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**Death**

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**Health – General Article  
Title 5  
Death**

**Subtitle 1. “Body” Defined.**

**5–101.**

In this title, “body” means a dead human body.

**Subtitle 2. Determination of Death.**

**5–201.**

Notwithstanding any other law, a pronouncement of death under this subtitle shall be used for all purposes in this State, including the trials of civil and criminal cases.

**5–202.**

(a) An individual is dead if, based on ordinary standards of medical practice, the individual has sustained either:

(1) Irreversible cessation of circulatory and respiratory functions; or

(2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(b) (1) This subsection does not apply to the removal of a vital organ while the individual is alive, if the individual gives informed consent to the removal.

(2) A pronouncement of death under this section shall be made before any vital organ is removed for transplantation.

**5–203.** [Repealed]

**Subtitle 3. Postmortem Examiners Commission.**

**5–301.**

(a) In this subtitle the following words have the meanings indicated.

(b) “Commission” means the State Postmortem Examiners Commission.

(c) “Medical examiner’s case” means a death that a medical examiner is required by law to investigate.

**5-302.**

There is a State Postmortem Examiners Commission in the Department.

**5-303.**

(a) The Commission consists of the following 5 members:

(1) The Baltimore City Commissioner of Health;

(2) The head of the Pathology Department of the University of Maryland School of Medicine;

(3) The head of the Pathology Department of Johns Hopkins University School of Medicine;

(4) The Secretary of State Police; and

(5) A representative of the Department, chosen by the Secretary.

(b) (1) From among its members, the Commission shall elect a chairman and a vice chairman.

(2) The manner of election of officers and their terms of office shall be as the Commission determines.

(3) The vice chairman shall act as chairman when the chairman is absent or cannot act.

**5-304.**

(a) The Commission shall determine the times and places of its meetings.

(b) A member of the Commission may not receive compensation.

**5-305.**

(a) (1) The Commission may employ a staff in accordance with the State budget for the operation of the Commission and to maintain accreditation.

- (2) The staff shall include:
- (i) 1 chief medical examiner;
  - (ii) 2 deputy chief medical examiners;
  - (iii) Assistant medical examiners;
  - (iv) 1 chief State toxicologist, 1 deputy chief State toxicologist, lead toxicologists, and assistant toxicologists;
  - (v) 1 serologist;
  - (vi) 4 resident medical doctors who are training in forensic pathology;
  - (vii) 1 chief forensic investigator, 2 deputy chief forensic investigators, lead forensic investigators, and assistant forensic investigators; and
  - (viii) 1 autopsy services supervisor, 1 deputy supervisor, lead autopsy technicians, and assistant autopsy technicians.
- (3) The Commission may employ any physician on a contract basis for part-time services.
- (b) (1) The Chief Medical Examiner and deputy chief medical examiners shall be board certified in anatomic and forensic pathology by the American Board of Pathology.
- (2) Assistant medical examiners appointed on or after October 1, 2008, shall be certified by the American Board of Pathology in anatomic and forensic pathology or obtain that certification within 3 years of appointment.
- (c) With the approval of the Secretary of Budget and Management, the Commission shall set the compensation for personnel appointed under subsection (a)(2) of this section.
- (d) For the use of these medical examiners, the Commission shall see that proper equipment is provided.
- (e) The Chief Medical Examiner, a deputy chief medical examiner, or an assistant medical examiner shall be on call at all times to perform the duties set forth in this subtitle.

(f) The State budget shall include an appropriation to carry out this subtitle, including provisions for:

(1) The fee for an authorized pathologist;

(2) The necessary expenses for transportation of a body for examination by a medical examiner or for autopsy; and

(3) In the case of a victim of homicide, the necessary expenses for transportation of the body from the site of the autopsy or examination to a location within the State specified by the victim's family.

**5-306.**

(a) This section does not apply to Baltimore City.

(b) (1) The Commission may appoint one or more deputy medical examiners and forensic investigators for each county.

(2) The Commission shall appoint a deputy medical examiner for a county from a list of qualified individuals submitted to the Commission by the medical society of the county. The number of names on the list shall be at least twice the number of vacancies. However, if a county does not have a medical society or if the medical society does not submit a list of names, the Commission may appoint a deputy medical examiner for the county without a list.

(c) Each deputy medical examiner appointed under subsection (b) of this section shall be a physician.

(d) If necessary, a deputy medical examiner may deputize another physician in the county to act as deputy medical examiner.

(e) Each deputy medical examiner is entitled:

(1) For each medical examiner's case that the examiner investigates, to a fee that is set in accordance with the State budget;

(2) If the examiner is called as a witness before a grand jury or in a criminal case, to the fee that the court sets; and

(3) To any additional compensation that a county provides.

**5-307.**

The Commission may adopt rules and regulations to carry out the provisions of this subtitle.

**5-308.**

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Commission makes under authority specifically delegated by law to the Commission.

(b) The power of the Secretary to transfer by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Commission.

**5-309.**

(a) (1) A medical examiner shall investigate the death of a human being if the death occurs:

(i) By violence;

(ii) By suicide;

(iii) By casualty;

(iv) Suddenly, if the deceased was in apparent good health or unattended by a physician; or

(v) In any suspicious or unusual manner.

(2) A medical examiner shall investigate the death of a human fetus if:

(i) Regardless of the duration of the pregnancy, the death occurs before the complete expulsion or extraction of the fetus from the mother; and

(ii) The mother is not attended by a physician at or after the delivery.

(b) If a medical examiner's case occurs, the police or sheriff immediately shall notify the medical examiner and State's Attorney for the county where the body is found and give the known facts concerning the time, place, manner, and circumstances of the death.

(c) Immediately on notification that a medical examiner's case has occurred, the medical examiner or an investigator of the medical examiner shall go to and take charge of the body. The medical examiner or the investigator shall investigate fully the essential facts concerning the medical cause of death and, before leaving the premises, reduce these facts and the names and addresses of witnesses to writing, which shall be filed in the medical examiner's office.

(d) The medical examiner or the investigator shall take possession of and deliver to the State's Attorney or the State's Attorney's designee any object or article that, in the opinion of the medical examiner or the investigator, may be useful in establishing the cause of death.

(e) (1) If the next of kin of the deceased is not present at the investigation, the police officer or sheriff at the investigation or, if a police officer or sheriff is not present, the medical examiner or the investigator shall:

(i) Take possession of all property of value found on the body;

(ii) In the report of the death, make an exact inventory of the property; and

(iii) Deliver the property to the appropriate sheriff or police department.

(2) The sheriff or police department shall surrender the property to the person who is entitled to its possession or custody.

(f) (1) If the case involves the unexpected death of a child, the medical examiner shall notify the chairperson of the local child fatality review team for the county in which the child resided.

(2) If the case involves the death of a child and the death is believed to be caused by abuse or neglect, or there is evidence suggesting that the child was a victim of abuse or neglect, the Office of the Chief Medical Examiner shall orally report the findings and deliver a copy of the child's final autopsy report to the local department of social services and the local law enforcement agency of the county in which the child last resided in accordance with § 5-704 of the Family Law Article.

### **5-310.**

(a) If the cause of death is established to a reasonable degree of medical certainty, the medical examiner who investigates the case shall file in the medical examiner's office a report on the cause of death within 30 days after notification of the case.

(b) (1) If the medical examiner who investigates a medical examiner's case considers an autopsy necessary, the Chief Medical Examiner, a deputy chief medical examiner, an assistant medical examiner, or a pathologist authorized by the Chief Medical Examiner shall perform the autopsy.

(2) If the family of the deceased objects to an autopsy on religious grounds, the autopsy may not be performed unless authorized by the Chief Medical Examiner or by the Chief Medical Examiner's designee.

(3) (i) In accordance with normal standards of medical practice, the medical examiner performing the autopsy may retain any medical evidence, tissue, or organ needed to carry out the duties of this subtitle.

(ii) The medical examiner shall dispose of any medical evidence, tissue, or organ under subparagraph (i) of this paragraph in accordance with normal standards of medical practice.

(c) (1) A medical examiner shall conduct an autopsy of any fire fighter and any sworn personnel of the State Fire Marshal's Office who dies in the line of duty or as a result of injuries sustained in the line of duty.

(2) The autopsy shall include:

(i) A toxicological analysis for toxic fumes;

(ii) Gross and microscopic studies of heart, lung, and any other tissue involved;

(iii) Appropriate studies of blood and urine; and

(iv) Appropriate studies of body fluids and body tissues.

(3) If the medical examiner determines toxic fumes were the cause of death, the medical examiner shall:

(i) Investigate to the extent possible the source of the fumes; and

(ii) Prepare a written report on the specific effects of the fumes on human tissue.

(4) The autopsy and analysis shall be sufficient to determine eligibility for benefits under the federal Public Safety Officers' Benefits Act of 1976.

(d) (1) The individual who performs the autopsy shall prepare detailed written findings during the progress of the autopsy. These findings and the conclusions drawn from them shall be filed in the office of the medical examiner for the county where the death occurred. The original copy of the findings and conclusions shall be filed in the office of the Chief Medical Examiner.

(2) (i) Except in a case of a finding of homicide, a person in interest as defined in § 4–101(e) of the General Provisions Article may request the medical examiner to correct findings and conclusions on the cause and manner of death recorded on a certificate of death under § 4–502 of the General Provisions Article within 60 days after the medical examiner files those findings and conclusions.

(ii) If the Chief Medical Examiner denies the request of a person in interest to correct findings and conclusions on the cause of death, the person in interest may appeal the denial to the Secretary, who shall refer the matter to the Office of Administrative Hearings. A contested case hearing under this paragraph shall be a hearing both on the denial and on the establishment of the findings and conclusions on the cause of death.

(iii) The administrative law judge shall submit findings of fact to the Secretary.

(iv) After reviewing the findings of the administrative law judge, the Secretary, or the Secretary's designee, shall issue an order to:

1. Adopt the findings of the administrative law judge; or
2. Reject the findings of the administrative law judge, and affirm the findings of the medical examiner.

(v) The appellant may appeal a rejection under subparagraph (iv)2 of this paragraph to a circuit court of competent jurisdiction.

(vi) If the final decision of the Secretary, or of the Secretary's designee, or of a court of competent jurisdiction on appeal, establishes a different finding or conclusion on the cause or manner of death of a deceased than that recorded on the certificate of death, the medical examiner shall amend the certificate to reflect the different finding or conclusion under §§ 4–212 and 4–214 of this article and § 4–502 of the General Provisions Article.

