendars of attorneys involved. The Judiciary is in the best position to schedule the matters before it in consideration of all relevant factors.
- Most petitions filed by hospitals include requests for the appointment of a guardian of the property. There is no public guardianship of property, so courts must rely on the group of attorneys who do this work and who are paid from the person under guardianship's assets.
- Other initiatives to address the problem:
  - In 2011, Maryland SB 726 was introduced to provide for the appointment of a temporary limited guardian to consent to discharge of an adult with a disability from a hospital. Although the bill failed, a workgroup was convened to "develop a uniform statewide policy relating to the appointment of temporary limited guardians for hospitalized adult disabled persons. The workgroup ultimately advised against such a policy, finding that t]he [] process of establishing guardianship, which relies on the courts to hear

  guardianship cases, substantially and often times permanently restricts the rights of individuals, and requires costly and lengthy processes when essentially what is needed is 'consent for placement' in the least restrictive setting . . . upon discharge from a hospital."
  - In 2019, the Supreme Court of Maryland amended its court rules to provide for an expedited guardianship process "in connection with medical treatment. . .. Since those rules went into effect, courts and public guardianship agencies have noted an increase in petitions from healthcare facilities and pressure to move on them faster, further burdening these already under-resourced public structures.
  - In 2021, the Judiciary received a grant from the Administration for Community living at the USDHHS, to perform an assessment of Maryland's guardianship system and to examine the pipeline. The project is ongoing but has helped identify drivers of the pipeline and ways to divert patients to less restrictive and more person-centered options than guardianship.

Baltimore City Administration

- Comments are similar to the state Dept. of Aging in that Baltimore City Health Dept. serves as the city's AAA which in turn serves as the court-appointed "guardian of the person" for City residents ages 65 and older who have been legally adjudicated disabled when the individual has no family members or friends who can serve as their guardian.

Maryland Developmental Disabilities Coalition

- Refers to the state's supported decision-making statute which was passed in 2022. The law assists adults in: (1) obtaining support for the adult in making, communicating, or effectuating decisions that correspond to the will, preferences, and choices of the adult, and (2) preventing the need for that appointment of a substitute decision maker for the adult, including a guardian of the person or property.
- The adoption of SDM is in line with the recommendations of national experts and MD workgroups, which includes a 2011 report which found that "less restrictive alternatives" are a more efficient approach to facilitating moving an adult disabled person to a less restrictive and appropriate setting in an expedited time frame, not implanting a "temporary limited" guardianship policy.
- Additionally, Md. Code, Est. & Trusts Sec. 13-705(f) already provides a mechanism for an expedited hearing process for decisions related to medical decisions, which includes the discharge and transfer process.
- The real barrier for many patients . . . is not the lack of a guardian, but the lack of affordable, accessible and safe discharge locations.

- We are deeply concerned about the risks HB 698 creates for people with disabilities being placed under unnecessary, plenary guardianship orders.

Disability Rights Maryland

- DRM is the federally designated Protection and Advocacy agency in Maryland, mandated to advance the civil rights of people with disabilities.
- The over-reliance on and improper use of guardianship is a complex problem rooted in disability discrimination and ageism. HB0698 will only add to these risks and problems within the guardianship system.
- DRM is part of the working group set up by the Judiciary to address the "healthcare-to-guardianship pipeline," which includes examining the contributing factors that created and supports this pipeline, developing a toolkit to be used by the Judiciary and health care providers, and issuing a final report of the project's findings.
- DRM urges the legislature to wait until the final report is out before amending the guardianship law.

Maryland Long-Term Care Ombudsman Program

- It is critical that individuals have a right to make informed decisions about their care. Guardianship should only be explored as a last resort.
- The LT Ombudsman Program has seen cases where guardianship was granted when an individual was delirious and was temporarily unable to make their own decisions.
- Expediting the guardianship process would not allow for informed decision making around placement to occur or provide the opportunity to explore other options.
- It may take time for the court to appoint counsel for the alleged disabled person. Once appointed, the attorney needs time to prepare for this important work including looking at less restrictive alternatives such as surrogacy and supported decision-making.

Montgomery County Dept. of Health and Human Services

- Under the bill, county APS programs will have to investigate and respond to petitions to obtain consent to discharge or transfer an alleged disabled person within 10 days rather than 30 days.
- Further, the bill amends the Est. & Trusts Article 13-705(f) which deals specifically with guardianship in connection with medical treatment. Although "medical treatment" is not defined in statute or caselaw, consent to discharge or transfer from hospital may not fall within the definition of treatment. Generally, this statute has been used for alleged disabled persons who require time-sensitive emergency surgery or treatment and a guardian of the person was required for the treatment.

Other opposing parties who submitted testimony:

- Maryland Chapter of the National Association of Social Workers
- Anne Arundel County Dept. of Aging and Disabilities
- AARP Maryland
- Maryland Senior Citizens Action Network
- Mental Health Association of Maryland

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Legislative District 32
Anne Arundel County

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THE MARYLAND HOUSE OF DELEGATES
Annapolis, Maryland 21401

December 27, 2025

Appendix C

Professor Dianne Hoffman
University of Maryland Francis King Carey School of Law
500 W. Baltimore Street
Baltimore, MD 21201-1786

Dear Professor Hoffman,

I am writing to request your assistance in convening a workgroup to address a long-standing issue related to the appointment of guardians for health care decision making. It is not a statutorily authorized workgroup, but if you are able to convene interested parties, any recommendations from the workgroup would be considered and appreciated. Your experience in both health law and ethics makes you particularly well suited for this work and to serve as the neutral convener.

