Uniform Health-Care Decisions Act (2023)

drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

WITH COMMENTS

This act supersedes the Uniform Health-Care Decisions Act, promulgated in 1993.

January 8, 2024

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Uniform Health-Care Decisions Act (2023)

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Prefatory Note

This Act enables individuals to appoint agents to make health care decisions for them should they be unable to make those decisions for themselves, to provide their health-care professionals and agents with instructions about their values and priorities regarding their health care, and to indicate particular medical treatment they do or do not wish to receive. It also authorizes certain people to make health-care decisions for individuals incapable of making their own decisions but who have not appointed agents, thus avoiding the need to appoint a guardian or otherwise involve a court in most situations. In addition, it sets forth the related duties and powers of agents and health-care professionals, and provides immunity to both under specified circumstances.

The Act modernizes and expands on the Uniform Health-Care Decisions Act approved by the Uniform Law Commission ("ULC") in 1993 ("1993 Act"). The key goals of the 1993 Act, as articulated in its prefatory note, included: (1) acknowledging the right of a competent individual to make decisions about the provision, withdrawal or withholding of health care; (2) providing a single statute to govern the appointment of a health-care agent and the recording of an individual's wishes regarding the individual's own health care; (3) simplifying and facilitating the making of an advance health-care directive; (4) ensuring that decisions about an individual's health care will be governed, to the extent possible, by the individual's own desires; (5) addressing compliance with an individual's instructions by health-care institutions and professionals; and (6) providing a procedure for resolution of disputes.

This Act shares those goals but is revised to reflect many changes that have occurred since 1993. These changes include how health care is delivered, increases in the number of non-traditional familial relationships and living arrangements, the proliferation of the use of electronic documents, the growing use of separate advance directives exclusively for mental health care, and other more recent developments. The Act also seeks to improve upon the 1993 Act based on decades of experience and knowledge about how people make health-care decisions and about the challenges associated with creating and using advance directives.

Some of the more important improvements to the 1993 Act are highlighted below.

First, this Act incorporates approaches designed to facilitate the use of advance directives. Although all states have enacted statutes enabling the use of advance directives, many Americans have never made one. Without an advance directive, individuals' wishes are less likely to be honored. In addition, their health-care professionals, family, and friends may struggle to determine how to make health-care decisions for them and to identify what decisions to make. The Act therefore seeks to increase the number of Americans who have a valid advance directive by reducing unnecessary barriers to execution of these documents.

Second, this Act adds clarity around when an agent may act. Patients, surrogates, and health-care professionals are all disadvantaged when it is unclear whether an agent has authority to make decisions. The Act adds provisions clearly indicating when that power commences. In addition, it addresses a key issue on which state statutes are typically silent: what happens if patients object

to surrogates making a decision for them.

Third, this Act adds provisions to guide determinations of incapacity, which is important because surrogates' authority to make health-care decisions for patients typically commences when patients lack capacity to make decisions for themselves. The Act modernizes the definition of capacity to account for the functional abilities of an individual and clarifies that an individual may lack capacity to make one decision but retain capacity to make other decisions. In addition, recognizing the growth of allied health professions, and that a variety of health-care professionals may have training and expertise in assessing capacity, the Act expands the list of health-care professionals who are recognized as being able to determine that an individual lacks capacity.

Fourth, this Act authorizes the use of advance directives exclusively for mental health care. Since the 1993 Act, many states have authorized such advance directives, sometimes called "psychiatric advance directives". Among other things, these allow individuals with chronic mental health challenges to provide specific instructions as to their preferences for mental health care and to choose to allow those instructions to be binding in the event of an acute mental health crisis.

Fifth, this Act modernizes default surrogate provisions that allow family members and certain other people close to a patient to make decisions in the event the patient lacks capacity and has not appointed a health-care agent. The new default surrogate provisions update the priority list from the 1993 Act to reflect a broader array of relationships and family structures.

Sixth, this Act clearly sets forth duties and powers of surrogates and health-care professionals have regarding advance directives. For example, to reduce the likelihood that an individual's health-care needs will go unmet due to financial barriers, the Act authorizes a health-care surrogate to apply for health insurance for a patient who does not have another fiduciary authorized to do so. It also provides that an agent has certain powers only if those powers are expressly authorized in the power of attorney that appointed the agent.

Seventh, this Act substantially updates the model form included in the 1993 Act. The revised form is designed to be readily understandable and accessible to diverse populations. In addition, it creates a new opportunity for individuals to share a range of information to guide future health-care decisions. Many commentators have expressed concern that instructions included in advance directives focus unduly on preferences for specific treatments, and do not provide health-care professionals or surrogates with the type of information about patients' goals and values that could be used to make value-congruent decisions when novel or unexpected situations arise. Responding to these concerns, the new form provides an opportunity for individuals to indicate goals and values, in addition to specific treatment preferences.

This Act supersedes the 1993 Act. A state enacting it should repeal that Act or any other statute governing the issues addressed in this Act.

Uniform Health-Care Decisions Act (2023)

Section 1. Title

This [act] may be cited as the Uniform Health-Care Decisions Act (2023).

Section 2. Definitions

In this [act]:

(1) "Advance health-care directive" means a power of attorney for health care, health-care instruction, or both. The term includes an advance mental health-care directive.

(2) "Advance mental health-care directive" means a power of attorney for health care, health-care instruction, or both, created under Section 9.

(3) "Agent" means an individual appointed under a power of attorney for health care to make a health-care decision for the individual who made the appointment. The term includes a co-agent or alternate agent appointed under Section 20.

(4) "Capacity" means having capacity under Section 3.

(5) "Cohabitant" means each of two individuals who have been living together as a couple for at least one year after each became an adult or was emancipated and who are not married to each other[or are not [domestic partners] with each other].

(6) "Default surrogate" means an individual authorized under Section 12 to make a health-care decision for another individual.

(7) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

(8) "Family member" means a spouse,[domestic partner,] adult child, parent, or grandparent, or an adult descendant of a spouse,[domestic partner,] child, parent, or grandparent.

(9) "Guardian" means a person appointed under other law by a court to make

decisions regarding the personal affairs of an individual, which may include health-care decisions. The term does not include a guardian ad litem.

(10) "Health care" means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual's physical or mental illness, injury, or condition. The term includes mental health care.

(11) "Health-care decision" means a decision made by an individual or the individual's surrogate regarding the individual's health care, including:

(A) selection or discharge of a health-care professional or health-care institution;

(B) approval or disapproval of a diagnostic test, surgical procedure, medication, therapeutic intervention, or other health care; and

(C) direction to provide, withhold, or withdraw artificial nutrition or hydration, mechanical ventilation, or other health care.

(12) "Health-care institution" means a facility or agency licensed, certified, or otherwise authorized or permitted by other law to provide health care in this state in the ordinary course of business.

(13) "Health-care instruction" means a direction, whether or not in a record, made by an individual that indicates the individual's goals, preferences, or wishes concerning the provision, withholding, or withdrawal of health care. The term includes a direction intended to be effective if a specified condition arises.

(14) "Health-care professional" means a physician or other individual licensed, certified, or otherwise authorized or permitted by other law of this state to provide health care in this state in the ordinary course of business or the practice of the physician's or individual's

profession.

(15) “Individual” means an adult or emancipated minor.

(16) “Mental health care” means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual’s mental illness or other psychiatric, psychological, or psychosocial condition.

(17) “Nursing home” means a nursing facility as defined in Section 1919(a)(1) of the Social Security Act, 42 U.S.C. Section 1396r(a)(1)[, as amended] or skilled nursing facility as defined in Section 1819(a)(1) of the Social Security Act, 42 U.S.C. Section 1395i–3(a)(1)[, as amended].

(18) “Person” means an individual, estate, business or nonprofit entity, government or governmental subdivision, agency, or instrumentality, or other legal entity.

(19) “Person interested in the welfare of the individual” means:

(A) the individual’s surrogate;

(B) a family member of the individual;

(C) the cohabitant of the individual;

(D) a public entity providing health-care case management or protective services to the individual;

(E) a person appointed under other law to make decisions for the individual under a power of attorney for finances; or

(F) a person that has an ongoing personal or professional relationship with the individual, including a person that has provided educational or health-care services or supported decision making to the individual.

(20) “Physician” means an individual authorized to practice medicine under [cite

to state law authorizing the practice of medicine][or osteopathy under [cite to state law authorizing the practice of osteopathy]].

(21) "Power of attorney for health care" means a record in which an individual appoints an agent to make health-care decisions for the individual.

(22) "Reasonably available" means being able to be contacted without undue effort and being willing and able to act in a timely manner considering the urgency of an individual's health-care situation. When used to refer to an agent or default surrogate, the term includes being willing and able to comply with the duties under Section 17 in a timely manner considering the urgency of an individual's health-care situation.

(23) "Record" means information:

(A) inscribed on a tangible medium; or

(B) stored in an electronic or other medium and retrievable in perceivable form.

(24) "Responsible health-care professional" means:

(A) a health-care professional designated by an individual or the individual's surrogate to have primary responsibility for the individual's health care or for overseeing a course of treatment; or

(B) in the absence of a designation under subparagraph (A) or, if the professional designated under subparagraph (A) is not reasonably available, a health-care professional who has primary responsibility for overseeing the individual's health care or for overseeing a course of treatment.

(25) "Sign" means, with present intent to authenticate or adopt a record:

(A) execute or adopt a tangible symbol; or

(B) attach to or logically associate with the record an electronic symbol, sound, or process.

(26) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any other territory or possession subject to the jurisdiction of the United States. The term includes a federally recognized Indian tribe.

(27) "Supported decision making" means assistance, from one or more persons of an individual's choosing, that helps the individual make or communicate a decision, including by helping the individual understand the nature and consequences of the decision.

(28) "Surrogate" means:

(A) an agent;

(B) a default surrogate; or

(C) a guardian authorized to make health-care decisions.

Legislative Note: *If the state recognizes domestic partnerships, insert the term used in the state in the bracketed text in paragraphs (5) and (8), and wherever the term appears in this act. If the state does not recognize domestic partnerships, delete the bracketed text.*

It is the intent of this act to incorporate future amendments to the federal law cited in paragraph (17). A state in which the constitution or other law does not permit incorporation of future amendments when a federal statute is incorporated into state law should omit the phrase "as amended". A state in which, in the absence of a legislative declaration, future amendments are incorporated into state law also should omit the phrase.

If the state has separate terms for and laws authorizing the practice of medicine and osteopathy, remove the brackets in paragraph (20) and cite to the appropriate statutes. However, if the practice of osteopathy in the state is included in the term "medicine" and is authorized by the state's law regarding the practice of medicine, the bracketed text related to osteopathy should be deleted.

Comment

This Section contains definitions central to the Act's purpose and scope.

First, it defines "advance health-care directive" as either a power of attorney for health care or a health-care instruction. The first appoints an agent to make health-care decisions; the second

provides information about an individual's treatment preferences, goals, values, and related wishes to guide future health care decision-making. The term "health-care instruction" includes oral and written directions. The instruction may relate to a particular health-care decision or to health care in general. The term "health-care instruction" replaces the term "individual instruction," which was used in the 1993 Act. The change is intended to provide clarity and to indicate that an instruction may include more than one piece of information.

Second, this Section defines the subject matter covered by the Act with the term "health-care decision". Consistent with the purposes of the Act, the Act defines "health-care decision" very broadly. The term includes decisions about a full range of medical interventions and types of providers. It is not limited to decisions about customary medical and surgical care, but extends, for example, to dental, vision, and mental health care.

The term "health-care decision" references the definition of "health care". The definition of "health care" is to be given the broadest possible construction. It includes the types of care referred to in the definition of "health-care decision" and to care, including personal and custodial care, provided at a "health-care institution" or in a home-based setting. It also includes alternative medical treatment and traditional healing practices. Similarly, the definition of "mental health care" is to be read as broadly as possible within the confines of the definition. It may include treatment of or care provided for alcohol and substance abuse disorders.

The term "health-care institution" is likewise defined broadly. It includes a hospital, nursing home, residential-care facility, home health agency, or hospice.