(vii) The final decision of the Secretary, or the Secretary's designee, or of a court under this paragraph may not give rise to any presumption concerning the application of any provision of or the resolution of any claim concerning a policy of insurance relating to the deceased.

(viii) If the findings of the medical examiner are upheld by the Secretary, the appellant is responsible for the costs of the contested case hearing. Otherwise, the Department is responsible for the costs of the hearing.

(e) The Chief Medical Examiner shall set a reasonable fee for performing an autopsy by an authorized pathologist.

### **5-311.**

(a) (1) The Office of the Chief Medical Examiner shall keep complete records on each medical examiner's case.

(2) The records shall be indexed properly and include:

(i) The name, if known, of the deceased;

(ii) The place where the body was found;

(iii) The date, cause, and manner of death; and

(iv) All other available information about the death.

(b) The original report of the medical examiner who investigates a medical examiner's case and the findings and conclusions of any autopsy shall be attached to the record of the medical examiner's case.

(c) The Chief Medical Examiner or, if the Chief Medical Examiner is absent or cannot act, the Deputy Chief Medical Examiner or an assistant medical examiner, and each deputy medical examiner promptly shall deliver to the State's Attorney for the county where the body was found a copy of each record that relates to a death for which the medical examiner considers further investigation advisable. A State's Attorney may obtain from the office of a medical examiner a copy of any record or other information that the State's Attorney considers necessary.

(d) (1) In this subsection, "record":

(i) Means the result of an external examination of or an autopsy on a body; and

(ii) Does not include a statement of a witness or other individual.

(2) A record of the Office of the Chief Medical Examiner or any deputy medical examiner, if made by the medical examiner or by anyone under the medical examiner's direct supervision or control, or a certified transcript of that record, is competent evidence in any court in this State of the matters and facts contained in it.

(e) (1) The Office of the Chief Medical Examiner shall charge a reasonable fee for reports as specified in a schedule of fees defined in the regulations of the Office of the Chief Medical Examiner.

(2) A deputy medical examiner may keep any fee collected by the deputy medical examiner.

### **5-312.**

Subject to the limitations in § 5-311(c) of this subtitle, a medical examiner may administer oaths, take affidavits, and make examinations as to any matter within the medical examiner's jurisdiction.

## **Subtitle 4. Anatomy Board.**

### **5-401.**

(a) In this subtitle the following words have the meanings indicated.

(b) "Board" means the State Anatomy Board.

(c) "Medical study program" means any research or teaching activity conducted at or under the sponsorship of a hospital or other institution devoted to research, teaching, or study of medicine, dentistry, or any related health profession or advanced human biological science.

(d) "Public officer" means an officer of this State or of a county or other political subdivision of this State.

### **5-402.**

There is a State Anatomy Board in the Department.

### **5-403.**

(a) (1) The Board consists of:

(i) 1 member of the Anatomy Department of the University of Maryland School of Dentistry;  
and

(ii) 2 members of the anatomy department of each medical school in this State.

(2) The administrative officer of each school shall name the members from that school.

(b) (1) From among its members, the Board every 2 years shall elect a chairman and a vice chairman.

(2) The manner of election of officers shall be as the Board determines.

(3) The vice chairman shall act as chairman when the chairman is absent or cannot act.

#### **5-404.**

(a) The Board shall determine the times and places of its meetings.

(b) A member of the Board:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

#### **5-404.1.**

In addition to the powers and duties set forth elsewhere in this title, the Board has the following powers and duties:

(1) To adopt regulations to carry out the provisions of this title; and

(2) To set reasonable fees, by regulation, for its services.

#### **5-405.**

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Board makes under authority specifically delegated by law to the Board.

(b) The power of the Secretary to transfer by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Board.

#### **5-406.**

(a) (1) A public officer who has control of a body immediately shall notify the chairman of the Board if, after a reasonable search, the public officer has not found a person who will take control of the body for its final disposition.

(2) Subject to the limitations imposed on nursing homes under § 10-214 of the Human Services Article, any other person who has control of a body may notify the Board if, after a reasonable search, the person has not found a person who will take control of the body for its final disposition.

(b) (1) Subject to the time limitations in this subsection, when the Board is notified of the existence of a body, the Board may remove the body to a morgue in Baltimore City that the Board designates for that purpose.

(2) If the person who notifies the Board can refrigerate the body suitably, the body may be removed only at the expiration of 72 hours after death.

(3) If the person who notifies the Board cannot refrigerate the body suitably, the body may be removed as soon as feasible after death, and, on arrival at the morgue, shall be refrigerated until the expiration of 72 hours after death.

(c) (1) On expiration of 72 hours after death, the body shall be under the exclusive control of the Board and may be embalmed.

(2) If the body is embalmed, it shall be embalmed in a proper manner by an individual whom the Board designates.

(3) Any relative or friend of the deceased may claim the body and, on payment to the Board of its cost of moving and embalming the body, shall receive it.

(4) The Board may waive its costs under this section upon a showing of hardship by the relative or friend.

#### **5-406.1.**

(a) Any person who has custody of a donated body immediately shall notify the chairman of the Board.

(b) When the Board is notified of the existence of a donated body, the Board may remove the body to a designated morgue in Baltimore City.

(c) (1) The donated body shall be under the exclusive control of the Board and may be embalmed.

(2) If the body is embalmed, it shall be embalmed in a proper manner by an individual whom the Board designates.

#### **5-407.**

The Board shall first distribute bodies or body parts that are under its exclusive control equitably among the schools described in § 5-403 of this subtitle, and then, at the Board's discretion, distribute bodies or body parts to other medical study programs. These bodies or body parts may be used only for the promotion and application of medical sciences.

#### **5-408.**

(a) (1) A person may not sell or buy any body or any part of a body that is under the exclusive control of the Board.

(2) A person other than a nonprofit organization that qualifies under § 501(c)(3) of the Internal Revenue Code, may not sell, buy, or act as a broker for a profit in the transfer of any human organ that:

(i) Is removed from a human body that is alive or dead at the time of removal; and

(ii) Is not under the exclusive control of the Board.

(3) In this section, "human organ" does not include blood and plasma.

(b) (1) Except as provided in paragraphs (2) and (3) of this subsection, a person may not send, transport, or permit or cause to be sent or transported out of the State any body or any part of a body that is under the exclusive control of the Board.

(2) The Board may authorize, by regulation, the transporting of human specimens under its exclusive control to an out-of-state medical study program, provided that:

- (i) The needs of the schools of the State are met;
  - (ii) The requesting party demonstrates the need for a specimen;
  - (iii) The circumstances of the request are that:
    1. No other sufficient source of specimens within the requesting state exists; or
    2. A preexisting organ tissue donation was made by an individual in compliance with the Maryland Revised Uniform Anatomical Gift Act;
  - (iv) The requesting party bears the responsibility for transporting and the specialized care of the specimen and all associated costs; and
  - (v) The Board retains the right of exclusive control of the specimen including the final disposition when appropriate or necessary to fulfill an obligation to return the remains of a donated specimen to the donor's family.
- (3) The Board may authorize a physician, teacher, demonstrator, or investigator of advanced human biological sciences to send or transport human specimens out of the State for use by medical study programs.

#### **5-408.1.**

Except as provided in § 5-408(a)(2) of this subtitle, this subtitle does not deny the right of a donor to provide by last will and testament or by contract for the ultimate disposition and repose of the donor's last remains.

#### **5-409.**

- (a) A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$500 or imprisonment not exceeding 1 year or both.
- (b) A public officer or an officer or employee of any institution who neglects or refuses to comply with the provisions of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$100 for each offense.

### **Subtitle 5. Miscellaneous Provisions.**

**5-501.**

(a) Consent for a postmortem examination of a body by a physician is sufficient if the consent is given as provided in this section.

(b) (1) The consent may be given by any one of the following persons if that person, whether alone or with another, has assumed control of the body for its final disposition:

(i) A parent;

(ii) A spouse;

(iii) A domestic partner;

(iv) A child;

(v) A guardian;

(vi) A next of kin; or

(vii) In the absence of these persons, any other person.

(2) If a person does not assume control of a body under paragraph (1) of this subsection, the consent may be given by the State Anatomy Board.

(c) The consent may be in the form of:

(1) A written document;

(2) A telegram; or

(3) A recorded telephonic or other recorded message.

**5-502.**

(a) This section does not apply to the disposition of a body by a school of medicine or dentistry.

(b) Except as otherwise provided in this section, a person may not cremate a body until it has been identified by:

- (1) The next of kin;
  - (2) A person who is authorized to arrange for final disposition of the body under §§ 5-508 through 5-512 of this subtitle; or
  - (3) A medical examiner.
- (c) If a person who is authorized to arrange for final disposition of a body is not available to identify the body and authorize cremation, that person may delegate that authority to another person by sending to the delegate an electronic communication that contains the name, address, and relationship of the sender to the deceased and the name and address of the individual to whom authority is delegated. Written authorization shall follow by mail but does not take precedence over the electronic communication authorizing the identification and cremation.

**5-503.**

A person may not cremate a body until at least 12 hours after death.

**5-504.**

A person may not transport a body to a crematory without using a cot and pouch or receptacle.

**5-505.**

- (a) Except as provided in subsection (b) of this section, a person may not require that a cremation be performed with a casket. However, the use of a simple container may be required.
- (b) The person arranging for final disposition of a body may specify that a casket:
- (1) Be used before cremation;
  - (2) Be consumed during cremation;
  - (3) Be used after cremation; or
  - (4) Not be used before, during, or after cremation.

**5-506.**

(a) A health officer may take control of a body that is being kept in a room where an individual lives and that is in a condition that endangers an individual in the house where the body is kept if:

(1) At least 3 individuals living near the house or a physician asks the health officer, in writing, to order final disposition of the body;

(2) The health officer issues an order for final disposition, within a time period stated in the order; and

(3) Final disposition of the body is not made within that time.

(b) A person may not obstruct the carrying out of an order of a health officer under this section.

#### **5-507.**

(a) A person who violates any provision of § 5-502, § 5-503, § 5-504, or § 5-505 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$1,000.

(b) A person who violates any provision of § 5-506(b) of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$200 or imprisonment not exceeding 6 months.

#### **5-508.**

(a) In this subtitle the following words have the meanings indicated.

(b) “Authorizing agent” means the individual who has legal authority to arrange for and make decisions regarding the final disposition of a dead human body, including by cremation.

(c) “Cremation” means the disposition of a dead human body by means of incineration.

(d) “Crematory” is a building in which cremations are performed.

(e) “Decedent” means a dead human being.

(f) “Practitioner” means a person who is licensed by the State as a funeral director, mortician, or surviving spouse licensee to practice mortuary science.