Specifically, hospitals are concerned with the time it takes for the appointment of a guardian for individuals who are in the hospital and unable to consent for treatment but who no longer need acute care services. While waiting for a guardian to be appointed, patients' conditions often deteriorate due to isolation and the inability to be placed in the appropriate treatment setting. When a patient who no longer needs acute care cannot be discharged, it limits access to care for those who need to be admitted. This also impacts hospital emergency departments because those patients often end up "boarding" in the emergency department.

I sponsored legislation this past session (HB 698/SB 759) to speed up the guardianship appointment process, but there was significant opposition including the disability community, local offices on aging, the mental health community, and the judiciary. These organizations raised legitimate concerns about protecting the rights of individuals to make their own health care decisions and the need to find the least restrictive approach.
Thank you for your consideration of this request.

Sincerely,
Sandy
J. Sandy Bartlett, Esq.

Appendix D
Maryland Health Care Guardianship Working Group
Working Group Members

Hospital Representatives
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Organizers
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Rebecca Hall, JD
Working Group Coordinator
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Requester:
Del. Sandy Bartlett
Vice Chair, Judiciary Commitee
Maryland House of Representatives

Appendix E

Working Group Meetings and Process

The Working Group (WG) met initially at the University of Maryland Carey School of Law on August 30, 2024 to discuss the history of efforts in the state to address consent problems related to hospitalized unrepresented patients. At that meeting, the WG agreed to separately address the issues relevant to treatment decisions for unrepresented patients and discharge issues for this population. The Group heard from Dr. Yoram Unguru, a physician and chair of the ethics committee at Sinai hospital and member of the Johns Hopkins Berman institute of Bioethics, as to the kinds of cases they see involving unrepresented patients and the harm that delays in obtaining consent for treatment decisions can cause these patients when the hospital must apply for a guardian to make these decisions. Brandon Floyd, from the Maryland Hospital Ass'n followed up with a presentation about the issue from the perspective of the Hospital Association. The Group then heard from Nisa Subasinghe from the Administrative Office of the Courts and Erica Costello from the ABA Commission on Law & Aging about the "healthcare to guardianship pipeline," and a grant they received from the federal Department of Health and Human Services to study the drivers of the pipeline, what other states have done to address the problem, and some of the recommendations they have derived from their research.

The WG focused initially on the problem of making treatment decisions for unrepresented patients and discussed the proposal from the 2011 Dept. of Human Resources "Report of the Workgroup on Hospitalized Adult Disabled Persons—Appointment of Temporary Limited Guardian," calling for a committee inside the hospital, such as an Ethics Committee to make these decisions. There was some initial support for this approach. After the meeting, Prof. Hoffmann asked the WG members to submit written comments on the approach.

During the month of October, 2024 the WG met three times via Zoom to hear from experts on the issues related to unrepresented hospital patients and challenges that arise when treatment or discharge decisions must be made. These speakers included a hospital care manager (Kai Shea), hospital attorney (Dena Terra), long term care attorney (Holly O'Shea), attorney representing Maryland financial institutions (Christopher Rahl), an attorney who serves as Court Appointed Special Counsel for alleged disabled persons and who has been a court-appointed Guardian of the Property (Barrett King), the Maryland Deputy Director for Medicaid Eligibility Policy (Lorie Mayorga), the Community Client Services Director for the Maryland Department of Aging (Leslie Smith-Ray), the Director for the Office of Adult Services at the Maryland Department of Human Services (Greg Sesek), and a managing attorney from Disability Rights Maryland (Randi Ames).

On Nov. 12, 2024, the Working Group had a Zoom meeting to discuss the process of making treatment decisions for unrepresented patients. The meeting started with a brief presentation by Diane Hoffmann, Professor of Law and Director of the Maryland Healthcare Ethics Committee Network, who shared data with the members of the WG, several of whom had asked for data about the scope of the problem and how often hospitals needed someone to make decisions for this patient population. Hoffmann presented data provided by the Administrative Office of the Courts (AoC) regarding the "Number of Requests for Expedited Hearing in Connection w/ Medical Treatment Events by Location and Fiscal Year." This data indicated that from 2020 to 2024 the requests ranged from 175 – 247/year across the state. The AoC indicated, however, that the data was far from perfect and that going forward efforts would be made to improve the data collection process. The WG also asked the Maryland Hospital Association to request this data from their members, which it thought, might be a more accurate source.

The remainder of the meeting was spent discussing written feedback submitted by WG members on the 2011 DHR Report and other proposals to address treatment decision-making for unrepresented patients. Three alternative approaches emerged from that meeting including: 1) establishing a committee internal to each hospital (much like a Patient Care Advisory or Ethics Committee) with additional representation from outside of the hospital including representation from disability advocates or individuals living with a disability), 2) establishing a committee external to hospitals that would be at the county or regional level and would include a physician, nurse, social worker, chaplain, attorney or lay patient advocate and a disability advocate or an individual with a disability; and 3) an ombudsman-like program for hospitals that would fund 4 – 5 full time ombudspersons who would serve as the decision-maker for unrepresented patients at hospitals across the state (with each ombudsperson covering a different region of the state).