Third, this Section defines an "individual" as an adult or emancipated minor. This reflects the fact that the Act only covers adults and emancipated minors, leaving other state law to govern decision-making for unemancipated minors. Importantly, the Act is not intended to displace developing state law regarding health-care decision-making by or for "mature" minors. This policy choice is reflected in other ways throughout the Act with the use of the term. For instance, only an adult may be an agent or a cohabitant as a result of the reference to an "individual" in those definitions.

Fourth, this Section defines surrogate to include an agent under a power of attorney for health care, a default surrogate, or a guardian. It also provides definitions to help differentiate these different types of surrogates. An "agent" is an individual appointed under a power of attorney for health care. The definition of "agent" is not limited to a single individual because the Act permits the appointment of co-agents and alternate agents. A "guardian" is a person appointed by a court under other law. A "default surrogate" is an individual authorized under Section 12 to make a health-care decision when there is neither an agent nor a guardian willing and able to make the decision. All three types are referred to in this Act, collectively, as surrogates. Notably, this terminology represents a change from the 1993 Act, which used the term "surrogate" only to refer to a default surrogate. The change reflects the more common use of these terms and is intended to provide clarity to users.

The Act also contains a variety of definitions that were not in the 1993 Act and that help update that Act to reflect modern developments. For example, reflecting a growing recognition that

individuals' decisions should be respected even when they use help to reach those decisions, the Act defines the term "supported decision making". Notably, this definition is consistent with the definition of that term in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017) ("Guardianship Act").

Likewise, the Act adds several terms that are intended to recognize a broad array of family and interpersonal arrangements. For example, reflecting the growing trend in the country of couples living together without getting married, the Act includes a patient's "cohabitant" in the expanded default surrogate list found in Section 12 and in other places in the Act where the inclusion is appropriate. The definition of "cohabitant" in this Section is derived from the same definition in the Uniform Cohabitants' Economic Remedies Act, approved by the ULC in 2021, but with a modification requiring a living-together relationship of at least 1 year. This modification reflects the different purposes of the two acts.

In addition, this Section includes other terms that facilitate clarity. For example, the term "reasonably available" is used in the Act to accommodate the reality that individuals will sometimes not be timely available. A person need not be available in person to be considered reasonably available. A person should be considered reasonably available if available in person, by phone, by videoconferencing, or by other means that allow for adequate communication.

Similarly, it adds the term "responsible health-care professional". A responsible health-care professional is a health-care professional with primary responsibility for an individual's health care in general, or for overseeing a particular course of treatment. Some individuals may only have one responsible health-care professional. For example, a patient who lacks an existing relationship with a primary-care provider (sometimes called a "PCP"), may need urgent care at an emergency department of a local hospital. During a period in which the attending physician in that emergency department assumes responsibility for coordinating the patient's care, that attending physician may be the individual's sole responsible health-care professional. However, an individual also may have more than one provider who fits this category. For example, a cancer patient might have a primary-care physician who coordinates the patient's health care in general, and an oncologist who oversees the patient's cancer treatment. Both physicians would be considered a "responsible health-care professional" under this definition. Thus, the term accommodates the reality of modern health-care systems in which an individual may not have a single provider who is responsible for all care, but rather a team of providers.

In addition, the Act defines the term "nursing home" using definitions of "nursing facility" and "skilled nursing facility" found in sections of the United States Code governing Medicaid and Medicare payments. Consistent with these long-standing federal definitions, the term refers to "an institution (or a distinct part of an institution) which is primarily engaged in providing to residents … (A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons or (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities" and which is "not primarily for the care and treatment of mental diseases." See 42 U.S.C. §§ 1396r(a)(1), 1395i–3(a)(1).

Section 3. Capacity

(a) An individual has capacity for the purpose of this [act] if the individual:

(1) is willing and able to communicate a decision independently or with appropriate services, technological assistance, supported decision making, or other reasonable accommodation; and

(2) in making or revoking:

(A) a health-care decision, understands the nature and consequences of the decision, including the primary risks and benefits of the decision;

(B) a health-care instruction, understands the nature and consequences of the instruction, including the primary risks and benefits of the choices expressed in the instruction; and

(C) an appointment of an agent under a health-care power of attorney or identification of a default surrogate under Section 12(b)(1), recognizes the identity of the individual being appointed or identified and understands the general nature of the relationship of the individual making the appointment or identification with the individual being appointed or identified.

(b) The right of an individual who has capacity to make a decision about the individual's health care is not affected by whether the individual creates or revokes an advance health-care directive.

Comment

The Act governs advance directives and default surrogates. It is not intended to affect the rights of individuals who have the capacity to make health-care decisions for themselves.

Core to the Act's goal of enabling decisions for individuals unable to make decisions for themselves, this section defines what it means to have "capacity" to make decisions covered by the Act. The definition is consistent with the functional approach to determining abilities and

limitations found in the Guardianship Act. This definition also recognizes that what an individual must be able to understand to make a health-care decision or create an instruction may be different than what the individual must be able to understand to appoint an agent. As a result, it is possible that the individual could be found to lack capacity to do one and not the other. For example, an individual might know that they want their adult child to make health-care decisions for them, and that appointing their adult child as their agent would allow that to happen. At the same time, the individual might not have the ability to understand the risks and benefits of particular health-care treatments. Thus, the individual might be found to lack capacity to make an instruction, but to nevertheless have capacity to create a health-care power of attorney. Similarly, the individual might have the capacity to make certain instructions and not others.

Subsection (a)(2) should be read as governing both the initial making and the subsequent amendment of decisions, instructions, and appointments. Amending a health-care decision, instruction, or appointment involves making, at least in part, a new health-care decision, instruction or appointment.

Section 4. Presumption of Capacity; Overcoming Presumption

(a) An individual is presumed to have capacity to make or revoke a health-care decision, health-care instruction, and power of attorney for health care unless:

(1) a court has found the individual lacks capacity to do so; or

(2) the presumption is rebutted under subsection (b).

(b) Subject to Sections 5 and 6, a presumption under subsection (a) may be rebutted by a finding that the individual lacks capacity:

(1) subject to subsection (c), made on the basis of a contemporaneous examination by any of the following:

(A) a physician;

(B) a psychologist licensed or otherwise authorized to practice in this state; [or]

[(C) an individual with training and expertise in the finding of lack of capacity who is licensed or otherwise authorized to practice in this state as:

(i) a physician assistant;

(ii) an advanced practice registered nurse; or

(iii) a social worker; or]

(D) a responsible health-care professional not described in subparagraph (A)[,] [or] (B)[, or (C)] if:

(i) the individual about whom the finding is to be made is experiencing a health condition requiring a decision regarding health-care treatment to be made promptly to avoid loss of life or serious harm to the health of the individual; and

(ii) an individual listed in subparagraph (A)[,] [or] (B)[, or (C)] is not reasonably available;

(2) made in accordance with accepted standards of the profession and the scope of practice of the individual making the finding and to a reasonable degree of certainty; and

(3) documented in a record signed by the individual making the finding that includes an opinion of the cause, nature, extent, and probable duration of the lack of capacity.

(c) The finding under subsection (b) may not be made by:

(1) a family member of the individual presumed to have capacity;

(2) the cohabitant of the individual or a descendant of the cohabitant; or

(3) the individual's surrogate, a family member of the surrogate, or a descendant of the surrogate.

(d) If the finding under subsection (b) was based on a condition the individual no longer has or a responsible health-care professional subsequently has good cause to believe the individual has capacity, the individual is presumed to have capacity unless a court finds the individual lacks capacity or the presumption is rebutted under subsection (b).

Legislative Note: *If the state decides to include physician assistants, advanced practice registered nurses, and social workers in the list of health professionals who may make a finding*

that an individual lacks capacity even if the conditions under subparagraph (D) do not exist, it should include bracketed subsection (b)(1)(C) and include reference to subparagraph (C) in subsection (b)(1)(D).

Comment

Under this Act, an individual is presumed to have capacity to make or revoke a health-care decision, create or revoke an advance directive, and designate or revoke the designation of an agent. This Section states the presumption and provides the methods for rebutting it.

This Section also governs how a determination that an individual lacks capacity is made for the purposes of the Act; it does not govern how such determinations are made for other purposes. A diagnosis, or a finding that an individual takes a particular medication or is receiving a particular treatment, is not a finding that the individual lacks capacity. It may be evidence to be taken into consideration as part of an evaluation; it is not a substitute for that evaluation.

Unlike some states that require two professionals to make the determination that an individual lacks capacity, this provision only requires one. However, as set forth in Section 5, a second finding may be required for the determination to be treated as valid should the individual, their surrogate, or a person interested in the individual's welfare object to the first determination.

The professional making the finding must contemporaneously examine the individual. This means that the professional's finding must be based, at least in part, on the professional's own examination of the patient in the patient's current condition. The professional may not simply rely on a potentially outdated examination or on the examination made by another. The examination may occur in person or by other means (e.g., telehealth) if consistent with applicable law in the enacting state.

A finding under this Section that an individual lacks capacity must be made in accordance with accepted standards of the profession of the professional making the finding, within the scope of practice of the professional making the finding, and to a reasonable degree of certainty.

A wide variety of types of experiences and training might give rise to the training and expertise that similarly-situated professionals would recognize as sufficient. To adequately assess whether a person has the requisite cognitive and functional limitations, an individual making the finding should have training that includes the legal standards in this Act. In addition, the professional making a finding—especially one based on a diagnosis of mental illness or cognitive, intellectual, or developmental disability—should have training and expertise in the assessment of functional and cognitive abilities and limitations of persons with similar disabilities.

Notably, consistent with the way capacity is defined in Section 3, an individual might be determined to lack capacity to make certain medical decisions and not others. For example, an individual might be determined to have the capacity to set goals for treatment, but not to select among therapies to meet those goals. Similarly, an individual might have capacity to make the decision to accept nutrition and hydration, but not have capacity to make more complex decisions.

It is important to recognize that capacity may fluctuate and that a reassessment is appropriate where there is reason to believe that a prior finding may not reflect the individual's current abilities. Mindful of this, and as set forth in subsection (d), if an individual is found to lack capacity because of a particular condition the individual has currently, that finding is not effective to rebut the presumption of capacity if the individual should later no longer have that condition. For example, if an individual is found to lack capacity because the individual is delirious due to an acute infection, and the infection subsides, the finding of lack of capacity becomes ineffective. Similarly, if a responsible health care professional has good cause to believe that the individual has capacity at the current time, a prior finding that the individual lacks capacity will be insufficient to rebut the presumption of capacity. In both such situations, a new assessment and finding will be needed to rebut the presumption.

Nothing in this Section supplants the existing common law rules regarding when a medical provider does or does not need informed consent. State statutory and common law recognize a variety of circumstances when a medical provider may treat without consent. In these situations, treatment may be provided without consent even without a determination that the patient lacks capacity.

Similarly, nothing in this Section affects a court's ability to find that an individual lacks capacity under the Guardianship Act or similar state law.

Section 5. Notice of Finding of Lack of Capacity; Right to Object

(a) As soon as reasonably feasible, an individual who makes a finding under Section 4(b) shall inform the individual about whom the finding was made or the individual's responsible health-care professional of the finding.

(b) As soon as reasonably feasible, a responsible health-care professional who is informed of a finding under Section 4(b) shall inform the individual about whom the finding was made and the individual's surrogate.

(c) An individual found under Section 4(b) to lack capacity may object to the finding:

(1) by orally informing a responsible health-care professional;

(2) in a record provided to a responsible health-care professional or the health-care institution in which the individual resides or is receiving care; or

(3) by another act that clearly indicates the individual's objection.

(d) If the individual objects under subsection (c), the finding under Section 4(b) is not

sufficient to rebut a presumption of capacity in Section 4(a) and the individual must be treated as having capacity unless:

(1) the individual withdraws the objection;

(2) a court finds the individual lacks the presumed capacity;

(3) the individual is experiencing a health condition requiring a decision regarding health-care treatment to be made promptly to avoid imminent loss of life or serious harm to the health of the individual; or

(4) subject to subsection (e), the finding is confirmed by a second finding made by an individual authorized under Section 4(b)(1) who:

(A) did not make the first finding;

(B) is not a family member of the individual who made the first finding; and

(C) is not the cohabitant of the individual who made the first finding or a descendant of the cohabitant.