(g) “Pre-need contract” means an agreement prior to the time of death between a consumer and a practitioner to provide any goods and services regarding the final disposition of a dead human body.

**5-509.**

(a) (1) Any individual who is 18 years of age or older may decide the disposition of the individual’s own body after that individual’s death without the predeath or post-death consent of another person by executing a document that expresses the individual’s wishes regarding disposition of the body or by entering into a pre-need contract.

(2) The person designated on a United States Department of Defense Record of Emergency Data (DD Form 93), or its successor form, as the person authorized to direct disposition may arrange for the final disposition of the body of a decedent, including by cremation under § 5-502 of this subtitle, if the decedent:

(i) Died while serving in the United States armed forces; and

(ii) Executed the United States Department of Defense Record of Emergency Data (DD Form 93), or its successor form.

(b) In order to be valid, any document executed under subsection (a) of this section must be written and signed by the individual in the presence of a witness, who, in turn, shall sign the document in the presence of the individual.

(c) Unless a person has knowledge that contrary directions have been given by the decedent, if a decedent has not executed a document under subsection (a) of this section, the following persons, in the order of priority stated, have the right to arrange for the final disposition of the body of the decedent, including by cremation under § 5-502 of this subtitle:

(1) The surviving spouse or domestic partner of the decedent;

(2) An adult child of the decedent;

(3) A parent of the decedent;

(4) An adult brother or sister of the decedent;

(5) A person acting as a representative of the decedent under a signed authorization of the decedent;

(6) The guardian of the person of the decedent at the time of the decedent's death, if one has been appointed; or

(7) In the absence of any person under items (1) through (6) of this subsection, any other person willing to assume the responsibility to act as the authorizing agent for purposes of arranging the final disposition of the decedent's body, including the personal representative of the decedent's estate, after attesting in writing that a good faith effort has been made to no avail to contact the individuals under items (1) through (6) of this subsection.

(d) (1) Subject to paragraph (2) of this subsection, if a decedent has more than one survivor under subsection (c)(1) through (4) of this section, any adult child, parent, or adult brother or sister of the decedent who confirms in writing to a practitioner that all of the other members of the same class have been notified may serve as the authorizing agent for purposes of § 5-502 of this subtitle unless the practitioner receives a written objection to the cremation from another member of that class within 24 hours.

(2) If a decedent has more than one survivor under subsection (c)(1) through (4) of this section, the majority of a class may serve as the authorizing agent.

(e) In the case of an individual whose final disposition is the responsibility of the State or any of its instrumentalities, a public administrator, medical examiner, coroner, State-appointed guardian, or any other public official charged with arranging the final disposition of the decedent may serve as the authorizing agent for purposes of § 5-502 of this subtitle.

(f) In the case of an individual who has donated the individual's body to medical science or whose death occurred in a nursing home or other private institution, a representative of the institution to which the body was donated or in which the decedent died shall authorize cremation for purposes of § 5-502 of this subtitle if the decedent executed cremating authorization forms and the institution is charged with making arrangements for the final disposition of the body.

#### **5-510.**

(a) (1) If the majority of individuals under § 5-509(c) of this subtitle cannot agree on the arrangements, any individual specified in § 5-509(c) of this subtitle or the practitioner who has custody of the body, or both, may file a petition in the circuit court for the county in which the decedent was domiciled at the time of death or the county in which the body is located requesting the court to decide the final disposition of the body.

(2) The practitioner may add the court costs associated with a petition under this subsection to the costs of final disposition.

(b) In the event of a disagreement under subsection (a) of this section, a practitioner is not liable for refusing to accept the body or to inter or otherwise dispose of the body of the decedent or complete the arrangements for the final disposition of the body until the practitioner receives a court order or other written agreement signed by the parties in the disagreement that decides the final disposition of the body.

(c) If the practitioner retains the body for final disposition in accordance with a court order or written agreement among the parties, the practitioner may embalm or refrigerate and shelter the body, or both, in order to preserve it while awaiting the final decision and may add the costs of embalming and refrigeration and sheltering to the final disposition costs.

(d) (1) This section may not be construed to require or to impose a duty upon a practitioner to bring an action under this section.

(2) A practitioner may not be held criminally or civilly liable for choosing not to bring an action under this section.

#### **5-511.**

(a) A practitioner and an operator of a crematory may rely on the representations made by an authorizing agent and are not guarantors of the reliability of those representations.

(b) A practitioner and an operator of a crematory have no responsibility to contact or to independently investigate the existence of any next of kin of the decedent.

(c) An individual may file a petition with the appropriate court to obtain the authority to be authorizing agent:

(1) If the individual alleges that permitting one or more of the individuals with priority under § 5-509(c) of this subtitle to authorize arrangements for the final disposition of the body of a decedent may cause substantial injustice; or

(2) If, considering all the circumstances, an individual other than an individual with priority under § 5-509(c) of this subtitle had a closer personal affinity to the decedent and should be allowed to make the arrangements.

(d) Pending the outcome of a petition filed under this section, a practitioner shall suspend any arrangements with the individuals under § 5-509(c) of this subtitle.

5-512.

(a) A practitioner or an operator of a crematory may not require an authorizing agent to obtain appointment as personal representative of the decedent's estate as a condition precedent to making final arrangements or authorizing cremation of a decedent.

(b) A person may not authorize cremation when a decedent has left instructions in a document that the decedent does not wish to be cremated.

5-513.

(a) On taking custody of the body of a decedent in accordance with all authorizations required by law, a funeral establishment or crematory shall maintain the body in a manner that provides for complete coverage of the body and prevents leakage or spillage except during:

(1) Identification, embalming, or preparation of an unembalmed body for final disposition;

(2) Restoration and dressing of a body in preparation for final disposition; and

(3) Viewing during a visitation or funeral service.

(b) If the unembalmed body of a decedent is to be stored for more than 48 hours before final disposition, a funeral establishment or crematory shall maintain the body with refrigeration and at a temperature determined by regulation.

(c) (1) If a funeral establishment or crematory cannot secure the body of a decedent or cannot store the body as required in subsection (b) of this section due to an unforeseen circumstance, the funeral establishment or crematory shall notify the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight and the person authorized to arrange for the final disposition of the body under § 5-509 of this subtitle.

(2) The notification required under paragraph (1) of this subsection shall:

(i) Be made within 24 hours after the occurrence of the unforeseen circumstance; and

(ii) Include the name and location of the facility where the body is being transferred, the reason for the transfer, and the method of storage.

(d) The body of a decedent may not be embalmed or artificially preserved without:

(1) The express permission of the person authorized to arrange for the final disposition of the body under § 5–509 of this subtitle; or

(2) A court order.

(e) A funeral establishment or crematory shall store the body of a decedent until final disposition at:

(1) A funeral establishment licensed under Title 7 of the Health Occupations Article;

(2) A crematory licensed under Title 7 of the Health Occupations Article;

(3) A crematory permitted under Title 5 of the Business Regulation Article; or

(4) Another facility that has passed an inspection with the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight within the past 2 years.

(f) A funeral establishment, crematory, or transportation service may not transport or store the body of a decedent together with animal remains in the same confined space.

(g) (1) Except as provided in paragraph (2) of this subsection, while the body of a decedent is in the custody of a funeral establishment or crematory in the State, the body may not be transported for preparation or storage to a facility that is not within the jurisdiction of the State, licensed by the State Board of Morticians and Funeral Directors, or permitted by the Office of Cemetery Oversight.

(2) The body of a decedent may be transported for preparation or storage to a facility that is not within the jurisdiction of the State, licensed by the State Board of Morticians and Funeral Directors, or permitted by the Office of Cemetery Oversight if:

(i) The facility has entered into a written agreement with the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight to allow the State to make unannounced inspections of the facility; and

(ii) The person authorized to arrange for the final disposition of the body under § 5–509 of this subtitle:

1. Has given written permission for the body to be transported to the facility; or
2. A. Has given oral permission for the body to be transported to the facility; and  
B. Within 36 hours after giving oral permission, provides written verification of the oral permission.

**5-514.**

- (a) An individual may not bury or dispose of a body except:
  - (1) In a family burial plot or other area allowed by a local ordinance;
  - (2) In a crematory;
  - (3) In a cemetery;
  - (4) By donating the body to medical science; or
  - (5) By removing the body to another state for final disposition in accordance with the laws of the other state.
- (b) An individual who violates this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding \$5,000 or both.

**Subtitle 6. Health Care Decisions Act.**

**5-601.**

- (a) In this subtitle the following words have the meanings indicated.
- (b) “Advance directive” means:
  - (1) A witnessed written or electronic document, voluntarily executed by the declarant in accordance with the requirements of this subtitle; or
  - (2) A witnessed oral statement, made by the declarant in accordance with the provisions of this subtitle.

(c) “Agent” means an adult appointed by the declarant under an advance directive made in accordance with the provisions of this subtitle to make health care decisions for the declarant.

(d) “Attending physician” means the physician who has primary responsibility for the treatment and care of the patient.

(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.

(f) “Competent individual” means a person who is at least 18 years of age or who under § 20–102(a) of this article has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision.

(g) “Declarant” means a competent individual who makes an advance directive while capable of making and communicating an informed decision.

(h) “Electronic signature” has the meaning stated in § 21–101 of the Commercial Law Article.

(i) “Emergency medical services ‘do not resuscitate order’” means a physician’s, physician assistant’s, or nurse practitioner’s written order in a form established by protocol issued by the

Maryland Institute for Emergency Medical Services in conjunction with the State Board of Physicians which, in the event of a cardiac or respiratory arrest of a particular patient, authorizes certified or licensed emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation including cardiac compression, endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures.

(j) “End-stage condition” means an advanced, progressive, irreversible condition caused by injury, disease, or illness:

(1) That has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and

(2) For which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

(k) “Health care practitioner” means:

(1) An individual licensed or certified under the Health Occupations Article or § 13-516 of the Education Article to provide health care; or

(2) The administrator of a hospital or a person designated by the administrator in accordance with hospital policy.

(l) (1) “Health care provider” means a health care practitioner or a facility that provides health care to individuals.

(2) “Health care provider” includes agents or employees of a health care practitioner or a facility that provides health care to individuals.

(m) (1) “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.

(2) For the purposes of this subtitle, a competent individual who is able to communicate by means other than speech may not be considered incapable of making an informed decision.

(n) (1) “Life-sustaining procedure” means any medical procedure, treatment, or intervention that:

(i) Utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function; and

(ii) Is of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition, persistent vegetative state, or end-stage condition.