On November 15, 2024, the WG had its second in-person meeting at the University of Maryland School of Law during which the group focused on the discharge process for unrepresented hospital patients. Nisa Subasinghe (AoC) presented to the group on proposals that were already being considered by other groups within the state to improve the hospital discharge process for unrepresented patients. These included (1) changes to the judicial rules to clarify the provisions of Maryland Estates & Trusts Art. Sec. 13-204 regarding court authorization for an individual to make specific transactions for unrepresented patients without appointment of a guardian, including application for Medicaid and access to financial records; and (2) payment of attorneys who serve as court appointed guardians of the property through establishment of a designated fund (recommended by state Task Force on Preventing Elder Abuse). Eric Crowder, Associate General Counsel, Luminis Health, followed with a presentation suggesting that the WG "piggyback" onto these recommendations by suggesting a statutory amendment to the Estates & Trusts Statute, Sec. 13-204. Specifically, he suggested the addition of the following language to clarify the types of transactions that a Court may authorize:

(a) An action or series of actions, described in a court order, that meet a demonstrated need of a minor or disabled person and that serve as a less restrictive alternative to the appointment of a guardian of the property, including
    i. accessing a minor or disabled person's financial records
    ii. consenting to a hospital discharge or transfer, and to admission to a post acute facility
    iii. consenting to any financial arrangements or medical care necessary to affect such hospital discharge, transfer or admission to a post acute healthcare facility.

The statutory amendment was thought to be helpful for transactions with financial institutions that are often reluctant to share financial information even with an individual who has clear authority from the court to access that information. The WG discussed several other possible ways in which the discharge process for unrepresented hospital patients could be made more efficient without depriving the unrepresented individual of their rights and ensuring that they have access to the appropriate level of care.

On Dec. 19, 2024 the WG met via Zoom to discuss both responses to treatment option proposals and proposals for improving the discharge process. Given that the WG was unable to reach a consensus on the different treatment options, the WG members decided to postpone any written submission or recommendation to the General Assembly until the next legislative session (2026).

During the spring (2025), Professor Diane Hoffmann and Rebecca Hall from the University of Maryland Carey School of Law met individually with working group members via zoom and spoke with them about their specific concerns with the different approaches to making treatment decisions for unrepresented patients and compiled the results.

On May 30, 2025, the WG met again to review the comments from the member interviews. During that meeting, the WG discussed concerns that were expressed about conflicts of interest on the part of hospital committee members and potential for bias against patients with a disability and how a WG proposal could mitigate those concerns. The WG further discussed the pros and cons of an external committee model, focusing on Public Guardianship Review Boards and hospitals using a hospital committee at another hospital. Additionally, the group debated the merits of having an individual state employee serve as the decision-maker/surrogate. The last agenda item addressed the feasibility of a pilot study, comparing the proposed models. The discussion focused on whether there would be funding for such a study, including whether hospitals might be "assessed" a fee to fund the study, and whether a pilot could yield useful data and what type of data evaluators would need to collect.

At the end of the meeting, the group had narrowed the options down to an internal hospital committee or a single individual employed by the state. Pros and cons of each option were identified and presented in the following table, to narrow further discussion:

Pros and Cons of Each Model

	Hospital Committee (3 internal/3 external)	State employee/single individual
Pros	• Greater and more varied medical expertise • More representation of community values • Includes person with lived experience (PWLE) • More likely to be convened quickly than external committee • Would not require state budget allocation • Benefits of group discussion	• Should not take long for individual to respond to request • Unlikely to have conflicts of interest
Cons	• Could potentially have conflict of interest among hospital employees (these should be mitigated by external members) • Committee may be subject to "group think" • Committee members may have biases against individuals based on age, disability, race, gender (should be mitigated by training)	• Individual will need to interview medical experts, which will take time • Will require state budget outlay to pay new state employees • Would not have benefit of community input • Could have biases against individuals based on age, disability, race, gender (should be mitigated by training) • May defer to medical experts

A memo from the group facilitator, Diane Hoffmann, was distributed to the WG recommending a way forward that would take into account the concerns expressed by members at the May 30th meeting. In that memo, dated August 25, 2025, the recommendation was for a committee that included seven members, four from the hospital and three external. The committee would be established by each hospital. Voting members would include two from the hospital and the three external members. All three external members would have to agree to the proposed treatment. Prof. Hoffmann then asked for feedback on that proposal. The feedback was collected (See Appendix H) and sent back to the WG members for their review and consideration. A final meeting on the proposal was held on October 28, 2025, to address comments made by WG members. At that meeting, the members agreed:

1. To include a provision that either makes clear the scope of treatment decisions requiring the surrogate committee to meet, i.e., de minimis or routine and low risk interventions that do not require the convening of the surrogate committee OR a provision stating that the surrogate committee should be convened when a treatment decision needs to be made that would otherwise require appointment of a guardian.
2. To change the voting to allow all seven committee members to vote and require that at least two out of four hospital members and two out of three community members approve of the proposed treatment decision.
3. That enough safeguards were in place to allow the hospital to select and recruit the external members of the committee.
4. To make clear that the surrogate committee can make transfer decisions based on medical needs/treatment (e.g., to a more specialized medical facility) but not for discharge to a setting that does not involve medical treatment or requires a lower level of treatment.
5. To consider adding a provision that would protect the records, files and proceedings of the surrogate committee from discovery, similar to a medical review committee. This might involve reviewing the Patient Care Advisory Committee Act to see if its records are discoverable.
6. To include a provision stating the members of the committee have immunity from liability similar to the provision in the Patient Care Advisory Committee Act.
7. To change number vi. under committee members to: An individual who is not employed by the hospital and WHO HAS BEEN A PATIENT WITHIN THE HOSPITAL SYSTEM OR is (or has been) a caretaker of a patient who lacks decision-making capacity.