(e) A second finding that the individual lacks capacity under subsection (d)(4) is not sufficient to rebut the presumption of capacity if the individual is requesting the provision or continuation of life-sustaining treatment and the finding is being used to make a decision to withhold or withdraw the treatment.

(f) As soon as reasonably feasible, a health-care professional who is informed of an objection under subsection (c) shall:

(1) communicate the objection to a responsible health-care professional; and

(2) document the objection and the date of the objection in the individual's medical record or communicate the objection and the date of the objection to an administrator

with responsibility for medical records of the health-care institution providing health care to the individual, who shall document the objection and the date of the objection in the individual's medical record.

Comment

This Section addresses an important question on which the 1993 Act was silent: what happens if the individual does not agree with a non-judicial finding of incapacity? It provides that if an individual is found to lack capacity under Section 4(b), the individual may object to that finding. It further provides that the finding will not be effective to rebut a presumption of capacity unless the individual withdraws the objection, a court determines the individual lacks capacity, the individual needs prompt treatment to avoid dying or experiencing serious harm, or the finding is confirmed by another qualified professional.

However, a finding confirmed by another professional is not sufficient to rebut the presumption of capacity if the finding will be used to withhold or withdraw life-sustaining treatment contrary to the current, expressed wishes of the individual. This caveat reflects a simple policy decision to prohibit removal of life-sustaining treatment over the patient's contemporaneous opposition when the patient has not had the full benefit of due process provided by a court proceeding.

If a health-care professional is aware that an individual making an objection has an attorney who represents the individual on related matters, it will usually be appropriate for the health-care professional to also notify the attorney of the objection.

Section 6. Judicial Review of Finding of Lack of Capacity

(a) An individual found under Section 4(b) to lack capacity, a responsible health-care professional, the health-care institution providing health care to the individual, or a person interested in the welfare of the individual may petition the [insert name of the appropriate court in the state for capacity cases] in the [county] in which the individual resides or is located to determine whether the individual lacks capacity.

(b) The court in which a petition under subsection (a) is filed shall appoint [legal counsel to represent the individual if the individual does not have legal counsel] [a guardian ad litem]. The court shall hear the petition as soon as possible[, but not later than [seven] days after the petition is filed]. As soon as possible[, but not later than [seven] days after the hearing], the court

shall determine whether the individual lacks capacity. The court may determine the individual lacks capacity only if the court finds by clear and convincing evidence that the individual lacks capacity.

Legislative Note: *A state that uses a different term for "county" should insert that term in the brackets in subsection (a).*

In subsection (b), the state should decide whether to require appointment of legal counsel, if the individual does not have legal counsel, or a guardian ad litem.

A state in which court proceedings are solely or primarily within the purview of the state's highest court may not wish to include the bracketed instructions to the court in subsection (b) regarding the timing of a hearing and a decision on a petition under subsection (a). A state in which that is not the case should include the bracketed material and insert an appropriate number of days.

Comment

Subsection (a) provides that an individual found to lack capacity under Section 4(b), certain health care providers, and persons interested in the welfare of the individual have standing to challenge the finding in court.

Subsection (b) requires prompt court action and requires the appointment of legal counsel or a guardian ad litem where a petition is brought under this Section. The legal counsel's duty is to represent the individual and the individual's wishes before the court; the guardian ad litem's duty is to assist the court by representing the individual's best interest. In appointing a guardian ad litem, a court should prioritize the appointment of someone with training and expertise in the type of abilities and limitations alleged.

An individual may also challenge a determination of lack of capacity made by a court under Section 4(a). However, the procedure for that challenge is not covered by this Act. Rather, it would be governed by the Guardianship Act, the state's own guardianship law, or by other state law.

Section 7. Health-Care Instruction

(a) An individual may create a health-care instruction that expresses the individual's preferences for future health care, including preferences regarding:

(1) health-care professionals or health-care institutions;

(2) how a health-care decision will be made and communicated;

(3) persons that should or should not be consulted regarding a health-care

decision;

(4) a person to serve as guardian for the individual if one is appointed; and

(5) an individual to serve as a default surrogate.

(b) A health-care professional to whom an individual communicates or provides an instruction under subsection (a) shall document the instruction and the date of the instruction in the individual's medical record or communicate the instruction and date of the instruction to an administrator with responsibility for medical records of the health-care institution providing health care to the individual, who shall document the instruction and the date of the instruction in the individual's medical record.

(c) A health-care instruction made by an individual that conflicts with an earlier health-care instruction made by the individual, including an instruction documented in a medical order, revokes the earlier instruction to the extent of the conflict.

(d) A health-care instruction may be in the same record as a power of attorney for health care.

Comment

The Act distinguishes between two types of advance directives—those which are instructions (i.e., an indication of an individual's preference for care) and those which appoint an agent—while recognizing that both may be created in a single document. This Section covers instructions but provides in subsection (d) that an instruction may be in the same record as a power of attorney for health care.

This Section enables the individual to make a wide variety of instructions. These may apply broadly, or may pertain to specific circumstances, such as in the event of terminal illness. Under subsection (a)(4), the individual may include, as part of the instructions, a nomination of a guardian. Such nomination does not provide any indication that the individual wishes to have a guardian appointed and should never be construed as consent to imposition of guardianship. Nor can such a nomination guarantee that the nominee will be appointed by the court. Rather, in the absence of cause to appoint another, the court will likely select the nominee. Notably, by nominating as guardian an agent appointed under a power of attorney for health care, the principal may reduce the likelihood that a guardianship could be used to thwart the agent's authority.

Creating an instruction under this Section does not require compliance with any particular set of formalities. This reflects the fact that people make instructions in many ways—in writing, orally, etc.—and limiting their ability to do so by adding procedural requirements could run afoul of long-established rights and reduce the likelihood that instructions will be made at all.

Subsection (c) addresses the issue of multiple instructions. It provides that the most current instruction governs, regardless of the location of the instruction. For example, if a medical order (including a POLST, sometimes referred to as a Physician Order for Life Sustaining Treatment) recorded an individual's preference inconsistent with the individual's preference stated in a previously created advance directive, the direction in the medical order would govern. Similarly, if the medical order recorded a preference, and an individual subsequently provided a different instruction, the subsequent instruction would govern.

Section 8. Power of Attorney for Health Care

(a) An individual may create a power of attorney for health care to appoint an agent to make health-care decisions for the individual.

(b) An individual is disqualified from acting as agent for an individual who lacks capacity to make health-care decisions if:

(1) a court finds that the potential agent poses a danger to the individual's well-being, even if the court does not issue a [restraining order] against the potential agent; or

(2) the potential agent is an owner, operator, employee, or contractor of a nursing home [or other residential care facility] in which the individual resides or is receiving care, unless the owner, operator, employee, or contractor is a family member of the individual, the cohabitant of the individual, or a descendant of the cohabitant.

(c) A health-care decision made by an agent is effective without judicial approval.

(d) A power of attorney for health care must be in a record, signed by the individual creating the power, and signed by an adult witness who:

(1) reasonably believes the act of the individual to create the power of attorney is voluntary and knowing;

(2) is not:

(A) the agent appointed by the individual;

(B) the agent's spouse[, domestic partner,] or cohabitant;

(C) if the individual resides or is receiving care in a nursing home[or other residential care facility], the owner, operator, employee, or contractor of the nursing home [or other residential care facility]; and

(3) is present when the individual signs the power of attorney or when the individual represents that the power of attorney reflects the individual's wishes.

(e) A witness under subsection (d) is considered present if the witness and the individual are:

(1) physically present in the same location;

(2) using electronic means that allow for real time audio and visual transmission and communication in real time to the same extent as if the witness and the individual were physically present in the same location; or

(3) able to speak to and hear each other in real time through audio connection if:

(A) the identity of the individual is personally known to the witness; or

(B) the witness is able to authenticate the identity of the individual by receiving accurate answers from the individual that enable the authentication.

(f) A power of attorney for health care may include a health-care instruction.

Legislative Note: *A state should insert the term the state uses for a protective order in place of the bracketed text in subsection (b)(2) and wherever it appears in this act.*

A state should insert the appropriate term or terms for the types of facilities the state wishes to include in subsection (b) and wherever the bracketed phrase "other residential care facility" appears in this act. These facilities are referred to by various names, including assisted-living facilities and board-and-care homes.

A power of attorney under this act is intended to prevail over a conflicting provision in other state law. A state should review and, if necessary, amend its law on powers of attorney to resolve

conflicts.

Comment

This Section provides for the second type of advance directive: the power of attorney for health care, which must be in a signed record. In some states, this document is referred to as a health care proxy. Notably, this type of directive is distinct from a power of attorney for finances (an arrangement governed by the Uniform Power of Attorney Act). Theoretically an individual could create a power of attorney for finances and a power of attorney for health care in the same document, but there is a consensus among experts that it is best to create separate records.

Consistent with the statement in Section 7 that an instruction may be in the same record as a power of attorney for health care, subsection (f) recognizes that a power of attorney for health care may be in the same record as a health-care instruction. Notably, putting both in the same record is typically advisable because the agent's decision-making should be guided by such instructions. Having both in the same place facilitates an agent's compliance with their duties under Section 17.

The requirement that a power of attorney be in a record should be understood in the context of the definition of a "record" in Section 2. As defined, a record is information inscribed on a tangible medium (e.g., paper) or stored in an electronic or other medium and retrievable in perceivable form. Thus, it allows for electronic powers of attorney, including those captured on video. The same, of course, is true of an advance directive that only includes a health-care instruction and not a power of attorney, although this Act does not require a health-care instruction to be in a record.

This Section includes execution requirements, as states overwhelmingly have adopted such requirements. However, consistent with concerns about undue barriers to execution, this Section aims to minimize the burden of execution by requiring only a single witness and allowing witnessing to occur in various ways. To discourage forgery, it requires a witness, thus identifying someone who can describe what took place should a concern about the validity of the document arise. By contrast, the Section does not require notarization. A notary, however, can serve as a witness. In addition, an individual may opt to have additional witnesses beyond the required single witness.

Notwithstanding the acknowledgment in subsection (a) that multiple agents may be appointed, such appointment is not encouraged. Appointment of multiple agents where each can act separately can result in conflicting instructions being given to health-care professionals. It creates an opportunity for confusion and can frustrate the ability of agents to effectuate the individual's wishes as required under Section 17. Appointment of agents who must act together also creates problems. Agents may fail to reach consensus. Obtaining consensus may also slow the decision-making process, potentially delaying treatment for the individual.

Consistent with the 1993 Act, subsection (b) prohibits an owner, operator, employee, or contactor of a nursing home or other residential care facility in which the individual resides from serving as agent, unless related to the individual. For the definition of "family member," see

Section 2(8). This prohibition is not because such individuals are inherently suspicious. Individuals working in such facilities are critically important caregivers and may form strong, caring bonds with residents. Rather, the prohibition reflects the nature of these institutions—institutions in which highly vulnerable individuals tend to become highly dependent on the facility and its staff to meet their needs. In this environment, it is important that the agent is independent of the facility.

As indicated in the legislative note, a state will need to insert its own term or terms for the types of facilities the state wishes to include in subsection (b) and wherever else the bracketed phrase "other residential care facility" appears in the Act. Such facilities go by various names, including assisted-living facilities and board-and-care homes. To include facilities that provide residential services to people with intellectual disabilities and related conditions, states might include the term "Intermediate Care Facilities for Individuals with Intellectual Disability," a term used in the context of the federal Medicaid program.

Section 9. Advance Mental Health-Care Directive

(a) An individual may create an advance health-care directive that addresses only mental health care for the individual. The directive may include a health-care instruction, a power of attorney for health care, or both.

(b) A health-care instruction under this section may include the individual's:

(1) general philosophy and objectives regarding mental health care;

(2) specific goals, preferences, and wishes regarding the provision, withholding, or withdrawal of a form of mental health care, including:

(A) preferences regarding professionals, programs, and facilities;

(B) admission to a mental-health facility, including duration of admission;

(C) preferences regarding medications;

(D) refusal to accept a specific type of mental health care, including a medication; and

(E) preferences regarding crisis intervention.