(2) “Life-sustaining procedure” includes artificially administered hydration and nutrition, and cardiopulmonary resuscitation.

(o) “Medically ineffective treatment” means that, to a reasonable degree of medical certainty, a medical procedure will not:

(1) Prevent or reduce the deterioration of the health of an individual; or

(2) Prevent the impending death of an individual.

(p) “Nurse practitioner” means an individual licensed to practice registered nursing in the State and who is certified as a nurse practitioner by the State Board of Nursing under Title 8 of the Health Occupations Article.

(q) “Persistent vegetative state” means a condition caused by injury, disease, or illness:

(1) In which a patient has suffered a loss of consciousness, exhibiting no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response; and

(2) From which, after the passage of a medically appropriate period of time, it can be determined, to a reasonable degree of medical certainty, that there can be no recovery.

(r) “Physician” means a person licensed to practice medicine in the State or in the jurisdiction where the treatment is to be rendered or withheld.

(s) “Physician assistant” means an individual who is licensed under Title 15 of the Health Occupations Article to practice medicine with physician supervision.

(t) “Signed” means bearing a manual or electronic signature.

(u) “Terminal condition” means an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life–sustaining procedures, there can be no recovery.

#### **5–601.1.**

For purposes of this Part I of this subtitle, an electronic signature shall have the same effect as a manual signature if the electronic signature:

- (1) Uses an algorithm approved by the National Institute of Standards and Technology;
- (2) Is unique to the individual using it;
- (3) Is capable of verification;
- (4) Is under the sole control of the individual using it;
- (5) Is linked to data in such a manner that if the data are changed, the electronic signature is invalidated;
- (6) Persists with the document and not by association in separate files; and
- (7) Is bound to a digital certificate.

#### **5–602.**

(a) Any competent individual may, at any time, make a written or electronic advance directive regarding the provision of health care to that individual, or the withholding or withdrawal of health care from that individual.

(b) (1) In this subsection, “disqualified person” means:

- (i) An owner, operator, or employee of a health care facility from which the declarant is receiving health care; or
- (ii) A spouse, parent, child, or sibling of an owner, operator, or employee of a health care facility from which the declarant is receiving health care.

(2) Any competent individual may, at any time, make a written or electronic advance directive appointing an agent to make health care decisions for the individual under the circumstances stated in the advance directive.

(3) A disqualified person may not serve as a health care agent unless the person:

(i) Would qualify as a surrogate decision maker under § 5–605(a) of this subtitle; or

(ii) Was appointed by the declarant before the date on which the declarant received, or contracted to receive, health care from the facility.

(4) An agent appointed under this subtitle has decision making priority over any individuals otherwise authorized under this subtitle to make health care decisions for a declarant.

(c) (1) A written or electronic advance directive shall be dated, signed by or at the express direction of the declarant, and subscribed by two witnesses.

(2) (i) Except as provided in subparagraphs (ii) and (iii) of this paragraph, any competent individual may serve as a witness to an advance directive, including an employee of a health care facility, nurse practitioner, physician assistant, or physician caring for the declarant if acting in good faith.

(ii) The health care agent of the declarant may not serve as a witness.

(iii) At least one of the witnesses must be an individual who is not knowingly entitled to any portion of the estate of the declarant or knowingly entitled to any financial benefit by reason of the death of the declarant.

(3) An electronic advance directive that is created in compliance with the electronic witness protocols of the Advance Directive Registry of the Department shall satisfy the witness requirement of paragraph (1) of this subsection.

(d) (1) Any competent individual may make an oral advance directive to authorize the providing, withholding, or withdrawing of any life–sustaining procedure or to appoint an agent to make health care decisions for the individual.

(2) An oral advance directive shall have the same effect as a written or electronic advance directive if made in the presence of the attending physician, physician assistant, or nurse practitioner and one witness and if the substance of the oral advance directive is documented as

part of the individual's medical record. The documentation shall be dated and signed by the attending physician, physician assistant, or nurse practitioner and the witness.

(e) (1) Unless otherwise provided in the document, an advance directive shall become effective when the declarant's attending physician and a second physician certify in writing that the patient is incapable of making an informed decision.

(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician is not required under paragraph (1) of this subsection.

(f) (1) It shall be the responsibility of the declarant to notify the attending physician that an advance directive has been made. In the event the declarant becomes comatose, incompetent, or otherwise incapable of communication, any other person may notify the physician of the existence of an advance directive.

(2) An attending physician who is notified of the existence of the advance directive shall promptly:

(i) If the advance directive is written or electronic, make the advance directive or a copy of the advance directive a part of the declarant's medical records; or

(ii) If the advance directive is oral, make the substance of the advance directive, including the date the advance directive was made and the name of the attending physician, a part of the declarant's medical records.

(g) It shall be the responsibility of the declarant to notify a health care agent that the agent has been named in an advance directive to act on the declarant's behalf.

(h) Unless otherwise provided in the patient's advance directive, a patient's agent shall act in accordance with the provisions of § 5-605(c) of this subtitle.

(i) The absence of an advance directive creates no presumption as to the patient's intent to consent to or refuse life-sustaining procedures.

5-602.1.

(a) In this section, "mental health services" has the meaning stated in § 4-301(j)(1) of this article.

(b) An individual who is competent may make an advance directive to outline the mental health services which may be provided to the individual if the individual becomes incompetent and has a need for mental health services either during, or as a result of, the incompetency.

(c) (1) An individual making an advance directive for mental health services shall follow the procedures for making an advance directive provided under § 5–602 of this subtitle.

(2) The procedures provided under § 5–604 of this subtitle for the revocation of an advance directive shall apply to the revocation of an advance directive for mental health services.

(d) An advance directive for mental health services may include:

(1) The designation of an agent to make mental health services decisions for the declarant;

(2) The identification of mental health professionals, programs, and facilities that the declarant would prefer to provide mental health services;

(3) A statement of medications preferred by the declarant for psychiatric treatment; and

(4) Instruction regarding the notification of third parties and the release of information to third parties about mental health services provided to the declarant.

5–603.

Maryland Advance Directive:

Planning for Future Health Care Decisions

By: Date of Birth: \_\_\_\_\_

(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

#### PART I: SELECTION OF HEALTH CARE AGENT

##### A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name:

Address:

Telephone Numbers:

(home and cell)

##### B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(home and cell)

##### C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank)

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#### D. How My Agent Is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

#### E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s)

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F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

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G. Access to My Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of This Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

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((or))

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

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If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values

(Optional; form valid if left blank)



1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

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((or))

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

---

((or))

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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#### D. Preference in Case of End-Stage Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

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((or))

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

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((or))

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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#### E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

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#### F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

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G. Effect of Stated Preferences

(Read both of these statements carefully. Then, initial one only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

\_\_\_\_\_  
(or)

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

\_\_\_\_\_  
PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

\_\_\_\_\_  
(Signature of Declarant)                      (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

\_\_\_\_\_  
(Signature of Witness)                      (Date)

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
(Signature of Witness)                      (Date)

\_\_\_\_\_  
Telephone Number(s)

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does not require this document to be notarized.)

**AFTER MY DEATH**

(This form is optional. Fill out only what reflects your wishes.)

By: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Print Name) (Month/Day/Year)

**PART I: ORGAN DONATION**

(Initial the ones that you want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes. \_\_\_\_\_

Only the following organs, tissues, or eyes: \_\_\_\_\_

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I authorize the use of my organs, tissues, or eyes:

For transplantation \_\_\_\_\_

For therapy \_\_\_\_\_

For research \_\_\_\_\_

For medical education \_\_\_\_\_

For any purpose authorized by law \_\_\_\_\_

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

**PART II: DONATION OF BODY**

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

**PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS**

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. \_\_\_\_\_

((or))

This person:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

—

\_\_\_\_\_

—

Telephone Numbers: \_\_\_\_\_

(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

\_\_\_\_\_

—

\_\_\_\_\_

—

\_\_\_\_\_

—

\_\_\_\_\_

—

\_\_\_\_\_

—

**PART IV: SIGNATURE AND WITNESSES**

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

\_\_\_\_\_

(Signature of Donor) (Date)

The Donor signed or acknowledged signing this donation document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

\_\_\_\_\_

(Signature of Witness) (Date)

\_\_\_\_\_

Telephone Number(s)

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(Signature of Witness)

(Date)

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Telephone Number(s)

**5-604.**

(a) (1) Except as provided in paragraph (2) of this subsection, an advance directive may be revoked at any time by a declarant by a signed and dated written or electronic document, by physical cancellation or destruction, by an oral statement to a health care practitioner or by the execution of a subsequent directive.

(2) A declarant, knowingly and voluntarily, may elect in an advance directive to waive the right under paragraph (1) of this subsection to revoke any part or all of the advance directive, including the appointment of an agent, during a period in which the declarant has been certified incapable of making an informed decision under § 5-602(e) of this subtitle.

(b) If a declarant revokes an advance directive by an oral statement to a health care practitioner, the practitioner and a witness to the oral revocation shall document the substance of the oral revocation in the declarant's medical record.

(c) It shall be the responsibility of the declarant, to the extent reasonably possible, to notify any person to whom the declarant has provided a copy of the directive.

**5-604.1.**

(a) An advance directive may contain a statement by a declarant that the declarant consents to the gift of all or any part of the declarant's body for any one or more of the purposes specified in Title 4, Subtitle 5 of the Estates and Trusts Article.

(b) Notwithstanding any other provision of law, an anatomical gift in an advance directive is valid and effective for all purposes under Title 4, Subtitle 5 of the Estates and Trusts Article, including the immunity from civil or criminal liability set forth in § 4-514 of the Estates and Trusts Article.

**5-605.**

(a) (1) In this subsection, "unavailable" means:

- (i) After reasonable inquiry, a health care provider is unaware of the existence of a health care agent or surrogate decision maker;
- (ii) After reasonable inquiry, a health care provider cannot ascertain the whereabouts of a health care agent or surrogate decision maker;
- (iii) 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;
- (iv) A health care agent or surrogate decision maker is incapacitated; or
- (v) A health care agent or surrogate decision maker is unwilling to make decisions concerning health care for the individual.

(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.

(3) A friend or other relative may make decisions about health care for a patient under paragraph (2) 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.

(4) The attending physician shall include the affidavit presented under paragraph (3) of this subsection in the patient's medical record.