8. In section on training, to add information regarding Patient Rights and Surrogate Decision-making.
9. In section on discharge decisions, to the extent possible, the language of the WG proposal should be consistent with the proposed Rule Change proposed by the Judiciary.

A final version of the proposed legislation with these changes was then sent to the WG for a final review and opportunity for comment.

APPENDIX F

PROPOSED LEGISLATION AMENDING THE HEALTH CARE DECISIONS ACT

New language in ALL CAPS

Health Gen. §5–601, et. seq.

Health Gen. §5–601

(Y) UNREPRESENTED PATIENT MEANS A PATIENT (1) WHO HAS BEEN DETERMINED TO BE INCAPABLE OF MAKING AN INFORMED DECISION IN ACCORDANCE WITH §5–606(a) OF THIS ARTICLE; (2) WHO HAS NO ADVANCE DIRECTIVE; (3) FOR WHOM AN IDENTIFIABLE SURROGATE LISTED IN §5–605(a)(2) IS UNAVAILABLE; AND (4) FOR WHOM THERE IS NO OTHER EVIDENCE FROM THE PATIENT'S PAST OR FROM OTHER PARTIES THAT IS SUFFICIENT TO SUPPORT A REASONABLY CONCLUSIVE JUDGMENT ABOUT WHAT THE PATIENT WOULD LIKELY CHOOSE REGARDING THEIR MEDICAL TREATMENT.

Health Gen. §5–605.

(a)(2) The following individuals or groups, in the specified order of priority, may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent in accordance with this subtitle or whose health care agent is unavailable. Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable:

(i) A guardian for the patient, if one has been appointed;

(ii) The patient's spouse or domestic partner;

(iii) An adult child of the patient;

(iv) A parent of the patient;

(v) An adult brother or sister of the patient; or

(vi) A friend or other relative of the patient who meets the requirements of paragraph (3) of this subsection.

(VII) A SURROGATE COMMITTEE CONSISTING OF THE FOLLOWING INDIVIDUALS, SELECTED BY THE HEALTH CARE INSTITUTION HOUSING THE PATIENT:

1. A PHYSICIAN WHO IS NOT INVOLVED IN THE TREATMENT OF THE PATIENT BUT WHO HAS WORKED OR CURRENTLY WORKS IN THE HOSPITAL.

2. A NURSE WHO IS NOT INVOLVED IN THE TREATMENT OF THE PATIENT BUT WHO HAS WORKED OR CURRENTLY WORKS IN THE HOSPITAL.

3. A SOCIAL WORKER OR A MEMBER OF THE CLERGY WHO HAS WORKED OR CURRENTLY WORKS IN THE HOSPITAL.

4. A MEMBER OF THE HOSPITAL'S PATIENT CARE ADVISORY COMMITTEE.

5. A PATIENT ADVOCATE WHO IS NOT AFFILIATED WITH THE HOSPITAL. A PATIENT ADVOCATE MAY INCLUDE AN ATTORNEY OR SOCIAL WORKER WHO REPRESENTS OR SERVES INDIVIDUALS WITH HEALTH CARE ISSUES OR MAY BE AN INDIVIDUAL WHO WORKS FOR A NON-PROFIT OR FOR-PROFIT AGENCY THAT PROVIDES PATIENT ADVOCACY SERVICES.

6. AN INDIVIDUAL WHO IS NOT EMPLOYED BY THE HOSPITAL AND WHO IS (OR HAS BEEN) A PATIENT WITHIN THE HOSPITAL SYSTEM OR A CARETAKER OF A PATIENT WHO LACKS DECISION-MAKING CAPACITY.

7. AN EMPLOYEE OF, OR VOLUNTEER AFFILIATED WITH, A DISABILITY OR AGING PERSONS ADVOCACY ORGANIZATION, OR A PERSON WITH LIVED EXPERIENCE (I.E., A PERSON WITH (OR WHO HAS HAD) A DISABILITY.

(a)(3) A friend or other relative may make decisions about health care for a patient under paragraph (2)(VI) of this subsection if the person:

(i) Is a competent individual; and

(ii) Presents an affidavit to the attending physician stating:

1. That the person is a relative or close friend of the patient; and

2. Specific facts and circumstances demonstrating that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activities, health, and personal beliefs.

* * *

(A)(5) IF A PATIENT'S ATTENDING PHYSICIAN DETERMINES THE NEED FOR CONSENT TO TREATMENT FOR A PATIENT WHO LACKS ANY OF THE SURROGATES IN PARAGRAPH(2)(1-VI) OF THIS SUBSECTION, AND THE CONSENT WOULD OTHERWISE REQUIRE A SURROGATE DECISION, THE ATTENDING PHYSICIAN SHALL CONVENE THE SURROGATE DECISION-MAKING COMMITTEE DESCRIBED IN PARAGRAPH (2)(VII). THE COMMITTEE SHALL MEET PROMPTLY, AND IN NO EVENT LATER THAN A REASONABLE PERIOD NECESSARY TO ENSURE TIMELY ACTION UNDER THIS SUBTITLE. WHERE PRACTICABLE,

ALL COMMITTEE MEMBERS SHALL PERSONALLY OBSERVE THE PATIENT PRIOR TO MAKING THEIR DECISION. THE FINAL DETERMINATION MUST BE SUPPORTED BY AT LEAST TWO OF THE MEMBERS LISTED IN VII 1 - 4 AND TWO OF THE MEMBERS LISTED IN VII 5 – 7.