(c) A power of attorney for health care under this section may appoint an agent to make decisions only for mental health care.

[(d) An individual may direct in an advance mental health-care directive that, if the individual is experiencing a psychiatric or psychological event specified in the directive, the individual may not revoke the directive or a part of the directive.

(e) If an advance mental health-care directive includes a direction under subsection (d), the advance mental health-care directive must be in a record that is separate from any other advance health-care directive created by the individual and signed by the individual creating the advance mental health-care directive and at least two adult witnesses who:

(1) attest that to the best of their knowledge the individual:

(A) understood the nature and consequences of the direction, including its risks and benefits; and

(B) made the direction voluntarily and without coercion or undue influence;

(2) are not:

(A) the agent appointed by the individual;

(B) the agent's spouse[, domestic partner,] or cohabitant; and

(C) if the individual resides in a nursing home [or other residential care facility] the owner, operator, employee, or contractor of the nursing home [or other residential care facility]; and

(3) are physically present in the same location as the individual.]

Legislative Note: *A state that wishes to include an option to allow an individual to waive the individual's right to revoke an advance mental health-care directive in a specified situation (a "Ulysses clause") should include subsections (d) and (e), Section 15(a)(3), and Section 23(a)(6).*

Comment

This Section governs what have sometimes been called "psychiatric advance directives." The use of the term "mental health" instead of "psychiatric" reflects the fact that an individual might

wish to create an advance directive to address a wide variety of mental health-care needs and mental conditions, not simply those which stem from what are traditionally referred to as "psychiatric" conditions.

An advance mental health-care directive can be a power of attorney for only mental health care, an instruction for only mental health care, or a single record that includes both. An individual need not have a particular diagnosis to create an advance mental health-care directive. For example, an individual might wish to create one to govern in the event of an acute mental health crisis, but they might also create one to govern mental health care in the event of dementia or another cognitive disability. The list in subsection (b) of issues that can be addressed in an advance mental health-care instruction is not exhaustive. Thus, an individual could have an advance mental health-care directive and no general advance directive, could have a general advance directive and no advance mental health-care directive, or could have both.

An individual may choose to use an instruction only for mental health care to express a broad range of preferences. In many cases, these preferences may be based on prior experience and be a way to communicate to future health-care professionals what medication or treatments have had a positive or negative effect in the past. For example, an individual may wish to avoid a treatment method that had side effects that were personally intolerable or may desire an intervention that proved effective in the past.

Since a person may designate an agent to make health-care instructions or provide an instruction related to mental health care in a general power of attorney, this Section is unnecessary to empower either. What it does is (1) clarify that an individual may make an appointment or instruction exclusively for mental health care; (2) prevent a general advance directive from mistakenly revoking the specific one, and vice versa; and (3) allow, but in no way require, a state to offer an individual the opportunity to waive the right to revoke all or part of an advance directive in certain situations (i.e., to include a "Ulysses clause").

The Ulysses clause option is created by subsection (d), which allows an individual to include in the advance directive an instruction that prevents the individual from revoking the advance directive if the individual is experiencing the psychiatric or psychological event specified in the directive. This allows the advance directive to remain in effect and to be implemented if the individual is subsequently found to lack capacity.

The individual may choose how specific to be when identifying the event that would trigger the Ulysses clause. Some individuals might choose a broad category of event (e.g., "an acute mental health crisis"). Others might choose a much narrower event (e.g., if the individual is experiencing a particular type of mental health crisis or a particular symptom and is refusing a particular type of medication or intervention).

This Ulysses provision is entirely optional, and thus individuals are free to create an advance mental health-care directive without any such provision. Because a Ulysses clause authorizes health-care professionals to disregard otherwise valid revocations, subsection (e) requires additional formalities when one is included. Specifically, it requires two witnesses who are physically present in the same location as the individual creating the directive. Further, these

witnesses must attest that, to the best of their knowledge, the individual authorizing the provision understands the nature and consequences of the clause, and is making a voluntary decision (free of coercion or undue influence) to include it.

In addition to being optional for an individual, the Ulysses provision is also optional for the states to include in their respective versions of the Act.

The power of an agent under a power of attorney for mental health care to consent to voluntary admission to a mental health facility is governed by Section 18, which governs the powers of an agent.

Section 10. Relationship of Advance Mental Health-Care Directive and Other Advance Health-Care Directive

(a) If a direction in an advance mental health-care directive of an individual conflicts with a direction in another advance health-care directive of the individual, the later direction revokes the earlier direction to the extent of the conflict.

(b) An appointment of an agent to make decisions only for mental health care for an individual does not revoke an earlier appointment of an agent to make other health-care decisions for the individual. A later appointment revokes the authority of an agent under the earlier appointment to make decisions about mental health care unless otherwise specified in the power of attorney making the later appointment.

(c) An appointment of an agent to make health-care decisions for an individual other than decisions about mental health care made after appointment of an agent authorized to make only mental health-care decisions does not revoke the appointment of the agent authorized to make only mental health-care decisions.

Comment

This Section clarifies the relationship between an advance mental health-care directive and advance directives that are not limited in this way. It provides that when instructions in the two differ, the later directive to be created governs to the extent of the conflict. The Section also explains that appointment of an agent in an advance mental health-care directive does not revoke the prior appointment of an agent under a general power of attorney, and vice versa. However,

unless the later directive provides otherwise, the appointment of an agent in an advance mental-health-care care directive does revoke the authority of an agent appointed under a general power of attorney for health care to make mental health-care decisions for the individual.

Section 11. Optional Form

The following form may be used to create an advance health-care directive:

ADVANCE HEALTH-CARE DIRECTIVE

HOW YOU CAN USE THIS FORM

You can use this form if you wish to name someone to make health-care decisions for you in case you cannot make decisions for yourself. This is called giving the person a power of attorney for health care. This person is called your Agent.

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor after you die.

YOUR NAME AND DATE OF BIRTH

Name:

Date of birth:

PART A: NAMING AN AGENT

This part lets you name someone else to make health-care decisions for you. You may leave any item blank.

1. NAMING AN AGENT

I want the following person to make health-care decisions for me if I cannot make decisions for myself:

Name:

Optional contact information (it is helpful to include information such as address, phone, and email):

2. NAMING AN ALTERNATE AGENT

I want the following person to make health-care decisions for me if I cannot and my Agent is not able or available to make them for me:

Name:

Optional contact information (it is helpful to include information such as address, phone, and email):

3. LIMITING YOUR AGENT'S AUTHORITY

I give my Agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except the following:

(If you do not add a limitation here, your Agent will be able make all health-care decisions that an Agent is permitted to make under state law.)

PART B: HEALTH-CARE INSTRUCTIONS

This part lets you state your priorities for health care and to state types of health care you do and do not want.

1. INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your Agent to act while making decisions for you. You may mark or initial each choice. You also may leave any choice blank.

Treatment. Medical treatment needed to keep me alive but not needed for comfort or any other purpose should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "treatment" section.).

(____) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.

(____) Not be given to me if I am unconscious and I am not expected to be conscious again.

(____) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

Food and liquids. If I can't swallow and staying alive requires me to get food or liquids through a tube or other means for the rest of my life, then food or liquids should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "food and liquids" section).

(____) Not be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(____) Not be given to me if I am unconscious and am not expected to be conscious again.

(____) Not be given to me if I have a medical condition from which I am not

expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

Pain relief. If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark or initial all that apply):

(____) Always be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

(____) Never be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

(____) Be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(____) Be given to me if I am unconscious and am not expected to be conscious again.

(____) Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(____) Other (write what you want or do not want):

2. MY PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot. It also helps others understand your preferences.

You may mark or initial each choice. You also may leave any choice blank.

Staying alive as long as possible even if I have substantial physical limitations is:

(____) Very important

(____) Somewhat important

(____) Not important

Staying alive as long as possible even if I have substantial mental limitations is:

(____) Very important

(____) Somewhat important

(____) Not important

Being free from significant pain is:

(____) Very important

(____) Somewhat important

(____) Not important

Being independent is:

(____) Very important

(____) Somewhat important
(____) Not important

Having my Agent talk with my family before making decisions about my care is:
(____) Very important
(____) Somewhat important
(____) Not important

Having my Agent talk with my friends before making decisions about my care is:
(____) Very important
(____) Somewhat important
(____) Not important

3. OTHER INSTRUCTIONS

You can write in this section more information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

PART C: OPTIONAL SPECIAL POWERS AND GUIDANCE

This part lets you give your Agent additional powers, and to provide more guidance about your wishes. You may mark or initial each choice. You also may leave any choice blank.

1. OPTIONAL SPECIAL POWERS

My Agent can do the following things ONLY if I have marked or initialed them below:

(____) Admit me as a voluntary patient to a facility for mental health treatment for up to _____ days (write in the number of days you want like 7, 14, 30 or another number).
(If I do not mark or initial this choice, my Agent MAY NOT admit me as a voluntary patient to this type of facility.)

(____) Place me in a nursing home for more than [100] days even if my needs can be met somewhere else, I am not terminally ill, and I object.
(If I do not mark or initial this choice, my Agent MAY NOT do this.)

2. ACCESS TO MY HEALTH INFORMATION

My Agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself. If I mark or initial below, my Agent may also do that at any time my Agent thinks it will help me.

(____) I give my Agent permission to obtain, examine, and share information about my health needs and health care whenever my Agent thinks it will help me.

3. FLEXIBILITY FOR MY AGENT

Mark or initial below if you want to give your Agent flexibility in following instructions you provide in this form. If you do not, your Agent must follow the instructions even if your Agent thinks something else would be better for you.

(____) I give my Agent permission to be flexible in applying these instructions if my Agent thinks it would be in my best interest based on what my Agent knows about me.

4. NOMINATION OF GUARDIAN

You can say who you would want as your guardian if you needed one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

(____) My Agent named in this form. If my Agent cannot be a guardian, I want the Alternate Agent named in this form.

(____) Other (write who you would want and their contact information):

PART D: ORGAN DONATION

This part lets you donate your organs after you die. You may leave any item blank.

1. DONATION

You may mark or initial only one choice.

(____) I donate my organs, tissues, and other body parts after I die, even if it requires maintaining treatments that conflict with other instructions I have put in this form, EXCEPT for those I list below (list any body parts you do NOT want to donate):

(____) I do not want my organs, tissues, or body parts donated to anybody for any reason. (If you mark or initial this choice, you should skip the “purpose of donation” section.)

2. PURPOSE OF DONATION

You may mark or initial all that apply. (If you do not mark or initial any of the purposes below, your donation can be used for all of them.)

Organs, tissues, or body parts that I donate may be used for:

(____) Transplant
(____) Therapy
(____) Research
(____) Education
(____) All of the above

PART E: SIGNATURES

YOUR SIGNATURE

Sign your name:

Today's date:

City/Town/Village and State (optional):

SIGNATURE OF A WITNESS

You need a witness if you are using this form to name an Agent. The witness must be an adult and cannot be the person you are naming as Agent or the Agent's spouse[, domestic partner,] or someone the Agent lives with as a couple. If you live or are receiving care in a nursing home, the witness cannot be an employee or contractor of the home or someone who owns or runs the home.

Name of Witness:

Signature of Witness:
(Only sign as a witness if you think the person signing above is doing it voluntarily.)

Date witness signed:

PART F: INFORMATION FOR AGENTS

1. If this form names you as an Agent, you can make decisions about health care for the person who named you when the person cannot make their own.

2. If you make a decision for the person, follow any instructions the person gave, including any in this form.

3. If you do not know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences, and goals if you know them or can learn them. Some of these preferences may be in this form. You should also consider any behavior or communication

from the person that indicates what the person currently wants.

4. If this form names you as an Agent, you can also get and share the person' health information. But unless the person has said so in this form, you can get or share this information only when the person cannot make decisions about the person's health care.

Legislative Note: *In Part C.1, insert the same number of days in the brackets that is inserted in Section 18(g).*

Comment

This form is not designed to be used by individuals wishing to create an advance directive exclusively for mental health care. Individuals who wish to create such an advance directive will likely want to spell out preferences that are highly specific to their individual health needs and preferences.