(b) (1) If persons with equal decision making priority under subsection (a) of this section disagree about a health care decision, and a person who is incapable of making an informed decision is receiving care in a hospital or related institution, the attending physician or an individual specified in subsection (a) of this section shall refer the case to the institution's patient care advisory committee, and may act in accordance with the recommendation of the committee or transfer the patient in accordance with the provisions of § 5-613 of this subtitle. A physician who acts in accordance with the recommendation of the committee is not subject to liability for any claim based on lack of consent or authorization for the action.

(2) If a person who is incapable of making an informed decision is not in a hospital or related institution, a physician may not withhold or withdraw life-sustaining procedures if there is not agreement among all the persons in the same class.

(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 and, if the wishes of the patient are unknown or unclear, on the patient's best interest.

(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.

(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.

(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.

(d) A surrogate may not authorize:

(1) Sterilization; or

(2) Treatment for a mental disorder.

#### **5-606.**

(a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.

(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician is not required under paragraph (1) of this subsection.

(3) When authorization is sought for treatment of a mental illness, the second physician may not be otherwise currently involved in the treatment of the person assessed.

(4) The cost of an assessment to certify incapacity under this subsection shall be considered for all purposes a cost of the patient's treatment.

(b) A health care provider may not withhold or withdraw life-sustaining procedures on the basis of an advance directive where no agent has been appointed or on the basis of the authorization of a surrogate, unless:

(1) The patient's attending physician and a second physician have certified that the patient is in a terminal condition or has an end-stage condition; or

(2) Two physicians, one of whom is a neurologist, neurosurgeon, or other physician who has special expertise in the evaluation of cognitive functioning, certify that the patient is in a persistent vegetative state.

**5-607.**

A health care provider may treat a patient who is incapable of making an informed decision, without consent, if:

(1) The treatment is of an emergency medical nature;

(2) A person who is authorized to give the consent is not available immediately; and

(3) The attending physician determines that:

(i) There is a substantial risk of death or immediate and serious harm to the patient; and

(ii) With a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent.

**5-608.**

(a) (1) Certified or licensed emergency medical services personnel shall be directed by protocol to follow emergency medical services "do not resuscitate orders" pertaining to adult patients in the outpatient setting in accordance with protocols established by the Maryland Institute for Emergency Medical Services Systems in conjunction with the State Board of Physicians.

(2) Emergency medical services "do not resuscitate orders" may not authorize the withholding of medical interventions, or therapies deemed necessary to provide comfort care or to alleviate pain.

(3) A health care provider, other than certified or licensed emergency medical services personnel, who sees, in a valid form, an emergency medical services "do not resuscitate order" described in paragraph (1) of this subsection that is not superseded by a subsequent physician's order:

(i) May, before a patient's cardiac or respiratory arrest, provide, withhold, or withdraw treatment in accordance with the emergency medical services "do not resuscitate order"; and

(ii) Shall, after a patient's cardiac or respiratory arrest, withhold or withdraw treatment in accordance with the emergency medical services "do not resuscitate order".

(4) An order contained in a "Medical Orders for Life-Sustaining Treatment" form that resuscitation not be attempted shall be given the same effect as emergency medical services "do not resuscitate orders" described in paragraph (1) of this subsection.

(b) This section does not authorize emergency medical services personnel to follow an emergency medical services "do not resuscitate order" for any patient who, prior to cardiac or respiratory arrest, is able to, and does, express to those personnel the desire to be resuscitated.

(c) This section does not authorize emergency medical services personnel in the outpatient setting to follow an emergency medical services "do not resuscitate order" that is in any form other than:

(1) An emergency medical services "do not resuscitate order" described in subsection (a) of this section;

(2) An oral emergency medical services "do not resuscitate order" provided by an online, emergency medical services medical command and control physician;

(3) An oral emergency medical services "do not resuscitate order" provided by a physician, a physician assistant, or a nurse practitioner who is physically present on the scene with the patient and the emergency medical services personnel in the outpatient setting; or

(4) An order contained in a "Medical Orders for Life-Sustaining Treatment" form.

(d) (1) Except as provided in paragraph (2) of this subsection, in addition to the immunity provided in § 5-609 of this subtitle and any other immunity provided by law, an emergency medical services provider is not subject to criminal or civil liability, or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing or certifying authority, arising out of a claim concerning the provision of health care if:

(i) The claim is based on lack of consent or authorization for the health care;

(ii) Subsection (a) of this section would ordinarily apply; and

(iii) The emergency medical services provider:

1. Acts in good faith in providing the health care; and
2. Believes reasonably that subsection (a)(1) of this section does not apply.

(2) This subsection does not apply if the patient is wearing a valid, legible, and patient-identifying emergency medical services “do not resuscitate order” in bracelet form.

#### **5-608.1.**

(a) In this section, “health care facility” means:

- (1) An assisted living program;
- (2) A home health agency;
- (3) A hospice;
- (4) A hospital;
- (5) A kidney dialysis center; or
- (6) A nursing home.

(b) (1) (i) The Department, in conjunction with the Maryland Institute for Emergency Medical Services Systems and the State Board of Physicians, shall develop and revise periodically a “Medical Orders for Life-Sustaining Treatment” form and instructions for completing and using the form.

(ii) The “Medical Orders for Life-Sustaining Treatment” form and the instructions for its completion and use shall be developed in consultation with:

1. The Office of the Attorney General;
2. The State Board of Nursing;
3. The State Advisory Council on Quality Care at the End of Life; and
4. Any other individual or group the Department determines is appropriate.

(2) The “Medical Orders for Life–Sustaining Treatment” form developed under paragraph (1) of this subsection shall be suitable for containing a physician’s, physician assistant’s, or nurse practitioner’s written medical orders relating to a patient’s medical condition, including:

(i) The use of life–sustaining procedures;

(ii) The use of medical tests;

(iii) Transfer of the patient to a hospital from a nonhospital setting; and

(iv) Any other matter considered appropriate by the Department to implement treatment preferences and orders regarding life–sustaining treatments across health care settings.

(3) The “Medical Orders for Life–Sustaining Treatment” form is not an advance directive.

(c) (1) A health care facility shall:

(i) 1. Accept a completed “Medical Orders for Life–Sustaining Treatment” form during the admission process for each patient being admitted to the health care facility; and

2. Update the form as indicated in the instructions for the completion and use of the form; or

(ii) Complete a “Medical Orders for Life–Sustaining Treatment” form:

1. For a health care facility that is not a hospital, during the admission process for each patient being admitted to the health care facility; or

2. For a hospital, during an inpatient hospital stay for patients who are being discharged to another health care facility.

(2) When a health care facility updates or completes a “Medical Orders for Life–Sustaining Treatment” form under paragraph (1) of this subsection, the health care facility shall:

(i) Offer the patient, health care agent, or surrogate decision maker the opportunity to participate in updating or completing the form;

(ii) Note in the medical record when a patient, health care agent, or surrogate decision maker declines to participate in updating or completing the form, indicating the date and with whom the form was discussed;

(iii) On request of the patient, offer any physician, physician assistant, or nurse practitioner selected by the patient the opportunity to participate in updating or completing the form; and

(iv) Inform the patient, health care agent, or surrogate decision maker that the form will become a part of the patient's medical record and can be accessed through the procedures used to access a medical record.

(3) Except as provided for a treatment that has been certified as medically ineffective in accordance with § 5-611 of this subtitle, the "Medical Orders for Life-Sustaining Treatment" form shall be consistent with:

(i) The known decisions of:

1. The patient if the patient is a competent individual; or

2. A health care agent or surrogate decision maker as authorized by this subtitle; and

(ii) Any known advance directive of the patient if the patient is incapable of making an informed decision.

(d) (1) A health care provider other than a health care facility may choose to use a "Medical Orders for Life-Sustaining Treatment" form.

(2) A health care provider who chooses to use a "Medical Orders for Life-Sustaining Treatment" form shall offer a patient, health care agent, or surrogate decision maker the opportunity to participate in the completion of the form.

(e) The original or a copy of a "Medical Orders for Life-Sustaining Treatment" form shall:

(1) Be kept by a health care provider in the patient's medical record;

(2) Physically accompany the patient or be transmitted electronically or by facsimile in accordance with the instructions for the use of the form when the patient is transferred to a health care facility; and

(3) Be given to the patient, health care agent, or surrogate decision maker within 48 hours of completion of the form or sooner if the patient is transferred or discharged.

(f) Except as provided in § 5–611 or § 5–613 of this subtitle, a health care facility shall comply with all medical orders contained in a “Medical Orders for Life–Sustaining Treatment” form regardless of whether the physician, physician assistant, or nurse practitioner who signed the form has admitting privileges or is otherwise credentialed at the health care facility.

(g) In the event of a conflict between more than one “Medical Orders for Life–Sustaining Treatment” form, the most recent form shall be followed.

(h) A health care provider may rely in good faith on the presumed validity of a “Medical Orders for Life–Sustaining Treatment” form.

(i) (1) The Department shall adopt regulations that specify the “Medical Orders for Life–Sustaining Treatment” form and the instructions for the completion and use of the form that are developed as required by subsection (b) of this section, including instructions on how a “Medical Orders for Life–Sustaining Treatment” form is revised or revoked.

(2) Regulations adopted under paragraph (1) of this subsection shall be consistent with the Health Care Decisions Act.

(j) The Department shall make the “Medical Orders for Life–Sustaining Treatment” form and the instructions for the completion and use of the form, including instructions on how the form is revised or revoked, available on its Web site and may print and distribute the form, the instructions, and training materials.

#### **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 who authorizes 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 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.

(2) The distribution to patients of written advance directives in a form provided in this subtitle and assistance to patients in the completion and execution of such forms does not constitute the unauthorized practice of law.

(d) An advance directive made in accordance with this subtitle shall be presumed to have been made voluntarily by a competent individual. Authorization for the provision, withholding, or withdrawal of life-sustaining procedures in accordance with this subtitle shall be presumed to have been made in good faith.

#### **5-610.**

(a) Any person who willfully conceals, cancels, defaces, obliterates, or damages the advance directive of another without the declarant's or patient's consent or who falsifies or forges a revocation of the advance directive of another, thereby causing life-sustaining procedures to be utilized in contravention of the previously expressed intent of the patient, shall be guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$10,000 or imprisonment not exceeding 1 year or both.

(b) Any person who falsifies or forges the advance directive of another, or falsifies or forges an affidavit under § 5-605 of this subtitle, or willfully conceals or withholds personal knowledge of the revocation of an advance directive with the intent to cause a withholding or withdrawal of life-sustaining procedures, contrary to the wishes of the declarant and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$10,000 or imprisonment not exceeding 1 year or both.

(c) The penalties provided in this section shall be in addition to any other penalties provided by law.