* * *

(c)(1) Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient[45] and, if the wishes of the patient are unknown or unclear, on the patient's best interest.[46]

* * *

(c)(3) The decision of a surrogate regarding whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic disadvantage.

(c)(4) A surrogate shall inform the patient, to the extent possible, of the proposed procedure and the fact that someone else is authorized to make a decision regarding that procedure. IN THE CASE OF A SURROGATE COMMITTEE, A MEMBER OF THE COMMITTEE, TO THE EXTENT POSSIBLE, SHALL INFORM THE PATIENT THAT THE COMMITTEE HAS BEEN ESTABLISHED TO MAKE A TREATMENT DECISION FOR THE PATIENT THAT MAY INCLUDE THE PROVISION, WITHHOLDING OR WITHDRAWING OF TREATMENT. THIS NOTICE SHALL INCLUDE THE NAMES OF THE MEMBERS OF THE SURROGATE COMMITTEE.

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[45] (c) (2) In determining the wishes of the patient, a surrogate shall consider the patient's: (i) Current diagnosis and prognosis with and without the treatment at issue; (ii) Expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments; (iii) Relevant religious and moral beliefs and personal values; (iv) Behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally; (v) Reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and (vi) Expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.

[46] (e) "Best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment, taking into account:
(1) The effect of the treatment on the physical, emotional, and cognitive functions of the individual;
(2) The degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment;
(3) The degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and dependency;
(4) The effect of the treatment on the life expectancy of the individual;
(5) The prognosis of the individual for recovery, with and without the treatment;
(6) The risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and
(7) The religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.

(C)(5) THE SURROGATE COMMITTEE SHALL PROVIDE A WRITTEN DETERMINATION OF, AND BASIS FOR, ITS DECISION FOR INCLUSION IN THE PATIENT'S MEDICAL RECORD.

(d) Exclusions – a surrogate, INCLUDING MEMBERS OF A SURROGATE COMMITTEE, may not authorize:

(1) Sterilization; or

(2) Treatment for a mental disorder.

A SURROGATE COMMITTEE MAY NOT AUTHORIZE THE DISCHARGE OF A PATIENT AND ITS DECISION-MAKING AUTHORITY SHALL BE LIMITED TO THE TIME DURING WHICH THE PATIENT IS IN THE HOSPITAL. A REQUEST BY A HOSPITAL TO MOVE THE PATIENT TO A HIGHER LEVEL OF CARE AT ANOTHER FACILITY IS NOT CONSIDERED A DISCHARGE.

(E) TRAINING FOR SURROGATE COMMITTEE MEMBERS - ALL SURROGATE COMMITTEE MEMBERS SHALL COMPLETE A TRAINING COURSE DEVELOPED OR ENDORSED BY THE DEPARTMENT OF HUMAN SERVICES AND THE OFFICE OF HEALTH CARE QUALITY, WITH INPUT FROM THE DEPARTMENT OF DISABILITIES, INCLUDING CONTENT ON:

1. CORE BIOETHICAL PRINCIPLES AND THE RELEVANT PROVISIONS OF THE HEALTH CARE DECISIONS ACT INCLUDING SURROGATE DECISION-MAKING, INFORMED CONSENT AND EMERGENCY EXCEPTIONS, CAPACITY ASSESSMENT, SUBSTITUTED JUDGMENT, AND THE BEST INTEREST STANDARD.
2. DUE PROCESS PROTECTIONS, PATIENT RIGHTS, WHEN CONSULTATION WITH THE PATIENT CARE ADVISORY COMMITTEE IS APPROPRIATE, CONFIDENTIALITY OBLIGATIONS, AND DOCUMENTATION REQUIREMENTS.
3. CONFLICTS OF INTEREST AND IMPLICIT BIAS, FOCUSING ON RACE, ETHNICITY, SEX, GENDER, DISABILITY, SOCIO-ECONOMIC AND IMMIGRATION STATUS.

(F) CONFIDENTIALITY – SURROGATE COMMITTEE

(I) THE PROCEEDINGS AND DELIBERATIONS OF A SURROGATE COMMITTEE SHALL BE KEPT CONFIDENTIAL.

(II) THE SURROGATE COMMITTEE SHALL BE ABLE TO RECEIVE AND REVIEW ALL RELEVANT MEDICAL RECORDS SUBJECT TO APPLICABLE FEDERAL AND STATE HEALTH CARE PRIVACY AND CONFIDENTIALITY LAWS. DOCUMENTS OR MATERIAL WHICH ARE CONFIDENTIAL AS PROVIDED BY LAW SHALL BE KEPT CONFIDENTIAL BY THE COMMITTEE.

(G) REPORTING. BY DECEMBER 31^{ST} OF EACH YEAR, ANY HOSPITAL THAT HAS USED THE SURROGATE COMMITTEE IDENTIFIED IN (a)(2)(VII) SHALL PREPARE A REPORT TO THE DEPARTMENT OF HEALTH, OFFICE OF HEALTH CARE QUALITY, THAT INCLUDES:

i. THE NUMBER OF TIMES THE SURROGATE COMMITTEE WAS CONVENED TO MAKE A TREATMENT DECISION FOR A PATIENT;
ii. FOR EACH PATIENT:
    a. THE NAMES OF MEMBERS OF THE COMMITTEE PRESENT AT THE MEETING;
    b. A DESCRIPTION OF THE PATIENT'S CONDITION;
    c. DEMOGRAPHIC INFORMATION ABOUT THE PATIENT INCLUDING RACE, SEX, GENDER, AND DISABILITY(IES)
    d. THE EFFORTS MADE BY THE HOSPITAL TO FIND A SURROGATE;
    e. THE TREATMENT DECISION UNDER CONSIDERATION;
    f. THE DECISION OF THE COMMITTEE;
    g. THE BASIS FOR THE COMMITTEE'S DECISION.
    h. WHETHER THE PATIENT WAS ABLE TO LEAVE THE HOSPITAL;
    i. WHETHER THE HOSPITAL WAS REQUIRED TO FILE FOR GUARDIANSHIP OF THE PATIENT PRIOR TO DISCHARGE.