The form includes two parts designed to reflect a growing concern that people too often provide detailed instructions that are not well-informed, and which do not reflect evolving preferences. Specifically, it allows the individual to (1) provide information about their values (and not merely specific instructions) and (2) give the individual's agent leeway in following instructions. The latter provision is a simplified version of one previously incorporated in the State of Maryland's statutory short form.

The optional form provided in this Section is designed to simply be a form, not advice. This helps make it simpler than many states' statutory forms. It also reduces the risk that the form will provide advice that is not appropriate for a given individual or provide advice which, although perhaps well-intentioned, lacks empirical support. Notably, the form could be packaged with advice or other resources by providers or other actors.

The form consists of five parts that the individual may complete, as well as instructions. An individual may complete all or any part of the form. Any part of the form left blank is not to be given effect. For example, an individual may complete the instructions for health care part of the form alone. Or an individual may complete the power of attorney for health care part of the form alone. Or an individual may complete both the instructions and power of attorney for health care parts of the form. An individual may also, but need not, complete the part of the form pertaining to donation of bodily organs and tissue.

Part A, the power of attorney for health care, appears first on the form in order to ensure to the extent possible that it will come to the attention of a casual reader. This reflects the reality that the appointment of an agent is a more comprehensive approach to the making of health-care decisions than is the giving of a health-care instruction, which cannot possibly anticipate all future circumstances that might arise. Part A requires only the designation of a single agent, but provides an opportunity to designate an alternate, if the individual chooses. As in the 1993 Act, in order not to encourage the practice, no provision is made in the form for the designation of co-agents. Designation of co-agents is discouraged because of the difficulties likely to be encountered if the co-agents are not all readily available or do not agree. If co-agents are

appointed, the advance directive should specify that either is authorized to act if the other is not reasonably available. It should also specify a method for resolving disagreements.

Part B of the form enables the individual to provide instructions about specific forms of potential future care, as well as the individual's priorities. Indeed, a key innovation in this part is to allow individuals to provide information about their goals and priorities, which can guide health-care decisions. This information can help surrogates make decisions that are consistent with the principal's preferences, values, goals, and wishes, recognizing that an individual cannot anticipate and provide specific instructions for all future circumstances that might arise. In this way, the form responds to growing calls from the medical community for advance planning to be goal-focused, not merely treatment-focused.

Part C.1 and C.2 enable the individual to give the agent powers that, under Section 18, require express authorization. For example, under Part C.2, the individual can make the agent's power to obtain and disclose medical information immediately effective. Similarly, Part C.3 allows an individual to give an agent more leeway in applying instructions than would otherwise be permitted under Section 17.

Part C.4 allows an individual to nominate a guardian. Nomination of a guardian provides no indication that the individual desires or needs a guardian.

Part D of the form provides the individual an opportunity to express an intention to donate bodily organs and tissues at death. An individual using this form to do so gives permission for the donation to be made even if procedures necessary to effectuate donation run contrary to other instructions in the directive (for example, they require the dying process to be prolonged). In this way, it aims to remove a common barrier to successful organ donation. The form allows a person to indicate purposes for which the gift is made. The option "therapy" means medical treatment other than transplant. The act uses the term "therapy" recognizing that this is the term used in the Revised Uniform Anatomical Gift Act (2006) (Last Revised or Amended in 2008).

Of course, Part D is only one way an individual can make such a gift. Failure to complete this portion does not preclude making a gift in another way. Notably, in some cases, an individual may have made a more limited gift in another form (e.g., as part of agreeing to donate for transplant). Finally, this Act leaves up to other state law what is included in the terms "organs", "tissues", and "body parts".

The form provides for a signature, which may consist of a broad range of marks made with intent to authenticate or adopt the form.

This form could be offered and completed in electronic form or as a traditional paper document.

Section 12. Default Surrogate

(a) A default surrogate may make a health-care decision for an individual who lacks capacity to make health-care decisions and for whom an agent, or guardian authorized to make

health-care decisions, has not been appointed or is not reasonably available.

(b) Unless the individual has an advance health-care directive that indicates otherwise, a member of the following classes, in descending order of priority, who is reasonably available and not disqualified under Section 14, may act as a default surrogate for the individual:

(1) an adult the individual has identified, other than in a power of attorney for health care, to make a health-care decision for the individual if the individual cannot make the decision;

(2) the individual's spouse[or domestic partner], unless:

(A) a petition for annulment, divorce, dissolution of marriage, legal separation, or termination has been filed and not dismissed or withdrawn;

(B) a decree of annulment, divorce, dissolution of marriage, legal separation, or termination has been issued;

(C) the individual and the spouse[or domestic partner] have agreed in a record to a legal separation; or

(D) the spouse[or domestic partner] has [abandoned] the individual for more than one year;

(3) the individual's adult child or parent;

(4) the individual's cohabitant;

(5) the individual's adult sibling;

(6) the individual's adult grandchild or grandparent;

(7) an adult not listed in paragraphs (1) through (6) who has assisted the individual with supported decision making routinely during the preceding six months;

(8) the individual's adult stepchild not listed in paragraphs (1) through (7) whom

the individual actively parented during the stepchild's minor years and with whom the individual has an ongoing relationship; or

(9) an adult not listed in paragraphs (1) through (8) who has exhibited special care and concern for the individual and is familiar with the individual's personal values.

(c) A responsible health-care professional may require an individual who assumes authority to act as a default surrogate to provide a declaration in a record under penalty of perjury stating facts and circumstances reasonably sufficient to establish the authority.

(d) If a responsible health-care professional reasonably determines that an individual who assumed authority to act as a default surrogate is not willing or able to comply with a duty under Section 17 or fails to comply with the duty in a timely manner, the professional may recognize the individual next in priority under subsection (b) as the default surrogate.

(e) A health-care decision made by a default surrogate is effective without judicial approval.

Legislative Note: *A state should insert the term used in the state for abandonment in subsection (b)(2)(D) and wherever the term "abandoned" or "abandonment" appears in this act.*

Comment

This Section governs the recognition of default surrogates.

Subsection (a) authorizes a default surrogate to make a health-care decision for an individual in the event the individual lacks capacity to make health-care decisions and an agent or guardian has not been appointed or the agent or guardian is not reasonably available.

Subsection (b) continues the 1993 Act's use of a priority list with some important modifications. At the top of the list is someone the individual has designated. This designation may be made in a record or it may be oral. This provision allows for an individual's preferences to be given effect even though the individual has not complied with the formalities necessary to appoint an agent to make health-care decisions. Subsection (b)(3) includes adult children and parents. It may be necessary to consult other law of the state to determine who constitutes a "child" or a "parent".

If the individual has not designated a surrogate, or the designee is not reasonably available, subsection (b) applies a default rule for selecting another to act as surrogate. Like all default

rules, it is not tailored to every situation, but attempts to reflect the desire of the majority of those who would find themselves so situated. To reflect a broad array of families and support systems, the Act expands the list of persons on the priority list beyond those included in the 1993 Act. Similarly, it grants certain family relationships equal priority (e.g., parents and adult children), recognizing which individual may be best equipped to serve in this role will vary based on the individual and family structure. An adult who has priority under (b)(7) because they have provided the individual with decision-making support may have done so informally, or pursuant to a formal decision-making agreement.

The priority list is designed to approximate the likely wishes of as many individuals as possible. Empirical research on surrogate decision-making indicates that most Americans choose close relatives as their health-care agents, with spouses being the most common first choice and children being the most common second choice. See Nina A. Kohn & Jeremy A. Blumenthal, *Designating Health Care Decision-Makers for Patients without Advance Directives: A Psychological Critique*, 42 GEORGIA LAW REVIEW 979, 990 (2008). Consistent with this, spouses and domestic partners are given top priority in the Act's priority list, and adult children are placed in the next priority group. Nevertheless, the priority list may be a poor fit for some individuals, and this is yet another reason why the Act attempts to encourage the use of powers of attorney for health care by, in other provisions, reducing the barriers to execution of powers of attorney for health care.

By adopting a priority list, the Act rejects an alternative approach taken by a minority of states that gives a patient's physician substantial discretion to select among potential surrogates. This choice reflects several considerations. First, the Act's approach appears to be more consistent with the preferences of most Americans. *Id* (reviewing empirical literature on surrogate decision-making preferences and concluding that "fixed priority lists … appear to do a reasonable job of capturing the process preferences of the majority"). Second, one role of the surrogate is to provide a check on health-care professionals. If health-care professionals have discretion to choose among potential surrogates, they would have the ability to choose surrogates whose views accord with their own, thus blunting any ability for the surrogate to serve as such a check. Third, many Americans do not have a close and trusting relationship with a physician. The physician treating the individual may not know the individual's values and preferences to the extent that would allow the physician to select a surrogate based on more than convenience or the physician's own assessment of a potential surrogate's capacities. Fourth, although it adopts a clear priority list, the Act does empower a responsible health-care professional to recognize a surrogate other than one with top priority under the limited circumstances set forth in subsection (d).

Subsection (c) permits the professional to obtain evidence of a claimed authority to act as default surrogate. The professional, however, does not have a duty to investigate the qualifications of an individual claiming the authority to act.

If a person who assumed authority does not comply with their duties under the Act, a health-care professional may affirmatively seek out other members of the same class to make a decision for a patient. In addition, subsection (d) allows a health-care professional to take direction from an individual of lower priority than the one who originally assumed authority to act as a default

surrogate if the individual who originally assumed authority fails to make decisions consistent with the default surrogate's fiduciary duty and the decision-making standards set forth in Section 17. In determining whether to look to an individual of lower priority to make such decisions, a responsible professional working in an institution that has an ethics committee may wish to consult that committee.

Section 13. Disagreement Among Default Surrogates

(a) A default surrogate who assumes authority under Section 12 shall inform a responsible health-care professional if two or more members of a class under Section 12(b) have assumed authority to act as default surrogates and the members do not agree on a health-care decision.

(b) A responsible health-care professional shall comply with the decision of a majority of the members of the class with highest priority under Section 12(b) who have communicated their views to the professional and the professional reasonably believes are acting consistent with their duties under Section 17.

(c) If a responsible health-care professional is informed that the members of the class who have communicated their views to the professional are evenly divided concerning the health-care decision, the professional shall make a reasonable effort to solicit the views of members of the class who are reasonably available but have not yet communicated their views to the professional. The professional, after the solicitation, shall comply with the decision of a majority of the members who have communicated their views to the professional and the professional reasonably believes are acting consistent with their duties under Section 17.

(d) If the class remains evenly divided after the effort is made under subsection (c), the health-care decision must be made as provided by other law of this state regarding the treatment of an individual who is found to lack capacity.

Comment

This Section addresses the situation where more than one member of the same class of default surrogates has assumed authority to act and a disagreement over a health-care decision arises of which a responsible health-care professional is informed. Should that occur, a responsible health-care professional must comply with the decision of a majority of the members of that class who have communicated their views to the professional and who the professional reasonably believes are acting in a manner that is consistent with their duties under Section 17. If the class is divided, a responsible health-care professional should make reasonable efforts to solicit the views of class members who have yet to make their views known. If the disagreement persists, however, the decision must be made as provided by other law of the state governing incapacity issues.

Finally, nothing in this Section requires a health-care professional to affirmatively seek out all members of a class.

Section 14. Disqualification to Act as Default Surrogate

(a) An individual for whom a health-care decision would be made may disqualify another individual from acting as default surrogate for the first individual. The disqualification must be in a record signed by the first individual or communicated verbally or nonverbally to the individual being disqualified, another individual, or a responsible health-care professional. Disqualification under this subsection is effective even if made by an individual who lacks capacity to make an advance directive if the individual clearly communicates a desire that the individual being disqualified not make health-care decisions for the individual.

(b) An individual is disqualified from acting as a default surrogate for an individual who lacks capacity to make health-care decisions if:

(1) a court finds that the potential default surrogate poses a danger to the individual's well-being, even if the court does not issue a [restraining order] against the potential surrogate;

(2) the potential default surrogate is an owner, operator, employee, or contractor of a nursing home [or other residential care facility] in which the individual is residing or receiving care unless the owner, operator, employee, or contractor is a family member of the individual, the cohabitant of the individual, or a descendant of the cohabitant; or

(3) the potential default surrogate refuses to provide a timely declaration under Section 12(c).