#### **5-611.**

(a) Except as provided in § 5–613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician or physician assistant to prescribe or render medical treatment to a patient that the physician or physician assistant determines to be ethically inappropriate.

(b) (1) Except as provided in § 5–613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician or physician assistant to prescribe or render medically ineffective treatment.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, a patient's attending physician may withhold or withdraw as medically ineffective a treatment that under generally accepted medical practices is life-sustaining in nature only if the patient's attending physician and a second physician certify in writing that the treatment is medically ineffective and the attending physician informs the patient or the patient's agent or surrogate of the physician's decision.

(ii) If the patient is being treated in the emergency department of a hospital and only one physician is available, the certification of a second physician is not required.

(c) Nothing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(d) A health care provider shall make reasonable efforts to provide an individual with food and water by mouth and to assist the individual as needed to eat and drink voluntarily.

(e) (1) Nothing in this subtitle is intended to preclude a separate decision by a health care agent or surrogate regarding the provision of or the withholding or withdrawal of nutrients and fluids administered by artificial means.

(2) Nothing in this subtitle authorizes any action with respect to medical treatment, if the health care provider is aware that the patient for whom the health care is provided has expressed disagreement with the action.

## **5–612.**

(a) (1) A health care provider for an individual incapable of making an informed decision who believes that an instruction to withhold or withdraw a life-sustaining procedure from the patient is inconsistent with generally accepted standards of patient care shall:

(i) Petition a patient care advisory committee for advice concerning the withholding or withdrawal of the life-sustaining procedure from the patient if the patient is in a hospital or related institution; or

(ii) File a petition in a court of competent jurisdiction seeking injunctive or other relief relating to the withholding or withdrawal of the life-sustaining procedure from the patient.

(2) In reviewing a petition filed under paragraph (1) of this subsection, the court shall follow the standards set forth in §§ 13-711 through 13-713 of the Estates and Trusts Article.

(b) On petition of the patient's spouse, domestic partner, a parent, adult child, grandchild, brother, or sister of the patient, or a friend or other relative who has qualified as a surrogate under § 5-605 of this subtitle to a circuit court of the county or city in which the patient for whom treatment will be or is currently being provided, withheld, or withdrawn under this subtitle resides or is located, the court may enjoin that action upon finding by a preponderance of the evidence that the action is not lawfully authorized by this subtitle or by other State or federal law.

(c) Except for cases that the court considers of greater importance, a proceeding under this section, including an appeal, shall:

(1) Take precedence on the docket;

(2) Be heard at the earliest practicable date; and

(3) Be expedited in every way.

### **5-613.**

(a) A health care provider that intends not to comply with an instruction of a health care agent or a surrogate shall:

(1) Inform the person giving the instruction that:

(i) The health care provider declines to carry out the instruction;

(ii) The person may request a transfer to another health care provider; and

(iii) The health care provider will make every reasonable effort to transfer the patient to another health care provider;

- (2) Assist in the transfer; and
  - (3) Pending the transfer, comply with an instruction of a competent individual, or of a health care agent or surrogate for an individual who is incapable of making an informed decision, if a failure to comply with the instruction would likely result in the death of the individual.
- (b) Nothing in this section authorizes a health care provider to provide health care to:
- (1) A competent individual over the objection of that individual; or
  - (2) An individual incapable of making an informed decision over the objection of another person authorized by law to consent to the provision of health care for the individual.

**5-614.**

- (a) The withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this subtitle shall not, for any purpose, constitute a suicide.
- (b) (1) The making of an advance directive under this subtitle does not affect the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance.
- (2) A policy of life insurance shall not be legally impaired or invalidated by the withholding or withdrawal of life-sustaining procedures from an insured patient in accordance with this subtitle, notwithstanding any term of the policy to the contrary.
- (c) A person may not be required to make an advance directive as a condition for being insured for, or receiving, health care services.
- (d) Any declaration of a patient or any designation of an agent made prior to October 1, 1993 shall be given full force and effect as provided in this subtitle.

**5-615.**

- (a) In this section, "health care facility" has the meaning stated in § 19-114 of this article.
- (b) Each health care facility shall provide each individual on admittance to the facility information concerning the rights of the individual to make decisions concerning health care,

including the right to accept or refuse treatment, and the right to make an advance directive, including a living will.

(c) (1) The Department, in consultation with the Office of the Attorney General, shall develop an information sheet that provides information relating to advance directives, which shall include:

(i) Written statements informing an individual that an advance directive:

1. Is a useful, legal, and well established way for an individual to direct medical care;
2. Allows an individual to specify the medical care that the individual will receive and can alleviate conflict among family members and health care providers;
3. Can ensure that an individual's religious beliefs are considered when directing medical care;
4. Is most effective if completed in consultation with family members, or legal and religious advisors, if an individual desires;
5. Can be revoked or changed at any time;
6. Is available in many forms, including model forms developed by religious organizations, estate planners, and lawyers;
7. Does not have to be on any specific form and can be personalized; and
8. If completed, should be copied for an individual's family members, physicians, and legal advisors; and

(ii) The following written statements:

1. That an individual should discuss the appointment of a health care agent with the potential appointee;
2. That advance directives are for individuals of all ages;
3. That in the absence of an appointed health care agent, the next of kin make an individual's health care decisions when the individual is incapable of making those decisions; and
4. That an individual is not required to complete an advance directive.

(2) The information sheet developed by the Department under this subsection shall be provided by:

(i) The Department, in accordance with § 15-109.1 of this article;

(ii) The Motor Vehicle Administration, in accordance with § 12-303.1 of the Transportation Article; and

(iii) A carrier, in accordance with § 15-122.1 of the Insurance Article.

(3) The information sheet developed by the Department under this subsection may not contain or promote a specific advance directive form.

#### **5-616.**

(a) The provisions of this subtitle are cumulative with existing law regarding an individual's right to consent or refuse to consent to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the provision, withholding, or withdrawal of life-sustaining procedures under the common law or statutes of the State.

(b) A valid living will or durable power of attorney for health care made prior to October 1, 1993 shall be given effect as provided in this article, even if not executed in accordance with the terms of this article.

#### **5-617.**

An advance directive, an emergency medical services "do not resuscitate order", or an order regarding life-sustaining treatment executed in another state shall be deemed to be validly executed for the purposes of this subtitle if executed in compliance with the laws of Maryland or the laws of the state where executed. Advance directives, emergency medical services "do not resuscitate orders", or an order regarding life-sustaining treatment executed in another state shall be construed to give effect to the patient's wishes to the extent permitted by the laws of Maryland.

#### **5-618.**

The provisions of this Part I of this subtitle shall be known and may be cited as the "Health Care Decisions Act".

## **Part II. Advance Directive Registry.**

### **5-619.**

- (a) In this Part II of this subtitle the following words have the meanings indicated.
- (b) “Advance directive” has the meaning stated in § 5-601 of this subtitle.
- (c) “Registrant” means an individual who registers an advance directive with the Department.
- (d) “Registry” means the repository for advance directives in the Department.

### **5-620.**

There is an Advance Directive Registry in the Department.

### **5-621.**

The Secretary may adopt regulations to ensure the efficient operation of the Registry.

### **5-622.**

- (a) (1) The Secretary shall, by regulation, set a fee for any service of the Registry, including an initial fee to utilize the services of the Registry and renewal fees.
- (2) The fees set by the Secretary may not, in the aggregate, exceed the Department’s costs to establish and operate the Registry.
- (b) (1) The Department may, by contract, obtain from any person services related to the establishment and operation of the Registry.
- (2) Notwithstanding any contract in accordance with paragraph (1) of this subsection, the Department is responsible for the Registry.
- (c) The Department shall carry out appropriate educational and outreach efforts to increase public awareness of the Registry.

### **5-623.**

- (a) An individual may register with the Department an advance directive.
- (b) (1) The registrant shall notify the Registry if the registrant has amended or revoked a registered advance directive.  
  
(2) A health care provider that becomes aware that a registrant has amended or revoked a registered advance directive shall, at the request of the registrant, provide the registrant with information on how to notify the Registry.
- (c) An individual is not required to submit an advance directive to the Registry.
- (d) Nothing in this Part II of this subtitle affects the validity of an advance directive that is not submitted to the Registry.

**5-624.**

- (a) The Registry shall consist of a secure, electronic database to which authorized access is available 24 hours per day, 7 days per week.
- (b) The Secretary shall specify in regulations the persons who are authorized to access the Registry, including:
  - (1) The registrant or the registrant's designee; and
  - (2) Representatives of a health care facility in which a registrant is receiving health care.
- (c) The Secretary shall adopt regulations regarding access to the Registry, including procedures to protect confidential information.
- (d) The Department may perform evaluations of the Registry.

**5-625.**

Before accepting an advance directive into the Registry, the Department shall review and verify that the advance directive includes:

- (1) The signature of the declarant;
- (2) The date on which the advance directive was signed by the declarant; and
- (3) The signature of two witnesses as provided in § 5-602(c) of this subtitle.

**5-626.**

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 for:

- (1) Failure to access the Registry; or
- (2) Relying on information provided by the Registry.

**Subtitle 7. Child Fatality Review Team.**

**5-701.**

- (a) In this subtitle the following words have the meanings indicated.
- (b) “Child” means an individual under the age of 18 years.
- (c) “Child death review case reporting system” means a national, standardized, web-based reporting system for the confidential collection, analysis, aggregation, and reporting of child death data that is maintained and operated by a national center for child death review.
- (d) “Data use agreement” means a contract between the Department and a national center for child death review that establishes the terms and conditions for the State and local child fatality review teams’ participation in a child death review case reporting system.
- (e) “Health care provider” means:
  - (1) An individual licensed or certified under the Health Occupations Article to provide health care; or
  - (2) A facility that provides health care to individuals.
- (f) “Local team” means the multidisciplinary and multiagency child fatality review team established for a county.
- (g) “Meeting” includes meetings through telephone conferencing.

(h) “National center for child death review” means a public, private, nonprofit, or governmental organization or entity that is funded or otherwise recognized by the United States Department of Health and Human Services and is responsible for:

- (1) Developing a child death review case reporting system;
- (2) Training and serving as a liaison to State agencies participating in the system; and
- (3) Disseminating national child death review data generated by the system.

(i) “State Team” means the State Child Fatality Review Team.

(j) “Unexpected child death” means a death of a child investigated by the office of the Chief Medical Examiner as required by § 5–309 of this title.

**5–702.**

- (a) There is a State Child Fatality Review Team.
- (b) The State Team is part of the Department for budgetary and administrative purposes.