THE REPORTS, REDACTED FOR PURPOSES OF PATIENT CONFIDENTIALITY, SHALL BE MADE AVAILABLE TO MEMBERS OF THE PUBLIC BY REQUEST TO THE HOSPITAL. HOSPITALS SHALL INCLUDE INFORMATION ON THEIR WEBSITES AS TO HOW TO OBTAIN A COPY OF THE REPORT.

§5–609.

(a) (1) A health care provider is not subject to criminal prosecution or civil liability or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing authority as a result of withholding or withdrawing any health care under authorization obtained in accordance with this subtitle.

(2) A health care provider providing, withholding, or withdrawing treatment under authorization obtained under this subtitle does not incur liability arising out of any claim to the extent the claim is based on lack of consent or authorization for the action.

(b) A person OR PERSONS who authorize(s) the provision, withholding, or withdrawal of life–sustaining procedures in accordance with a patient's advance directive, a "Medical Orders for Life–Sustaining Treatment" form, or as otherwise provided in this subtitle is not subject to:

(1) Criminal prosecution or civil liability for that action; or

(2) Liability for the cost of treatment solely on the basis of that authorization.

(c) (1) The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person OR PERSONS authorizing or effectuating the provision, withholding, or withdrawal of life–sustaining procedures in accordance with this subtitle did not, in good faith, comply with the provisions of this subtitle.

Appendix G

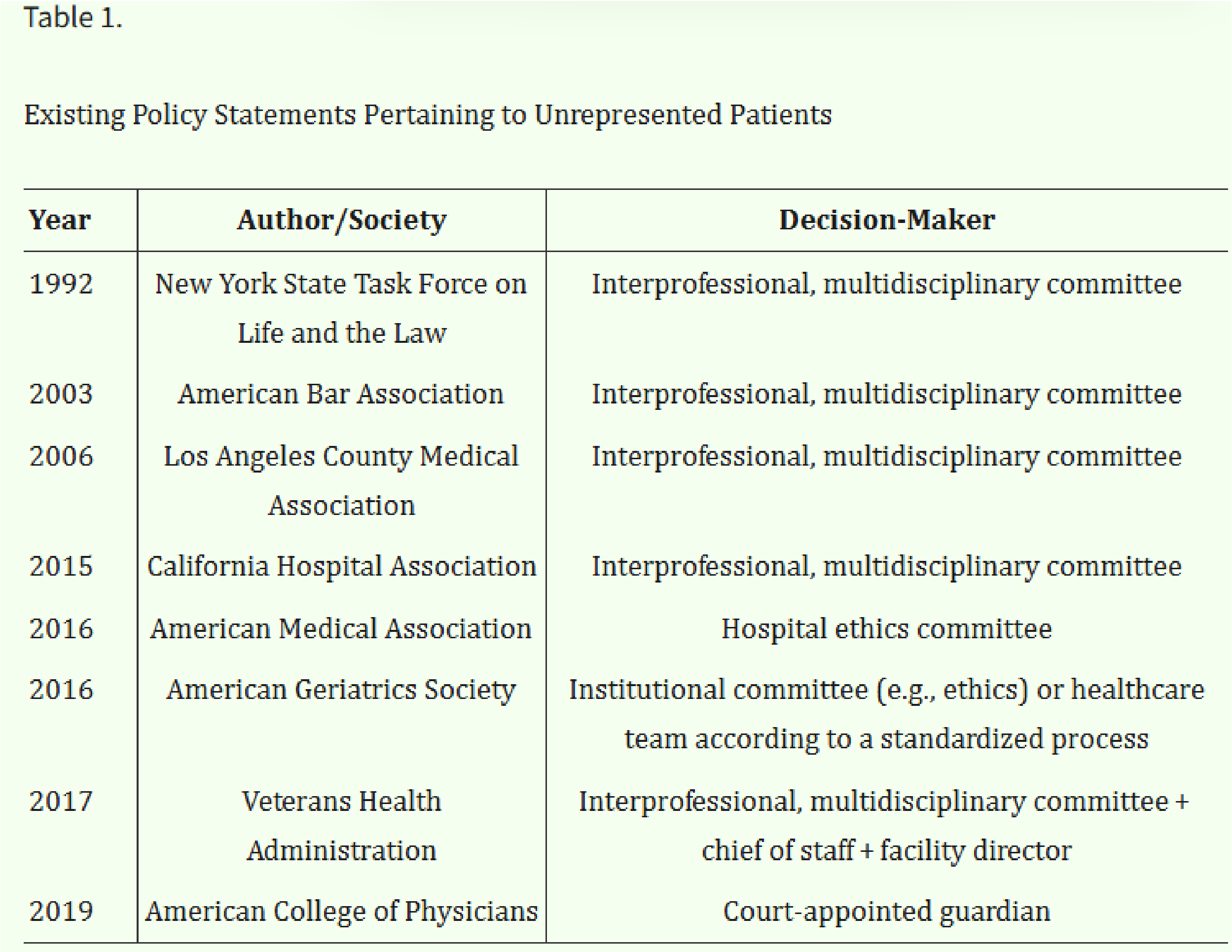

Table 1.