Comment

The provisions of this Section disqualify certain individuals from acting as a default surrogate, either because of the patient's stated wishes or as a matter of law.

Subsection (a) permits the individual to disqualify any other individual from acting as the patient's default surrogate. This ability is not conditioned on the patient having capacity; patients without capacity may have a strong sense that they do not feel comfortable with a particular individual making decisions for them, and the Act takes the position that such opinions should be respected regardless of the patient's cognitive disability.

Subsection (b)(1) disqualifies an individual who has been found by a court to pose a risk to the individual, regardless of whether the court has imposed a restraining order.

Subsection (b)(2) disqualifies an owner, operator, employee, or contractor of a nursing home or other residential care facility at which a patient is receiving care from acting as the patient's surrogate unless related to the patient. This disqualification is similar to that for appointed agents. For the definition of "family member," see Section 2(8).

Subsection (b)(3) disqualifies an individual who has refused to provide the written declaration required under Section 12(c) in a timely manner.

Section 15. Revocation

(a) An individual may revoke the appointment of an agent, the designation of a default surrogate, or a health-care instruction in whole or in part, unless:

(1) a court finds the individual lacks capacity to do so; [or]

(2) the individual is found under Section 4(b) to lack capacity to do so and, if the individual objects to the finding, the finding is confirmed under Section 5(d)(4)[; or

(3) the individual created an advance mental health-care directive that includes the provision under Section 9(d) and the individual is experiencing the psychiatric or psychological event specified in the directive].

(b) Revocation under subsection (a) may be by any act of the individual that clearly

indicates that the individual intends to revoke the appointment, designation, or instruction, including an oral statement to a health-care professional.

(c) Except as provided in Section 10, an advance health-care directive of an individual that conflicts with another advance health-care directive of the individual revokes the earlier directive to the extent of the conflict.

(d) Unless otherwise provided in an individual's advance health-care directive appointing an agent, the appointment of a spouse[or domestic partner] of an individual as agent for the individual is revoked if:

(1) a petition for annulment, divorce, dissolution of marriage, legal separation, or termination has been filed and not dismissed or withdrawn;

(2) a decree of annulment, divorce, dissolution of marriage, legal separation, or termination has been issued;

(3) the individual and the spouse[or domestic partner] have agreed in a record to a legal separation; or

(4) the spouse[or domestic partner] has [abandoned] the individual for more than one year.

Legislative Note: *A state that wishes to include an option for a Ulysses clause in an advance mental health care directive by including Section 9(d) and (e) should also include subsection (a)(3).*

Comment

This Section governs revocation of advance directives, including advance directives for mental health care. It allows for an advance directive to be revoked by a wide variety of acts.

With one caveat, subsection (a) allows an individual to revoke an appointment of an agent, the designation of a default surrogate, or a health-care instruction so long as they have not been found by a court or under Section 4, to lack capacity to do so. The caveat is that an individual cannot revoke an advance directive if doing so is inconsistent with their direction in an advance mental health-care directive that contains the Ulysses clause option enabled by Section 9(d).

It is possible that an individual would lack the capacity to make a particular health-care decision, but retain the capacity to revoke the appointment or designation, or vice versa. For example, the individual might not be able to understand a complex medical decision but know that they no longer want their sister, who they previously appointed but with whom they subsequently had a falling out, to make decisions for them.

Subsection (b) explains that a revocation can be accomplished by any act clearly indicating intent to revoke.

Subsection (c) explains that a subsequent advance health-care directive revokes a prior advance health-care directive to the extent that the two conflict. If there is no conflict, both are effective.

Subsection (d) automatically revokes the appointment of a spouse or domestic partner as agent upon the filing of an action for divorce or other change in legal status, a court order changing their legal status, an agreed upon separation evidenced by a record, or abandonment.

Section 16. Validity of Advance Health-Care Directive; Conflict with Other Law

(a) An advance health-care directive created outside this state is valid if it complies with:

(1) the law of the state specified in the directive or, if a state is not specified, the state in which the individual created the directive; or

(2) this [act].

(b) A person may assume without inquiry that an advance health-care directive is genuine, valid, and still in effect, and may implement and rely on it, unless the person has good cause to believe the directive is invalid or has been revoked.

(c) An advance health-care directive, revocation of a directive, or a signature on a directive or revocation may not be denied legal effect or enforceability solely because it is in electronic form.

(d) Evidence relating to an advance health-care directive, revocation of a directive, or a signature on a directive or revocation may not be excluded in a proceeding solely because the evidence is in electronic form.

(e) This [act] does not affect the validity of an electronic record or signature that is valid

under [cite to state's Uniform Electronic Transactions Act].

(f) If this [act] conflicts with other law of this state relating to the creation, execution, implementation, or revocation of an advance health-care directive, this [act] prevails.

Comment

This Section governs the portability of advance health-care directives, something especially important for individuals who travel, move, or live in multiple jurisdictions. Under this Section, the directive is valid if it complied with the procedural and substantive requirements of the state in which the individual was physically located at the time the individual created it or in the state in which the document is presented. Because this Section provides that an advance health-care directive is presumed to be valid, a health-care professional need not look behind the document unless the professional has good cause to believe it is invalid or has been revoked. In addition, this Section provides that an advance health-care directive or revocation of a directive may not be denied legal effect or enforceability simply because it is in an electronic form, as such directives increasingly are. Finally, if the document contains a choice-of-law provision, that provision will be honored.

Section 17. Duties of Agent and Default Surrogate

(a) An agent or default surrogate has a fiduciary duty to the individual for whom the agent or default surrogate is acting when exercising or purporting to exercise a power under Section 18.

(b) An agent or default surrogate shall make a health-care decision in accordance with the direction of the individual in an advance health-care directive and other goals, preferences, and wishes of the individual to the extent known or reasonably ascertainable by the agent or default surrogate.

(c) If there is not a direction in an advance health-care directive and the goals, preferences, and wishes of the individual regarding a health-care decision are not known or reasonably ascertainable by the agent or default surrogate, the agent or default surrogate shall make the decision in accordance with the agent's or default surrogate's determination of the individual's best interest.

(d) In determining the individual's best interest under subsection (c), the agent or default surrogate shall:

(1) give primary consideration to the individual's contemporaneous communications, including verbal and nonverbal expressions;

(2) consider the individual's values to the extent known or reasonably ascertainable by the agent or default surrogate; and

(3) consider the risks and benefits of the potential health-care decision.

(e) As soon as reasonably feasible, an agent or default surrogate who is informed of a revocation of an advance health-care directive or disqualification of the agent or default surrogate shall communicate the revocation or disqualification to a responsible health-care professional.

Comment

Once someone begins to act as an agent or default surrogate, they assume a fiduciary duty to the individual for whom they are making or purporting to make a health-care decision. This means that the agent or default surrogate must exercise reasonable care, diligence, and prudence in acting on behalf of that individual. It also means that the agent or default surrogate must act in a manner that is loyal to the individual. That will require the agent or default surrogate to put the wishes and interests of the individual first when making decisions for the individual, even if that results in choices that are inconsistent with the agent or default surrogate's own wishes and interests.

Subsections (b), (c) and (d) provide guidance as to the factors to be considered when making a health-care decision under the Act.

In subsection (b), the agent or default surrogate is instructed to make the decision the individual would have made if able. This approach is usually referred to as a "substituted judgment" standard. Notably, the preferences need not have been expressed exclusively prior to the onset of lack of capacity. Contemporaneous expressions may also be considered.

Subsections (c) and (d) allow an agent or default surrogate who does not know and cannot reasonably ascertain an individual's preferences, to act in the individual's interest. It then spells out factors to be considered in determining an individual's best interest. The emphasis is on considering the individual's contemporaneous expressions and values. For example, if the patient expressed pain during a certain treatment, the surrogate should take that into account in

determining whether that treatment is in the interest of the patient. Similarly, if the patient expresses pleasure when engaging in certain behavior, the surrogate should take that into account when making choices that would impact the patient's ability to engage in the behavior. Thus, even though the surrogate does know what the individual would have wanted prior to lacking the capacity to make decisions, the surrogate may be able to make an individualized determination as to what is in the patient's interest.

Subsection (e) imposes a duty on an agent or default surrogate who is informed of a revocation or disqualification to communicate it to a responsible health-care professional as soon as reasonably feasible.

Section 18. Powers of Agent and Default Surrogate

(a) Except as provided in subsection (c), the power of an agent or default surrogate commences when the individual is found under Section 4(b) or by a court to lack capacity to make a health-care decision. The power ceases if the individual later is found to have capacity to make a health-care decision, or the individual objects under Section 5(c) to the finding of lack of capacity under Section 4(b). The power resumes if:

(1) the power ceased because the individual objected under Section 5(c); and

(2) the finding of lack of capacity is confirmed under Section 5(d)(4) or a court finds that the individual lacks capacity to make a health-care decision.

(b) An agent or default surrogate may request, receive, examine, copy, and consent to the disclosure of medical and other health-care information about the individual if the individual would have the right to request, receive, examine, copy, or consent to the disclosure of the information.

(c) A power of attorney for health care may provide that the power of an agent under subsection (b) commences on appointment.

(d) If no other person is authorized to do so, an agent or default surrogate may apply for public or private health insurance and benefits on behalf of the individual. An agent or default surrogate who may apply for insurance and benefits does not, solely by reason of the power,

have a duty to apply for the insurance or benefits.

(e) An agent or default surrogate may not consent to voluntary admission of the individual to a facility for mental health treatment unless:

(1) voluntary admission is specifically authorized by the individual in an advance health-care directive in a record; and

(2) the admission is for no more than the maximum of the number of days specified in the directive or [insert the number of days a guardian may commit an adult subject to guardianship without using the state's involuntary commitment procedure], whichever is less.

(f) Except as provided in subsection (g), an agent or default surrogate may not consent to placement of the individual in a nursing home if the placement is intended to be for more than [100] days if:

(1) an alternative living arrangement is reasonably feasible;

(2) the individual objects to the placement; or

(3) the individual is not terminally ill.

(g) If specifically authorized by the individual in an advance health-care directive in a record, an agent or default surrogate may consent to placement of the individual in a nursing home for more than [100] days even if:

(1) an alternative living arrangement is reasonably feasible;

(2) the individual objects to the placement; and

(3) the individual is not terminally ill.

Comment

This Section governs the general powers of an agent or default surrogate. It also allows for additional powers to be explicitly granted to an agent.

An agent under a power of attorney for health care or a default surrogate may not make decisions

for an individual unless the individual lacks capacity to make those decisions for themselves. Thus, the power to consent to or refuse to consent to the provision of health care can be said to be "springing." The fact that the power is not immediately effective, however, does not mean that the individual with capacity cannot choose to defer to the agent's judgment in making decisions. To the contrary, an individual with capacity faced with a health-care decision could instruct a health-care professional to provide the care the agent thinks best in the particular situation.

The power of an agent to obtain and disclose the individual's health-care information, by contrast, commences upon appointment if the individual has so specified in an advance directive. The rationale for allowing immediate powers in this limited context is two-fold. First, making the power immediately effective allows an agent to obtain information that may be needed to determine if they should act as agent for the individual (e.g., does the individual lack capacity). Second, many people with capacity may wish to be supported by their agent in making decisions, even if they are ultimately making those decisions themselves. Agents will be better able to provide this type of decision-making support if they have the power to obtain and, where appropriate, share health-care information.

Subsection (d) allows the surrogate to apply for health-care benefits if no other person has authority to do so. This is a limited power and does not give the surrogate the power to do all things that might be necessary to establish eligibility for benefits. For example, it does not give the surrogate the power to spend-down assets to accelerate eligibility for Medicaid or other means-tested benefits. Subsection (d), moreover, merely permits the surrogate to apply for benefits; it does not create any duty for the surrogate to do so.

Subsections (e), (f), and (g) set forth two types of powers, in addition to the power to immediately access and disclose health-care information, that an agent or default surrogate has if explicitly granted by the terms of the power of attorney for health care.