**5–703.**

(a) The State Team shall be a multidisciplinary and multiagency review team, composed of at least 25 members, including:

- (1) The Attorney General;
- (2) The Chief Medical Examiner;
- (3) The Secretary of Human Resources;
- (4) The Secretary of Health and Mental Hygiene;
- (5) The State Superintendent of Schools;
- (6) The Secretary of Juvenile Services;
- (7) The Special Secretary for Children, Youth, and Families;

- (8) The Secretary of State Police;
  - (9) The president of the State's Attorneys' Association;
  - (10) The chief of the Division of Vital Records of the Department;
  - (11) A representative of the State SIDS Information and Counseling Program;
  - (12) The Director of the Behavioral Health Administration of the Department;
  - (13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the State Chapter of the American Academy of Pediatrics; and
  - (14) Eleven members of the general public with interest or expertise in child safety and welfare, appointed by the Governor, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children.
- (b) The members described under subsection (a)(1) through (12) of this section may designate representatives from their departments or offices to represent them on the State Team.
- (c) The State Team may employ a staff in accordance with the State budget. Each member of the Team under subsection (a)(1) through (12) of this section shall provide sufficient staff support to complete the State Team's responsibilities.
- (d) Members of the State Team shall serve without compensation, but may be reimbursed for reasonable expenses incurred in the performance of their duties in accordance with the Standard State Travel Regulations and as provided in the State budget.
- (e) The State Team shall select a chairperson from among its members.
- (f) The State Team shall meet not less than once every 3 months.

**5-704.**

- (a) The purpose of the State Team is to prevent child deaths by:
- (1) Developing an understanding of the causes and incidence of child deaths;

(2) Developing plans for and implementing changes within the agencies represented on the State Team to prevent child deaths; and

(3) Advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths.

(b) To achieve its purpose, the State Team shall:

(1) Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths;

(2) Review reports from local teams;

(3) Provide training and written materials to the local teams established under § 5–705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams;

(4) In cooperation with local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions;

(5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol;

(6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State or local laws in the annual report required by paragraph (12) of this subsection;

(7) Consider local and statewide training needs, including cross–agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs;

(8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children

from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection;

(9) Examine the policies and procedures of State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:

(i) The State plan under 42 U.S.C. § 5106a(b);

(ii) The child protection standards set forth in 42 U.S.C. § 5106a(b); and

(iii) Any other criteria that the State Team considers important to ensure the protection of children;

(10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths;

(11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams;

(12) Provide the Governor, the public, and subject to § 2–1246 of the State Government Article, the General Assembly, with annual written reports, which shall include the State Team’s findings and recommendations; and

(13) In consultation with local teams:

(i) Define “near fatality”; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

(c) The State Team shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort.

(d) (1) Except as provided in paragraph (2) of this subsection, members and staff of the State Team:

(i) May not disclose to any person or government official any identifying information about any specific child protection case about which the State Team is provided information; and

(ii) May make public other information unless prohibited by law.

(2) (i) In carrying out the responsibilities under this section and subject to subparagraph (ii) of this paragraph, the members and staff of the State Team may provide identifying information to a national center for child death review in accordance with a data use agreement that:

1. Authorizes access to identifiable information only to the members and staff of the State Team;

2. Authorizes the national center for child death review to access only de-identified information; and

3. Requires the national center for child death review to act as a fiduciary agent of the State and local teams.

(ii) Information provided to a national center for child death review in accordance with this subsection is confidential and subject to the same confidentiality and discovery protections that apply to the State and local teams as set forth in § 5-709 of this subtitle.

(e) In addition to any other penalties provided by law, the Secretary may impose on any person who violates subsection (d) of this section a civil penalty not exceeding \$500 for each violation.

#### **5-705.**

(a) (1) Except as provided in paragraph (2) of this subsection, there shall be a multidisciplinary and multiagency child fatality review team in each county.

(2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.

(3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(b) The local team membership shall be drawn from the following individuals, organizations, agencies, and areas of expertise, when available:

(1) The county health officer;

- (2) The director of the local department of social services;
  - (3) The State's Attorney;
  - (4) The superintendent of schools;
  - (5) A State, county, or municipal law enforcement officer;
  - (6) The director of the county substance abuse treatment program;
  - (7) The chief attorney who represents the local department of social services in child welfare proceedings;
  - (8) The Early Childhood Development Division in the State Department of Education;
  - (9) The director of the county mental health agency or core service agency;
  - (10) A pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the county health officer;
  - (11) A psychiatrist or psychologist with experience in child abuse and neglect or child injury, appointed by the director of the county mental health agency, core service agency, or local behavioral health authority;
  - (12) A member of the general public with interest or expertise in the prevention and treatment of child abuse and neglect, appointed by the county health officer; and
  - (13) Any other individual necessary to the work of the local team, recommended by the local team and appointed by the county health officer.
- (c) The members described under subsection (b)(1) through (9) of this section may designate representatives from their departments or offices to represent them on the local team.
- (d) From among its members, each local team shall elect a chairperson by majority vote.

**5-706.**

- (a) The purpose of the local team is to prevent child deaths by:

- (1) Promoting cooperation and coordination among agencies involved in investigations of child deaths or in providing services to surviving family members;
  - (2) Developing an understanding of the causes and incidence of child deaths in the county;
  - (3) Developing plans for and recommending changes within the agencies the members represent to prevent child deaths; and
  - (4) Advising the State Team on changes to law, policy, or practice to prevent child deaths.
- (b) To achieve its purpose, the local team shall:
- (1) In consultation with the State Team, establish and implement a protocol for the local team;
  - (2) Set as its goal the investigation of child deaths in accordance with national standards;
  - (3) Meet at least quarterly to review the status of child fatality cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent child deaths;
  - (4) Collect and maintain data as required by the State Team;
  - (5) Provide requested reports to the State Team, including discussion of individual cases, steps taken to improve coordination of services and investigations, steps taken to implement changes recommended by the local team within member agencies, and recommendations on needed changes to State and local law, policy, and practice to prevent child deaths; and
  - (6) In consultation with the State Team:
    - (i) Define “near fatality”; and
    - (ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.
- (c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5–707 of this subtitle.

**5–707.**

Upon request of the chair of the local team and as necessary to carry out the local team's purpose and duties, the local team shall be immediately provided:

(1) Access to information and records, including information on prenatal care, maintained by a health care provider regarding:

(i) A child whose death is being reviewed by the local team; or

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; and

(2) Access to all information and records maintained by any State or local government agency, including birth certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to:

(i) A child whose death is being reviewed by the local team;

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; or

(iii) The family of a child described in item (i) or (ii) of this paragraph.

#### **5-708.**

(a) Meetings of the State Team and of local teams shall be closed to the public and not subject to Title 3 of the General Provisions Article when the State Team or local teams are discussing individual cases of child deaths.

(b) Except as provided in subsection (c) of this section, meetings of the State Team and of local teams shall be open to the public and subject to Title 3 of the General Provisions Article when the State Team or local team is not discussing individual cases of child deaths.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased child;

(ii) A family member, guardian, or caretaker of a deceased child;

- (iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or
  - (iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.
- (2) During a public meeting, information may not be disclosed regarding the involvement of any agency with:
- (i) A deceased child;
  - (ii) A family member, guardian, or caretaker of a deceased child;
  - (iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or
  - (iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.
- (d) This section does not prohibit the State Team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.
- (e) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

**5-709.**

- (a) All information and records acquired by the State Team or by a local team, in the exercise of its purpose and duties under this subtitle, are confidential, exempt from disclosure under Title 4 of the General Provisions Article, and may only be disclosed as necessary to carry out the team's duties and purposes.
- (b) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.
- (c) Reports of the State Team and of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.
- (d) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting that is not public

under § 5-708 of this subtitle or any information the disclosure of which is prohibited by this section.

(e) Members of a team, persons attending a team meeting, and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting. This subsection does not prohibit a person from testifying to information obtained independently of the team or that is public information.

(f) (1) Except as provided in paragraph (2) of this subsection, information, documents, and records of the State Team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the team or are maintained by a team.

(g) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

### **Subtitle 8. Mortality and Quality Review Committee.**

**5-801.** [Amendment subject to abrogation]

(a) In this subtitle the following words have the meanings indicated.

(b) “Aggregate incident data” means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at health care facilities.

(c) “Committee” means the Mortality and Quality Review Committee.

EFFECTIVE DECEMBER 31, 2022 PER CHAPTERS 340 AND 341 OF 2012

In this subtitle, “Committee” means the Mortality Review Committee.

**5-802.** [Amendment subject to abrogation]

(a) There is a Mortality and Quality Review Committee established within the Department.

(b) The purpose of the Committee is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

EFFECTIVE DECEMBER 31, 2022 PER CHAPTERS 340 AND 341 OF 2012

- (a) There is a Mortality Review Committee established within the Department.
- (b) The purpose of the Committee is to prevent avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

**5-803.** [Amendment subject to abrogation]

The Committee shall:

- (1) Evaluate causes or factors contributing to deaths in facilities or programs:
  - (i) Operated or licensed by the Developmental Disabilities Administration;
  - (ii) Licensed by the Behavioral Health Administration to provide mental health services and identified in § 10-713(a) of this article; or
  - (iii) Operating by waiver under § 7-903(b) of this article;
- (2) Review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article;
- (3) Identify patterns and systemic problems and ensure consistency in the review process; and
- (4) Make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths and improve quality of care.

EFFECTIVE DECEMBER 31, 2022 PER CHAPTERS 340 AND 341 OF 2012

The Committee shall:

- (1) Evaluate causes or factors contributing to deaths in facilities or programs:
  - (i) Operated or licensed by the Developmental Disabilities Administration;
  - (ii) Licensed by the Behavioral Health Administration to provide mental health services and identified in § 10-713(a) of this article; or
  - (iii) Operating by waiver under § 7-903(b) of this article;

- (2) Identify patterns and systemic problems and ensure consistency in the review process; and
- (3) Make recommendations to the Secretary to prevent avoidable deaths and improve quality of care.

**5-804.**

- (a) The Committee shall consist of 18 members appointed by the Secretary, including the following:
  - (1) A licensed physician who is board certified in an appropriate specialty;
  - (2) A psychopharmacologist;
  - (3) A licensed physician on staff with the Department;
  - (4) Two specialists, one in the field of developmental disabilities and one in the field of mental health;
  - (5) Two licensed providers of community services, one for persons with developmental disabilities and one for persons with mental illnesses;
  - (6) Two consumers, one with a developmental disability and one with a mental illness;
  - (7) Two family members, one representing a consumer with a developmental disability and one representing a consumer with a mental illness;
  - (8) The Deputy Secretary for Behavioral Health or the Deputy Secretary's designee;
  - (9) The Director of the Office of Health Care Quality;
  - (10) A licensed physician representative from the Medical Examiner's Office;
  - (11) A licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community;
  - (12) A member of an advocacy group for persons with disabilities; and

(13) Two members of advocacy groups, one for persons with developmental disabilities and one for persons with mental illnesses.