Existing Policy Statements Pertaining to Unrepresented Patients

Year	Author/Society	Decision-Maker
1992	New York State Task Force on Life and the Law	Interprofessional, multidisciplinary committee
2003	American Bar Association	Interprofessional, multidisciplinary committee
2006	Los Angeles County Medical Association	Interprofessional, multidisciplinary committee
2015	California Hospital Association	Interprofessional, multidisciplinary committee
2016	American Medical Association	Hospital ethics committee
2016	American Geriatrics Society	Institutional committee (e.g., ethics) or healthcare team according to a standardized process
2017	Veterans Health Administration	Interprofessional, multidisciplinary committee + chief of staff + facility director
2019	American College of Physicians	Court-appointed guardian

Source: Making Medical Treatment Decisions for Unrepresented Patients in the ICU. An Official American Thoracic Society/American Geriatrics Society Policy Statement (2020).

Table 2.

State Healthcare Surrogate Decision Laws Pertaining to Unrepresented Patients

State	**Decision-Maker**
Connecticut, Nebraska, North Carolina, North Dakota, Oregon	Attending alone
Arizona, Arkansas, Louisiana, Tennessee, Texas	Attending + second physician
Alabama	Attending + ethics committee
California	Interdisciplinary team
Colorado, Montana	Medical proxy + ethics committee
Florida	Independent clinical social worker
Texas	Member of clergy
New York	Court

Source: Id.

Appendix H

Comments on Draft Legislation from members of WG on Alternatives to Guardianship for unrepresented and incapacitated hospital patients who need treatment decisions (Draft distributed on 8/25)

Bonnielin Swenor, Director, Johns Hopkins Disability Health Research Center

"Thank you for your continued work on this issue. This is great work, and I am supportive of what you are outlining.

I am truly appreciative for the time, care, and expertly balanced approach you and your team put into this effort."

Yoram Unguru, Division of Pediatric Hematology/Oncology, The Herman and Walter Samuelson Children's Hopsital at Sinai; Chairman, Sinai Hospital Ethics Committee, Berman Institute of Bioethics, Johns Hopkins University

"Two minor comments . . . ."

1) If feasible, it would be important that at least one of the external community members come from the same community / neighborhood as the patient. Alternatively, the member should represent a community that is served by the Hospital, e.g., as defined by zip code.

In response to: THE COMMITTEE SHALL PROVIDE A WRITTEN DETERMINATION OF ITS DECISION FOR INCLUSION IN THE PATIENT'S MEDICAL RECORD.

2) Only Hospital employees have access to the EMR to be included in the patient's EMR. Worth specifying that one of the internal Committee members is therefore responsible for this step.

In response to Committee including "A Member of the Hospitals' Patient Care Advisory Committee" - "Suggest renaming this "Ethics Committee" or including Ethics Committee as a parenthetical"

Holly O'Shea, atty, FutureCare

"Thank you for sharing. I am going to give it some more thought, but my initial thought/question was related to how this would integrate with the current Health Care Decision Act language. Do you see any conflicts, in that currently health care decisions are being made by providers everyday for individuals who do not have a surrogate decision maker and lack capacity? Certainly, emergency care falls outside of the need for authorization in the absence of an advanced directive, but there are a lot of health care decisions made by providers that are not emergency care decisions but are also not elective per se. Currently, those decisions are not being made via committee or guardianship. IF this process is put into place, would previously "routine" decisions being made by providers turn into health care decisions requiring this new committee to make? An example could be whether or not the patient should receive a flu vaccine or undergoing a colonoscopy to check for bowel cancer.. to name a few. I wouldn't want us to create unintended consequences such that further barriers to care are created by the formation of this committee.

Eric Crowder, Associate General Counsel, Luminis Health

"I think the approach you set forth in your memo is a great option. It is thorough, endeavors to diligently protect the interests of these vulnerable patients, and sets forth attainable guardrails that the hospitals will be responsible to stand up in order to effectuate legal decision making for incapacitated patients without otherwise eligible surrogates."

Peter Tallerico, Risk Management & Patient Safety/Holy Cross Health

"I believe the document as presented reflects the work and decisions of the workgroup.

As I have socialized the idea a bit, most seem to feel some stipend will be necessary to keep community members engaged and available. I suspect part of this is because the community members would need a rapid response to beat the turnaround time for emergency petitions that the MoCo courts have provided. Would payment/stipend erode the credibility of the community members as independent?"

Jeff Brauer, Ethics Committee, LifeBridge Health

"My brief answer to your email is that I would definitely support this approach as written, as I firmly believe that virtually everything we've discussed thus far would be much better than the status quo.

My main criticism, though, concerns the fact that the (independent) physician and nurse on the committee don't get to vote on the proposed treatment decision. Relatedly, a decision not only requires the consensus of all 3 community members, but can also be made without either of the hospital based members' support (a 3-2 vote).[47] It just feels like

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[47] The draft that is the basis of these comments proposed that only five members of the committee vote, the socialworker/clergy member and ethics committee member from the hospital and all three of the community members. It also required that all three community members must agree on the decision.

a lot of power to make what may be a very challenging patient care decision vested in people who likely have no clinical experience, medical expertise, or ethics training.

