D R A F T

FOR DISCUSSION ONLY

# Health-Care Decisions Act (2023)

Uniform Law Commission

April 22−23, 2022 Drafting Committee Meeting



*This draft, including the proposed statutory language and any comments or reporter's notes, has not been reviewed or approved by the Uniform Law Commission or the drafting committee. It does not necessarily reflect the views of the Uniform Law Commission, its commissioners, the drafting committee, or the committee's members or reporter.*

April 18, 2022

**Health-Care Decisions Act (2023)**

The Committee appointed by and representing the Uniform Law Commission in preparing this act consists of the following individuals:

| | |
|---|---|
| Nora Winkelman | Pennsylvania, *Chair* |
| Shea Backus | Nevada, *Vice Chair* |
| David M. English | Missouri |
| Norman L. Greene | New York |
| Jess O. Hale | Tennessee |
| Mary Gay Taylor Jones | Utah |
| Jacqueline T. Lenmark | Montana |
| Esson M. Miller | Virginia |
| William J. Quinlan | Illinois |
| Charles A. Trost | Tennessee |
| Suzanne B. Walsh | Connecticut |
| David J. Clark | California, *Division Chair* |
| Dan Robbins | California, *President* |

**Other Participants**

| | |
|---|---|
| Nina A. Kohn | New York, *Reporter* |
| Mary E. Anderson | Kentucky, *American Bar Association Advisor* |
| Gerard Brew | New Jersey, *American Bar Association Section Advisor* |
| Allan T. Hikoyeda | California, *American Bar Association Section Advisor* |
| Nathan Kottkamp | Tennessee, *American Bar Association Section Advisor* |
| Robyn S. Shapiro | Wisconsin, *American Bar Association Section Advisor* |
| Christine J. Wilson | California, *American Bar Association Section Advisor* |
| Steven L. Willborn | Nebraska, *Style Liaison* |
| Tim Schnabel | Illinois, *Executive Director* |

Copies of this act may be obtained from:

Uniform Law Commission
111 N. Wabash Ave., Suite 1010
Chicago, Illinois 60602
(312) 450-6600
www.uniformlaws.org

# Health-Care Decisions Act (2023)

## Table of Contents

# Health-Care Decisions Act (2023)

## Section 1. Title

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

## Comment

## Section 2. Definitions

In this [act]:

(1) "Advance health-care directive" means a power of attorney for health care or a health-care instruction.

(2) "Agent" means an individual appointed in a power of attorney for health care to make a health-care decision for the individual making the appointment.

(3) "Default surrogate" means an individual authorized under Section 11 to make a health-care decision for another individual.

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

(5) "Guardian" means a person appointed under other law by a court to make health-care decisions for an individual. The term includes a co-guardian. The term does not include a guardian ad litem.

(6) "Health care" means care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition.

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

(A) selection and discharge of health-care providers and health-care

institutions;

(B) approval or disapproval of health care, including diagnostic tests, surgical procedures, medication, and other therapeutic interventions; and

(C) directions to provide, withhold, or withdraw health care, including cardiac resuscitation, and artificial nutrition and hydration.

(8) “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.

(9) “Health-care instruction” means a direction, whether or not in a record, made by an individual that indicates the individual’s preference concerning provision of health care to the individual. The term includes a record which is intended to be effective at a future time if specified conditions arise.

(10) “Health-care provider” means a physician or other individual licensed, certified, or otherwise authorized or permitted by other law to provide health care in this state in the ordinary course of business or practice of the physician’s or individual’s profession.

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

(12) “Lacks capacity” means unable to understand and appreciate the nature and consequences of a decision or unable or unwilling to make or communicate a decision, even with appropriate services, technological assistance, supported decision making, or other reasonable accommodation.

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

(14) "Person interested in the welfare of an individual" means:

(A) a family member or friend of the individual;

(B) a public entity providing services to the individual; or

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

(15) "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]].

(16) "Power of attorney for health care" means a record granting an agent the authority to make health-care decisions for the individual granting the power.

(17) "Reasonably available" means able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of an individual's health-care need.

(18) "Record" means information:

(A) inscribed on a tangible medium; or

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

(19) "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.

(20) "Responsible health-care provider" means:

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

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

(21) "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.

(22) "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 potential consequences of the decision.

(23) "Surrogate" means:

(A) an agent appointed by an individual under this [act] to make health-care decisions for the individual;

(B) a default surrogate; or

(C) a guardian appointed under other law to make health-care decisions for an individual.