(b) (1) The term of each member appointed under subsection (a)(1), (2), (4), (5), (6), and (10) of this section is 3 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed.

(3) A member may not be appointed for more than two consecutive full terms.

(4) The terms of the members are as follows:

(i) One-third of the members shall be appointed for terms of 3 years commencing October 1, 2000;

(ii) One-third of the members shall be appointed for terms of 2 years commencing October 1, 2000; and

(iii) One-third of the members shall be appointed for terms of 1 year commencing October 1, 2000.

(5) At the end of a term, a member continues to serve until a successor is appointed.

(c) The Secretary may remove any member of the Committee for good cause.

(d) A member of the Committee:

(1) May not receive compensation for service on the Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) The Committee shall be staffed by the Department.

(f) (1) An employee of the Developmental Disabilities Administration or the Behavioral Health Administration may not be a member of the Committee or any subcommittee of the Committee.

(2) The Director of the Office of Health Care Quality may not serve on a subcommittee of the Committee or vote on the disposition of an individual mortality review that was previously reviewed by the Office of Health Care Quality.

(g) The Secretary shall select a chairperson from among the members of the Committee.

(h) A quorum of the Committee shall be a majority of the appointed membership of the Committee.

(i) The Committee shall meet not less than three times a year.

### **5-805.**

(a) (1) Except as provided in paragraph (3) of this subsection, the Office of Health Care Quality shall review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article, or any program approved, licensed, or operated by the Department under § 10-406 of this article or any program identified in § 10-713(a) of this article.

(2) The Office of Health Care Quality may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.

(3) Unless a member of the Committee requests a review, the Office of Health Care Quality may choose not to review a death if the circumstances, based on reasonable judgment, are readily explained and require no further investigation.

(b) Within 14 days of the completion of each investigation, the Office of Health Care Quality shall submit to the Committee its final report for each death.

(c) The Committee shall:

(1) Review each death report provided by the Office of Health Care Quality; or

(2) Appoint a subcommittee of at least four members, one of whom shall be a licensed physician or nurse, to review death reports and report and make recommendations to the full Committee.

(d) (1) On review of the death report, if the Committee or its subcommittee determines that further investigation is warranted, the Committee or subcommittee may request additional information, including consumer records, medical records, autopsy reports, and any deficiency statements and plans of correction.

(2) The Committee or subcommittee may choose to prepare questions for the provider, State residential center director, or other relevant person or may request the attendance of the provider, director, or other relevant person at a Committee or subcommittee meeting.

(3) Except as provided in paragraph (2) of this subsection, Committee members may not communicate directly with the provider, a State residential center director, a State psychiatric superintendent, or a family member or guardian of the individual who is the subject of a death report.

#### **5-806.**

Upon request of the chairman of the Committee or subcommittee, and as necessary to carry out the purpose of the Committee, the following shall immediately provide the Committee or subcommittee with access to information and records regarding an individual whose death is being reviewed:

(1) A provider of medical care, including dental and mental health care;

(2) A State or local government agency; and

(3) A provider of residential or other services.

#### **5-806.1.** [Section subject to abrogation]

EFFECTIVE UNTIL DECEMBER 31, 2022 PER CHAPTERS 340 AND 341 OF 2012

(a) (1) The Office of Health Care Quality shall provide aggregate incident data to the Committee once every 3 months.

(2) When providing aggregate incident data to the Committee, to the extent practicable, the Office of Health Care Quality shall identify trends and patterns that may threaten the health, safety, or well-being of an individual.

(b) The Committee shall review the aggregate incident data and make findings and recommendations to the Department on system quality assurance needs.

(c) The Committee may consult with experts as needed to carry out the provisions of this section.

**5-807.**

A person shall have the immunity from liability under § 5-637 of the Courts Article for any action as a member of the Committee or for giving information to, participating in, or contributing to the function of the Committee or subcommittee.

**5-808.** [Amendment subject to abrogation]

(a) (1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(5) The Developmental Disabilities Administration shall provide the report to the facilities or programs that are operated or licensed by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article.

(b) (1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the Developmental Disabilities Administration, the Director of the Behavioral Health Administration, or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under § 1-401 of the Health Occupations Article.

EFFECTIVE DECEMBER 31, 2022 PER CHAPTERS 340 AND 341 OF 2012

(a) (1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(b) (1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under § 1-401 of the Health Occupations Article.

#### **5-809.**

(a) The Committee shall maintain records of its deliberations including any recommendations.

(b) (1) Except for the public report issued under § 5-808(a) of this subtitle, any records of deliberations, findings, or files of the Committee shall be confidential and are not discoverable under § 1-401 of the Health Occupations Article.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

(c) (1) Members of the Committee or a subcommittee of the Committee, persons attending a Committee or subcommittee meeting, and persons who present information to the Committee or subcommittee may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information obtained independently of the Committee or subcommittee or that is public information.

(d) (1) Except as necessary to carry out the Committee's purpose and duties, members of the Committee or subcommittee and persons attending a Committee or subcommittee meeting may not disclose:

- (i) What transpired at a meeting that is not public under this subtitle; or
- (ii) Any information that is prohibited for disclosure by this section.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

#### **5-810.**

Meetings of the Committee and subcommittees shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article.

### **Subtitle 9. Drug Overdose Fatality Review Teams.**

#### **5-901.**

In this subtitle, “local team” means the multidisciplinary and multiagency drug overdose fatality review team established for a county.

#### **5-902.**

- (a) (1) Subject to paragraph (2) of this subsection, there may be a multidisciplinary and multiagency drug overdose fatality review team in each county.
- (2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.
- (3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.
- (b) The local team membership shall be drawn, if available, from the following individuals, organizations, agencies, and areas of expertise:
  - (1) The county health officer, or the officer’s designee;
  - (2) The director of the local department of social services, or the director’s designee;
  - (3) The State’s Attorney, or the State’s Attorney’s designee;

- (4) The superintendent of schools, or the superintendent's designee;
  - (5) A State, county, or municipal law enforcement officer;
  - (6) The director of behavioral health services in the county, or the director's designee;
  - (7) An emergency medical services provider in the county;
  - (8) A representative of a hospital;
  - (9) A health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders;
  - (10) A representative of a local jail or detention center;
  - (11) A representative from parole, probation, and community corrections;
  - (12) The Secretary of Juvenile Services, or the Secretary's designee;
  - (13) A member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer; and
  - (14) Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.
- (c) Each local team shall elect a chair from among its members.

**5-903.**

- (a) The purpose of each local team is to prevent drug overdose deaths by:
- (1) Promoting cooperation and coordination among agencies involved in investigations of drug overdose deaths or in providing services to surviving family members;
  - (2) Developing an understanding of the causes and incidence of drug overdose deaths in the county;
  - (3) Developing plans for and recommending changes within the agencies represented on the local team to prevent drug overdose deaths; and

(4) Advising the Department on changes to law, policy, or practice, including the use of devices that are programmed to dispense medications on a schedule or similar technology, to prevent drug overdose deaths.

(b) To achieve its purpose, each local team shall:

(1) In consultation with the Department, establish and implement a protocol for the local team;

(2) Set as its goal the investigation of drug overdose deaths in accordance with national standards;

(3) Meet at least quarterly to review the status of drug overdose death cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent drug overdose deaths;

(4) Collect and maintain data as required by the Department; and

(5) Provide requested reports to the Department, including:

(i) Discussion of individual cases;

(ii) Steps taken to improve coordination of services and investigations;

(iii) Steps taken to implement changes recommended by the local team within member agencies; and

(iv) Recommendations on needed changes to State and local laws, policies, or practices to prevent drug overdose deaths.

(c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of an individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5-904 of this subtitle.

#### **5-904.**

(a) On request of the chair of a local team and as necessary to carry out the purpose and duties of the local team, the local team shall be immediately provided with:

(1) Access to information and records, including information about physical health, mental health, and treatment for substance abuse, maintained by a health care provider for:

(i) An individual whose death is being reviewed by the local team; or

(ii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; and

(2) Access to information and records maintained by a State or local government agency, including death certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency, if the agency provided services to:

(i) An individual whose death is being reviewed by the local team;

(ii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; or

(iii) The family of an individual described in item (i) or (ii) of this item.

(b) Substance abuse treatment records requested or provided under this section are subject to any additional limitations on disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290DD-2 and 42 C.F.R. Part 2.

#### **5-905.**

(a) Meetings of local teams shall be closed to the public and are not subject to Title 3 of the General Provisions Article when the local teams are discussing individual cases of drug overdose deaths.

(b) Except as provided in subsection (c) of this section, meetings of local teams shall be open to the public and are subject to Title 3 of the General Provisions Article when the local team is not discussing individual cases of drug overdose deaths.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased individual;

(ii) A family member, guardian, or caretaker of a deceased individual; or

(iii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(2) During a public meeting, information may not be disclosed about the involvement of any agency with:

(i) A deceased individual;

(ii) A family member, guardian, or caretaker of a deceased individual; or

(iii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(d) This section does not prohibit a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

#### **5-906.**

(a) Subject to subsection (b) of this section, all information and records acquired by a local team in the exercise of its purpose and duties under this subtitle are confidential, exempt from disclosure under Title 4 of the General Provisions Article, and may be disclosed only as necessary to carry out the team's purpose and duties.

(b) (1) Mental health records are subject to the additional limitations under § 4-307 of this article for disclosure of a medical record developed primarily in connection with the provision of mental health services.

(2) Substance abuse treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290DD-2 and 42 C.F.R. Part 2.

(c) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.

(d) Reports of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.

(e) Except as necessary to carry out a local team's purpose and duties, members of a local team and persons attending a local team meeting may not disclose:

(1) What transpired at a meeting that is not public under § 5-905 of this subtitle; or

(2) Any information the disclosure of which is prohibited by this section.

(f) (1) Members of a local team, persons attending a local team meeting, and persons who present information to a local team may not be questioned in any civil or criminal proceeding about information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information that is obtained independently of a local team or that is public information.

(g) (1) Except as provided in paragraph (2) of this subsection, information, documents, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, or records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of a local team or are maintained by a local team.

(h) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.