First, an agent or default surrogate does not have the authority to consent to voluntary admission of the individual to a facility for mental health treatment unless expressly authorized to do so. Even if express authorization is given, however, the agent or surrogate cannot consent to voluntary admission for more than the greater of (1) the number days specified in the directive or (2) the number of days a guardian may commit an adult subject to guardianship without using the state's involuntary commitment procedure.

Second, an agent or surrogate has limited ability to consent to the long-term placement of an individual in a nursing home without express authorization. Specifically, without express authorization, the agent or surrogate may not consent to the placement for more than the period of time specified in the statute over the individual's contemporaneous objection unless (1) no alternative living arrangement is reasonably feasible or (2) the individual is terminally ill. The Act suggests 100 days as the time frame the state might use for this provision. That reflects, in part, a recognition that the federal Medicare program covers up to 100 days of nursing home care for qualified beneficiaries.

Section 19. Limitation on Powers

(a) If an individual has a long-term disability requiring routine treatment by artificial nutrition, hydration, or mechanical ventilation and a history of using the treatment without objection, an agent or default surrogate may not consent to withhold or withdraw the treatment unless:

(1) the treatment is not necessary to sustain the individual's life or maintain the individual's well-being;

(2) the individual has expressly authorized the withholding or withdrawal in a health-care instruction that has not been revoked; or

(3) the individual has experienced a major reduction in health or functional ability from which the individual is not expected to recover, even with other appropriate treatment, and the individual has not:

(A) given a direction inconsistent with withholding or withdrawal; or

(B) communicated by verbal or nonverbal expression a desire for artificial nutrition, hydration, or mechanical ventilation.

(b) A default surrogate may not make a health-care decision if, under other law of this state, the decision:

(1) may not be made by a guardian; or

(2) may be made by a guardian only if the court appointing the guardian specifically authorizes the guardian to make the decision.

Comment

The limitation on the surrogate's authority in subsection (a) recognizes that the use of artificial nutrition, hydration, and mechanical ventilation can be routine health care for some individuals with disabilities.

Subsection (b) denies a default surrogate the power to make a health-care decision if, under a state's other law, a guardian is prohibited from making that decision or is only permitted to make

that decision with specific court authorization. This provision is intended to prevent the default surrogate option from becoming an end-run around protections for individuals with disabilities that are found in states' guardianship laws. For example, if a state prohibits a guardian from consenting to sterilization of an individual without prior court approval, subsection (b) would deny a default surrogate the power to consent to sterilization. Thus, sterilization of an individual who lacks the ability to consent to it, and who has not themselves authorized that procedure by creating an advance directive, would be legally permitted only if court approval was obtained. One effect of subsection (b) may be to effectively require that a guardian be appointed, or a court order in lieu of guardianship (such as those authorized under Article 5 of the Guardianship Act) to be granted, before certain types of health care may be provided to an individual who has not appointed an agent.

Section 20. Co-Agents; Alternate Agent

(a) An individual in a power of attorney for health care may appoint multiple individuals as co-agents. Unless the power of attorney provides otherwise, each co-agent may exercise independent authority.

(b) An individual in a power of attorney for health care may appoint one or more individuals to act as alternate agents if a predecessor agent resigns, dies, becomes disqualified, is not reasonably available, or otherwise is unwilling or unable to act as agent.

(c) Unless the power of attorney provides otherwise, an alternate agent has the same authority as the original agent:

(1) at any time the original agent is not reasonably available or is otherwise unwilling or unable to act, for the duration of the unavailability, unwillingness, or inability to act; or

(2) if the original agent and all other predecessor agents have resigned or died or are disqualified from acting as agent.

Comment

This Section allows an individual to appoint more than one individual to serve as an agent. Where co-agents are appointed, subsection (a) establishes a default rule that each agent may act separately. An individual can opt out of this default by stating a different rule in the power of attorney for health care that appoints the co-agents. Thus, an individual naming co-agents could

require co-agents to reach consensus as to any health care decision or could stipulate that the views of the majority of individuals appointed as co-agents govern.
This Section also allows an individual to appoint one or more alternate agents to serve when the original agent or co-agents cannot or will not. It will typically be advisable for an individual to appoint one or more alternate agents.

Section 21. Duties of Health-Care Professional, Responsible Health-Care Professional, and Health-Care Institution

(a) A responsible health-care professional who is aware that an individual has been found to lack capacity to make a decision shall make a reasonable effort to determine if the individual has a surrogate.

(b) If possible before implementing a health-care decision made by a surrogate, a responsible health-care professional as soon as reasonably feasible shall communicate to the individual the decision made and the identity of the surrogate.

(c) A responsible health-care professional who makes or is informed of a finding that an individual lacks capacity to make a health-care decision or no longer lacks capacity, or that other circumstances exist that affect a health-care instruction or the authority of a surrogate, as soon as reasonably feasible, shall:

(1) document the finding or circumstance in the individual's medical record; and

(2) if possible, communicate to the individual and the individual's surrogate the finding or circumstance and that the individual may object under Section 5(c) to the finding under Section 4(b).

(d) A responsible health-care professional who is informed that an individual has created or revoked an advance health-care directive, or that a surrogate for an individual has been appointed, designated, or disqualified, shall:

(1) document the information as soon as reasonably feasible in the individual's

medical record; and

(2) if evidence of the directive, revocation, appointment, designation, or disqualification is in a record, request a copy and, on receipt, cause the copy to be included in the individual's medical record.

(e) Except as provided in subsections (f) and (g), a health-care professional or health-care institution providing health care to an individual shall comply with:

(1) a health-care instruction given by the individual regarding the individual's health care;

(2) a reasonable interpretation by the individual's surrogate of an instruction given by the individual; and

(3) a health-care decision for the individual made by the individual's surrogate in accordance with Sections 17 and 18 to the same extent as if the decision had been made by the individual at a time when the individual had capacity.

(f) A health-care professional or a health-care institution may refuse to provide health care consistent with a health-care instruction or health-care decision if:

(1) the instruction or decision is contrary to a policy of the health-care institution providing care to the individual that is based expressly on reasons of conscience and the policy was timely communicated to the individual or to the individual's surrogate;

(2) the care would require health care that is not available to the professional or institution; or

(3) compliance with the instruction or decision would:

(A) require the professional to provide care that is contrary to the professional's religious belief or moral conviction if other law permits the professional to refuse

to provide care for that reason;

(B) require the professional or institution to provide care that is contrary to generally accepted health-care standards applicable to the professional or institution; or

(C) violate a court order or other law.

(g) A health-care professional or health-care institution that refuses to provide care under subsection (f) shall:

(1) as soon as reasonably feasible, inform the individual, if possible, and the individual's surrogate of the refusal;

(2) immediately make a reasonable effort to transfer the individual to another health-care professional or health-care institution that is willing to comply with the instruction or decision; and

(3) either:

(A) if care is refused under subsection (f)(1) or (2), provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible, until a transfer is made; or

(B) if care is refused under subsection (f)(3), provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards, until a transfer is made or, if the professional or institution reasonably believes that a transfer cannot be made, for at least [10] days after the refusal.

Comment

This Section discusses health-care professionals' and institutions' obligations.

Subsection (a) requires a responsible health-care professional who knows that a patient has been found to lack capacity to make a health-care decision to make a reasonable effort to figure out if the patient has a surrogate. This increases the likelihood that decisions will be made by the agent chosen by the patient, if the patient has appointed an agent.

Subsection (b) further reinforces the Act's respect for patient self-determination by requiring a responsible health-care professional, if possible, to communicate to a patient, prior to implementation, a health-care decision made for the patient and the identity of the person making the decision.

Subsection (c) requires a responsible health-care professional who is aware of certain information related to an actual or potential change in capacity to document that knowledge and share the information with the individual and the individual's surrogate if possible. When a finding that the individual no longer lacks capacity has been made, this requirement helps ensure that surrogates are aware that their authority has ceased. Similarly, when a finding that the individual lacks capacity has been made, the requirement also helps ensure that the individual knows so that the individual can object to that finding.

Subsection (d), which requires a responsible health-care professional to reflect the existence or revocation of an advance directive in a patient's medical record, is intended to reduce the risk that a health-care professional will fail to comply with an advance directive that is in effect, or will rely on an advance directive that is no longer valid.

Subsection (e) requires health-care professionals and institutions to comply, absent an exception in subsection (f), with a patient's health-care instruction and with a reasonable interpretation of that instruction made by a person then authorized to make that health-care decision for the patient. A health-care professional or institution must also comply with a health-care decision made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity. These requirements help to protect the individual's right to self-determination and effectuate the surrogate decision making authorized by the Act.

Section (f) sets forth limited situations in which a responsible health-care professional may lawfully refuse to comply with a health-care instruction or decision. Subsection (f)(1) provides that failure to comply is permitted if the instruction or decision is contrary to a policy of the health-care institution providing health care to the individual which is expressly based on reasons of conscience and the policy was timely communicated to the individual who gave the instruction or about whom the decision was to be made or to the individual's surrogate. Subsection (f)(2) permits non-compliance if compliance would require the use of a form of care or treatment that is not available to the professional or institution. Subsection (f)(3) permits non-compliance if compliance would require the provision of care that is contrary to accepted medical standards. This would include care that is medically ineffective. It also permits non-compliance if compliance would violate a court order or other law.

In addition, subsection (f)(3)(a) recognizes that compliance is not required if other law—whether federal or state—permits non-compliance because compliance would require a professional to provide care that is contrary to the professional's religious beliefs or moral convictions. This provision thus neither expands nor constricts conscience-based objections created by other law. It simply acknowledges that other law may authorize a conscience-based exception and makes clear that the obligations in subsection (e) do not displace that other law.

Subsection (g) prescribes obligations for a health-care professional or institution that refuses to comply with an instruction or health-care decision. Regardless of the reason for the refusal, a health care-professional or institution must communicate the refusal to the patient, if possible, and to any person authorized to make health-care decisions for the patient. What more might be required depends on the reason for the refusal. If the refusal is under (f)(1) or (2)—the provisions governing refusals for reasons particular to the provider—the professional or institution must immediately make all reasonable efforts to effect the transfer of the patient to another health-care professional or health-care institution that is willing to comply with the instruction or decision. The professional or institution must also provide life-sustaining care and comfort care consistent with accepted medical standards until transfer is made. By contrast, if the refusal is under (f)(3), these obligations are time-limited. The individual, or persons interested in the welfare of the individual, may use the time in which continuing care must be provided to try to find a willing provider, ask a court to determine whether there is a basis for refusal, or prepare for discharge.

Section 22. Decision by Guardian

(a) A guardian may refuse to comply with or revoke the individual's advance health-care directive only if the court appointing the guardian expressly orders the noncompliance or revocation.

(b) Unless a court orders otherwise, a health-care decision made by an agent appointed by an individual subject to guardianship prevails over a decision of the guardian appointed for the individual.

Legislative Note: *If necessary to avoid a conflict with this act, a state should amend its guardianship laws*.

Comment

This Section is consistent with the Guardianship Act. It governs the relationship between a guardian and a health care agent.

Section 23. Immunity

(a) A health-care professional or health-care institution acting in good faith is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying with a health-care decision made for an individual by another person if compliance is based on a reasonable belief that the person has authority to make the

decision, including a decision to withhold or withdraw health care;

(2) refusing to comply with a health-care decision made for an individual by another person if the refusal is based on a reasonable belief that the person lacked authority or capacity to make the decision;

(3) complying with an advance health-care directive based on a reasonable belief that the directive is valid;

(4) refusing to comply with an advance health-care directive based on a reasonable belief that the directive is not valid, including a reasonable belief that the directive was not made by the individual or, after its creation, was substantively altered by a person other than the individual who created it; [or]

(5) determining that an individual who otherwise might be authorized to act as an agent or default surrogate is not reasonably available[; or

(6) complying with an individual's direction under Section 9(d)].

(b) An agent, default surrogate, or individual with a reasonable belief that the individual is an agent or a default surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for a health-care decision made in a good faith effort to comply with Section 17.

Legislative Note: *A state that includes Section 9(d) and (e) to permit a Ulysses clause in an advance mental health-care directive should also include subsection (a)(6).*

Comment

This Section provides immunities for providers, agents, and default surrogates who undertake or fail to take certain actions covered by the Act. It does not provide immunity from liability that stems from allegedly deficient health-care treatment.