***Legislative Note*:** *If the state has separate terms for and laws authorizing the practice of general medicine and osteopathy, use both sets of bracketed language in paragraph (15) and insert citations 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 general medicine, the second set of bracketed language should be deleted.*

**Comment**

This Section begins by defining "advance 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 directions as well as those in a record. 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 upon which this Act is based. The change is designed to provide clarity, and to indicate that an instruction may include more than one piece of information.

This Section provides definitions to help differentiate different types of surrogate decision-makers. First, there is an "agent", who is a person appointed under a power of attorney for health care. The definition of "agent" is not limited to a single individual. The Act permits the appointment of co-agents, and back-up agents. Second, there is a "guardian", who is appointed by a court under other law. Third, there is a "default surrogate", who is authorized to make a health-care decision under Section 11 when there is neither an agent nor a guardian willing and able to make a decision.

The term "default surrogate" does not include an individual who might have such authority under a given set of circumstances which have not occurred (such as a relative with priority to serve this role should an individual with capacity subsequently lose that capacity and not have appointed a surrogate). All three types are referred to, 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 designed to provide clarity to users.

This Section also defines the subject matter covered by this Act with the term "health-care decisions" Consistent with the purposes of the Act, the Act defines "health-care decision" very broadly. The term can include decisions about a full range of medical interventions and types of providers from which to receive health care. It is not limited to decisions about care for certain body parts, but extends to, for example, dental and vision care.

The term "health-care decisions" 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 custodial care, provided at a "health-care institution". It also includes alternative medical treatment.

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

This Section also contains several definitions that were not in the original Act. New definitions include "lacks capacity" and "supported decision-making," both of which are consistent with definitions in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017).

The term "reasonably available" is used in the Act to accommodate the reality that individuals will sometimes not be timely available.

**Section 3. Presumptions; Validity of Health-Care Instruction**

(a) This [act] does not affect the right of an individual to make a health-care decision unless the individual lacks capacity to do so.

(b) An individual is presumed to have capacity to:

(1) make a health-care decision;

(2) designate or disqualify a default surrogate;

(3) subject to Section 4, make an advance health-care directive; and

(4) revoke an advance health-care directive.

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

(d) An advance health-care directive is valid if it complies with:

(1) the law of the state in which the individual created the advance directive;

(2) the law of the state in which the individual who created it was domiciled at the time it was created; or

(3) this [act], regardless of when or where it was created.

**Comment**

This Section brings together a variety of provisions that were scattered throughout the prior Act. Among other things, it clearly states that an individual is presumed to have capacity to create or revoke an advance directive, and to designate or disqualify a surrogate.

**Section 4. Capacity to Make Health-Care Advance Directive.**

(a) The presumption under Section 3(b)(3) regarding creation of a health-care instruction may be rebutted if a preponderance of evidence demonstrates that the individual making the

instruction does not have the ability to understand and appreciate the nature and consequences of health-care decisions, including the benefits and risks of the choices expressed in the instruction.

(b) The presumption under Section 3(b)(3) regarding creation of a health-care power of attorney may be rebutted if a preponderance of evidence demonstrates that the individual creating the power of attorney does not understand:

(1) the consequences of appointing an agent under the power of attorney; or

(2) the identity of the individual being appointed or the general nature of the individual's existing relationship with the individual being appointed.

**Comment**

This Section sets forth how a presumption that an individual has capacity to make an advance directive may be rebutted. What an individual must be able to understand to 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 would 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.

**Section 5. Determination of Lack of Capacity to Make Health-Care Decision**

(a) A determination that an individual lacks capacity to make a health-care decision may be made by a court or by any of the following individuals who has personally examined the individual and is not related by blood, marriage, [domestic partnership,] or adoption to the individual or the individual's surrogate:

(1) a physician; [or]

(2) a licensed psychologist[.]; [or]

[(3) a physician's assistant[.]; [or ]

[(4) an advanced practice registered nurse[.]; [or]

[(5) a licensed social worker with training and expertise in the determination of capacity.]

(b) If a determination is made that an individual lacks capacity to make a health-care decision because of mental illness, cognitive disability, or developmental disability, the individual making the determination must have training and expertise in the assessment of functional and cognitive abilities and limitations.