I'm sure you've considered this, but I feel like it would be better if a decision would require at least 2 of 3 community members plus at least 2 of 4 hospital based members? This would seem more balanced and respectful of everyone's expertise."

James MacGill, Asst. Commissioner, Aging and Community Support, Baltimore City Health Dept.

"We have no objection in the committee model that you are proposing. I do have a few thoughts about it:

1. As I have said in the meetings, I think it is difficult these days to recruit volunteers to do this kind of work without compensation. In your pros and con table, you list under the pros: "Hospital has the burden of setting up the committee, including payment of external members if it chooses to do so." I am wondering if the draft legislation needs to require the hospitals at least to offer compensation to community members participating on the committee.
2. Your memo raises the concern that members of the committee be free from bias against individuals based on age, disability, race, or gender. This is a valid concern. I would raise two additional potential considerations , which applies to both the committee and State employee model. The Long-Term Care Ombudsman program, which we administer in Baltimore City, has strict guidelines to prevent recruitment of paid or volunteer ombudsman who may have a conflict of interest: e.g., they have a relationship with nursing homes or assisted living facilities in which they are doing advocacy, that may affect their work. This could include having a financial interest in the facility, or a family member who is an employee there.   In addition, when we recruit both paid and volunteer ombudsmen, we try to avoid recruiting ombudsmen who have a bias against long term care facilities, usually arising from poor care they have experienced or witnessed a family member or friend experience. I think we want to avoid similar conflicts of interest or bias against hospitals that may affect volunteer recruitment for the committee. I am not sure if anything can or should be included in the legislation addressing this but just wanted to provide you with my thoughts."

Leslie Smith-Ray, Maryland Dept. on Aging

"MDOA appreciates the chance to review this proposal and the work of this group to date. As you are aware, we remain committed to avoiding public guardianship for older adults whenever possible, and we support making medical decisions outside the realm of guardianship. However, we cannot commit to supporting this concept as described. At this point, we can share the following serious concerns about the draft language circulated, some of which we've shared previously.

- Opposition to MDOA being part of the training requirement for such a committee. While MDOA aims to avoid public guardianship where appropriate, it lacks the necessary in-house expertise to provide training on hospital decision-making rules, law, ethics, legal constraints, and other relevant issues that this training would presumably cover. The MDOA also lacks available resources and staff capacity to support a new training responsibility.

- Major concern about the hospital having the ability to make all appointments to this new committee, and the potential for inappropriate conflicts of interest or simply underqualified people being on this body.

- Major concerns about medical decisions as a way to change the level of care for a patient, becoming a new loophole for discharge.

We have additional concerns we'd be glad to share going forward. We are glad to stay engaged on this. Finally, we note, MDOA can't actually take positions of support for any privately sponsored bill pre-session; ultimate position determinations for state agencies are required to be put through the Governor's Legislative Office approximately 2 weeks ahead of bill hearings once introduced. So we're sharing early impressions but again, final decisions on any legislation that gets put in will be made in coordination with the Governor's Legislative Office in session.

Barb Hirsch, senior counsel, Clinical Affairs, NCR, Johns Hopkins Health System

“I had garnered feedback from my colleagues in the JHHS Legal Department Clinical Affairs practice group.

There are two points that we thought should be addressed in the statutory language:

1. Would this committee qualify as a medical review committee under Maryland law, such that the records, files and proceedings would be protected from discovery?
2. Would the members of the committee have immunity from liability, similar to the patient care advisory committee/ethics committee?”

Randi Ames, Disability Rights Maryland

(via phone call) In terms of composition of the committee, thinks it would be helpful to have someone on the committee who has lived experience of being a patient in the hospital using the committee. Suggested modifying No. 6 to incorporate this as an alternative to caretaker of a patient so # 6 would read:

An individual who is not employed by the hospital and who is (or has been) a caretaker of a patient who lacks decision-making capacity OR WHO IS (OR HAS BEEN) A CARETAKER OF A PATIENT WHO LACKS DECISION-MAKING CAPACITY OR WHO HAS BEEN A PATIENT WITHIN THE HOSPITAL SYSTEM.

Second, there should be a distinction made between transfer and discharge when you are not transferring someone into the community but to another facility, e.g., mental health facility, more specialized facility, etc. In that case, transfer should be considered a medical treatment decision.

Appendix I

Amendment to Maryland Estates & Trusts Art. § 13–204

New language is in ALL CAPS

(a) (1) If a basis exists as described in § 13–201 of this subtitle for assuming jurisdiction over the property of a minor or disabled person, the circuit court, without appointing a guardian, may authorize or direct a transaction with respect to the property, service, or care arrangement of the minor or disabled person.

(2) The transactions described under paragraph (1) of this subsection include:

(i) Payment, delivery, deposit, or retention of funds or property;

(ii) Sale, mortgage, lease, or other transfer of property;

(iii) Purchase of contracts for an annuity, life care, training, or education;

(iv) Making the election to take an elective share of an estate subject to election under § 3–403 of this article;

(V) GRANTING ACCESS TO FINANCIAL OR OTHER RECORDS RELATED TO A MINOR OR DISABLED PERSON

(VI) ESTABLISHING A MINOR OR DISABLED PERSON’S ELIGIBILITY FOR BENEFITS, SUCH AS MEDICAL ASSISTANCE; OR

(vii) Any other transaction described in:

1. § 13–203(c)(2) of this subtitle;
2. Title 9, Subtitle 2 of this article; or
3. § 15–102 of this article.