Subsection (a) provides immunity to a health-care professional who complies with an instruction of an individual who lacks authority to provide that instruction if the professional is acting in good faith and reasonably believes the person has such authority. Similarly, it provides immunity

to a professional acting in good faith who refuses to comply with an instruction by a person who does have such authority if the professional reasonably believes that the person does not have authority to make it, or that the instruction was not made by the patient or was subsequently altered by someone other than the patient. Thus, a provider who reasonably and in good faith believes that an advance directive has been tampered with or is a fake, may refuse to comply with the directive. Subsection (a) also provides immunity to a professional who, acting in good faith, reasonably determines that an agent or would-be default surrogate is not willing or able to assume the duties of an agent or default surrogate, and who therefore looks to someone else to make decisions for a patient. This includes a determination made under Section 12(d).

Subsection (b) provides immunity to agents and default surrogates who make health-care decisions in good faith. The underlying health-care decision need not be reasonable for immunity to apply. This allows the agent or default surrogate confidently to make decisions consistent with the individual's wishes, even if those decisions might not appear objectively reasonable to others.

Subsection (b) also protects from liability individuals who mistakenly but reasonably believe they have the authority to make a health-care decision for a patient. For example, an individual designated as agent in a power of attorney for health care might assume authority unaware that the power has been revoked. Or a family member might assume authority to act as a default surrogate unaware that a family member having a higher priority under Section 12 is reasonably available and authorized to act.

Section 24. Prohibited Conduct; Damages

(a) A person may not:

(1) intentionally falsify, in whole or in part, an advance health-care directive;

(2) for the purpose of frustrating the intent of the individual who created an advance health-care directive or with knowledge that doing so is likely to frustrate the intent:

(A) intentionally conceal, deface, obliterate, or delete the directive or a revocation of the directive without consent of the individual who created or revoked the directive; or

(B) intentionally withhold knowledge of the existence or revocation of the directive from a responsible health-care professional or health-care institution providing health care to the individual who created or revoked the directive;

(3) coerce or fraudulently induce an individual to create, revoke, or refrain from

creating or revoking an advance health-care directive or a part of a directive; or

(4) require or prohibit the creation or revocation of an advance health-care directive as a condition for providing health care.

(b) An individual who is the subject of conduct prohibited under subsection (a), or the individual's estate, has a cause of action against a person that violates subsection (a) for statutory damages of $[25,000] or actual damages resulting from the violation, whichever is greater.

(c) Subject to subsection (d), an individual who makes a health-care instruction, or the individual's estate, has a cause of action against a health-care professional or health-care institution that intentionally violates Section 21 for statutory damages of $[50,000] or actual damages resulting from the violation, whichever is greater.

(d) A health-care professional who is an [emergency medical responder] is not liable under subsection (c) for a violation of Section 21(e) if:

(1) the violation occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care was appropriate to avoid imminent loss of life or serious harm to the individual;

(2) the failure to comply is consistent with accepted standards of the profession of the professional; and

(3) the provision of care does not begin in a health-care institution in which the individual resides or was receiving care.

(e) In an action under this section, a prevailing plaintiff may recover reasonable attorney's fees, court costs, and other reasonable litigation expenses.

(f) A cause of action or remedy under this section is in addition to any cause of action or remedy under other law.

Legislative Note: *In subsection (d), a state should insert in the brackets the term used in the state to describe first responders.*

Comment

This Section prohibits certain conduct that would undermine the purpose of the Act. Unlike the 1993 Act, this Section expressly provides a private right of action, thus enabling the provisions of this Act to be directly enforced by the individual or the individual's estate.

Subsection (a) details prohibited conduct. Among other things, it prohibits coercing or fraudulently inducing an individual to create, revoke, or refrain from creating or revoking an advance health-care directive. It does not explicitly prohibit the use of "undue influence" as what constitutes "undue influence" is subjective and the concept has been criticized for enabling collateral attacks on individuals in non-traditional relationships or who make non-normative choices. See, e.g., Carla Spivack, *Why the Testamentary Doctrine of Undue Influence Should be Abolished*, 8 U. KAN. L. REV. 245 (2010) (summarizing prior critiques of the doctrine and arguing that its lack of clarity creates risk of unfair and unpredictable outcomes). However, much of the behavior that might be categorized as "undue influence" is captured by coercion and fraud. Subsection (a)(4), forbidding a health-care professional or institution to condition provision of health care on execution, non-execution, or revocation of an advance health-care directive, tracks the provisions of the federal Patient Self-Determination Act (42 U.S.C. 1395cc(f)(1)(C) (Medicare); 42 U.S.C. § 1396a(w)(1)(C) (Medicaid).

Subsections (b) and (c) establish minimum damage awards. A statutory damage provision is important because actual damages in these situations are often minimal, and thus provide little incentive for compliance. The enacting state will have to determine the amount of damages that should be authorized in order to encourage the level of potential private enforcement actions necessary to result in compliance with the obligations and responsibilities imposed by the Act. The damages provided by this Section do not supersede but are in addition to remedies available under other law.

Subsection (d) provides immunity to certain emergency medical responders who do not comply with a health-care instruction, or a reasonable interpretation of a health-care instruction, and thus violate Section 21(e). Specifically, it provides immunity where the violation of Section 21(e) occurred when the responder was providing care to an individual who was experiencing an urgent health condition. To obtain this immunity, the responder must have acted in a manner consistent with accepted standards of the responder's profession and the responder must have reasonably believed that the care provided by the responder was appropriate to avoid imminent loss of life or serious harm. The immunity does not apply in situations in which a responder is providing such care in a health-care institution in which the individual resides or was receiving care. For example, the provision would protect first responders who provide emergency medical care to an individual who experiences a heart attack or other life-threatening event at their house, in their apartment, or on the street. However, it would not provide such protection where the individual is receiving care in a health-care institution, a setting in which individuals should be able to expect their instructions, if known, to be followed.

As set forth in Subsection (f), the Act does not limit any claims that exist under other law of the

enacting state, including tort liability for medical malpractice. Thus, although subsection (a)(1)-(4) only apply to intentional misconduct, state tort law may provide a remedy for negligently engaging in the behaviors listed. Similarly, although subsections (b) and (c) only provide for actual damages or statutory damages, punitive damages might be available under other state law.

Section 25. Effect of Copy; Certified Physical Copy

(a) A physical or electronic copy of an advance health-care directive, revocation of an advance health-care directive, or appointment, designation, or disqualification of a surrogate has the same effect as the original.

(b) An individual may create a certified physical copy of an advance health-care directive or revocation of an advance health-care directive that is in electronic form by affirming under penalty of perjury that the physical copy is a complete and accurate copy of the directive or revocation.

Comment

The need to rely on an advance health-care directive may arise when the original is not readily accessible. For example, an individual may be receiving care from several health-care professionals or may be receiving care at a location distant from that where the original directive is kept. To facilitate prompt and informed decision making, this Section provides that a copy of an advance health-care directive, a revocation of a health-care directive, or a designation or disqualification of a surrogate in a record has the same effect as the original. The Section also recognizes the growing use of documents in electronic form.

Section 26. Judicial Relief

(a) On petition of an individual, the individual's surrogate, a health-care professional or health-care institution providing health care to the individual, or a person interested in the welfare of the individual, the court may:

(1) enjoin implementation of a health-care decision made by an agent or default surrogate on behalf of the individual, on a finding that the decision is inconsistent with Section 17 or 18;

(2) enjoin an agent from making a health-care decision for the individual, on a

finding that the individual's appointment of the agent has been revoked or the agent:

(A) is disqualified under Section 8(b);

(B) is unwilling or unable to comply with Section 17; or

(C) poses a danger to the individual's well-being;

(3) enjoin another individual from acting as a default surrogate, on a finding that the other individual acting as a default surrogate did not comply with Section 12 or the other individual:

(A) is disqualified under Section 14;

(B) is unwilling or unable to comply with Section 17; or

(C) poses a danger to the first individual's well-being; or

(4) order implementation of a health-care decision made:

(A) by and for the individual; or

(B) by an agent or default surrogate who is acting in compliance with the powers and duties of the agent or default surrogate.

(b) In this [act], advocacy for the withholding or withdrawal of health care or mental health care from an individual is not itself evidence that an agent or default surrogate, or a potential agent or default surrogate, poses a danger to the individual's well-being.

(c) A proceeding under this section is governed by [cite to the state's rules of procedure or statutory provisions governing expedited proceedings and proceedings affecting persons found or alleged to lack capacity].

Comment

While the provisions of the Act are in general to be effectuated without litigation, situations will arise where judicial proceedings may be appropriate. For example, a court may be called upon to determine whether a particular individual has authority to act as an agent or default surrogate or whether an agent's or default surrogate's purported decision on behalf of a patient is consistent

with the agent's or default surrogate's underlying duties or powers. Decisions made by guardians, however, are outside of the scope of this Act and are therefore excluded from the provisions of this Section. A state's guardianship laws will govern who has authority to challenge the decision of a guardian.

A court acting under this Section may grant only equitable relief. Other adequate avenues exist for those who wish to pursue money damages. The class of potential petitioners is limited to those with a direct interest in an individual's health care or well-being.

Section 27. Construction

(a) This [act] does not authorize mercy killing, assisted suicide, or euthanasia.

(b) This [act] does not affect other law of this state governing treatment for mental illness of an individual involuntarily committed to a [mental health-care institution] under [cite to state law governing involuntary commitments].

(c) Death of an individual caused by withholding or withdrawing health care in accordance with this [act] does not constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity.

(d) This [act] does not create a presumption concerning the intention of an individual who has not created an advance health-care directive.

(e) An advance health-care directive created before, on, or after [the effective date of this [act]] must be interpreted in accordance with other law of this state, excluding the state's choice-of-law rules, at the time the directive is implemented.

Legislative Note: *In subsection (b), include in the brackets the name for a mental health facility used in the state's law governing involuntary commitments and cite to the law.*

Comment

In the interest of avoiding all confusion, this Section clearly states certain things that the Act does not do. It also states that death caused by withholding or withdrawing health care in accordance with the Act does not constitute suicide or homicide, nor does it impair or invalidate an insurance policy or annuity providing a death benefit.

Section 28. Uniformity of Application and Construction

In applying and construing this uniform act, a court shall consider the promotion of uniformity of the law among jurisdictions that enact it.

Section 29. Saving Provisions

(a) An advance health-care directive created before [the effective date of this [act]] is valid if it complies with this [act] or complied at the time of creation with the law of the state in which it was created.

(b) This [act] does not affect the validity or effect of an act done before [the effective date of this [act]].

(c) An individual who assumed authority to act as default surrogate before [the effective date of this [act]] may continue to act as default surrogate until the individual for whom the default surrogate is acting has capacity or the default surrogate is disqualified, whichever occurs first.

Comment

An advance directive created before the Act became effective in a state is valid if it satisfies the requirements for validity in existence at the time the directive was created or if it satisfies the requirements for validity under this Act. However, under Section 27(e) the contents of the advance directive, including the powers and duties of agents appointed under the advance directive, by contrast, are to be interpreted according to the law after the date of enactment.

Section 30. Transitional Provision

This [act] applies to an advance health-care directive created before, on, or after [the effective date of this [act]].

[Section 31. Severability

If a provision of this [act] or its application to a person or circumstance is held invalid, the invalidity does not affect another provision or application that can be given effect without the

invalid provision.]

Legislative Note: *Include this section only if the state lacks a general severability statute or a decision by the highest court of the state stating a general rule of severability.*

Section 32. Repeals; Conforming Amendments

(a) [The Uniform Health-Care Decisions Act] is repealed.

(b) . . .

Legislative Note: *A state that has enacted the Uniform Health-Care Decisions Act or comparable statute should repeal it.*

A state should examine its statutes to determine whether repeals or conforming revisions are required by Section 8 {Power of Attorney for Health Care} and other provisions of this act relating to health-care powers of attorney, Section 22 {Decision by Guardian} and other provisions of this act relating to guardians.

Section 33. Effective Date

This [act] takes effect . . .