(c) A determination under this section must:

(1) be in a record signed by the individual making the determination;

(2) state the opinion of the individual making the determination as to the cause and nature of the other individual's lack of capacity to make a health-care decision and the extent and probable duration of the lack of capacity; and

(3) be made according to accepted standards of medical judgment and to a reasonable degree of medical certainty.

(d) A determination made under this section is presumed made according to accepted standards of medical judgment and to a reasonable degree of certainty unless shown otherwise by a preponderance of the evidence.

(e) A determination that an individual lacks capacity to make a health-care decision may apply to a particular health-care decision, to a specified set of health-care decisions, or to all health-care decisions.

(f) A health-care provider who makes or is informed of a determination that an individual lacks capacity or no longer lacks capacity, or that other circumstances exist that affect a health-care instruction or the authority of a surrogate, shall promptly record the determination or circumstance in the individual's medical record. As soon as reasonably possible, the provider

shall also communicate to the individual and, if possible, to the individual's surrogate**:**

(1) the determination or circumstance; and

(2) that the individual has a right to challenge the determination.

(g) If requested by an individual determined to lack capacity, the individual's surrogate, or another person interested in the welfare of the individual, a determination of lack of capacity to make a health-care decision is ineffective unless confirmed by another individual described in subsection (a). The second individual may not be a family member of, employed by, directly supervised by, or otherwise dependent upon the individual who made the first determination.

***Legislative Note:*** *If the state recognizes domestic partnerships, include the bracketed text in subsection (a) and wherever the term appears in this act.*

*In subsection (a), the state should decide whether to include physician's assistants, advanced practice registered nurses, and social workers in the list of health professionals who may make a determination that an individual lacks capacity and include the language in the brackets that reflects the decision.*

**Comment**

This Section sets forth who may determine that a person lacks capacity, and the nature of the determination. Unlike some states that require two persons to make the determination that a person lacks capacity, this provision only requires one unless the individual, their surrogate, or someone interested in the individual's welfare requests a second determination. The Section's primary purposes are to: (1) provide clarity for users (both providers and patients), and (2) create a minimum standard for triggering the authority of a surrogate.

As a practical matter, an individual completing the determination should have training as to the legal standards in this Act to be able to assess whether a person's cognitive and functional limitations satisfy that standard.

The presumption in subsection (d) only arises if the determination is made in accordance with the provisions of this section. Thus, it only arises if the determination is made in a signed record as required by subsection (c)(1) and states the opinion of the evaluator as required in subsection (c)(2).

Notably, consistent with the definition of "lacks capacity" in Section 2, 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 capacity to set goals for treatment, but not to select among therapies to meet those goals.

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 under which a medical provider can treat without consent. In these situations, treatment could be provided without consent even without a determination that the patient lacks capacity.

**Section 6. Objection to Determination of Lack of Capacity to Make Health-Care Decision**

(a) An individual determined to lack capacity under Section 5 may challenge the determination:

(1) in a record signed by the individual;

(2) by orally informing a health-care provider of the challenge; or

(3) by any other act that provides clear and convincing evidence that the individual wishes to challenge the determination.

(b) If a challenge is made under subsection (a):

(1) A health-care provider who is informed of the challenge shall promptly:

(A) communicate the challenge to a responsible health-care provider; and

(B) record the challenge in the individual's medical record or communicate the challenge to an administrator with responsibility for medical records of the health-care institution providing health care to the individual.

(2) The individual shall be treated as having capacity unless the court makes a determination under subsection (c) that the individual lacks capacity.

(c) An individual determined to lack capacity under Section 5, or another person interested in the welfare of the individual, may petition the [insert name of the appropriate local court in the state for capacity cases] court in the county in which the individual resides or is located to determine whether the individual lacks capacity. If a petition is filed under this

subsection, the court shall appoint a guardian ad litem to represent the individual for the purposes of this subsection. The court shall conduct a hearing on the petition as soon as possible but not later than [7] days after the petition is filed. As soon as possible but not later than [7] days after the hearing, the court shall determine whether the individual lacks capacity. The individual shall be found to lack capacity only if the court finds by clear and convincing evidence that the individual lacks capacity.

**Comment**

This Section addresses an important question on which the earlier Act was silent: what happens if the individual does not agree with the determination of incapacity.

In appointing a guardian ad litem, a court should prioritize appointment of someone with training and expertise in the type of abilities and limitations alleged.

**Section 7. Health-Care Instruction**

(a) A health-care instruction may include an individual's goals for health care and wishes regarding the provision, withholding, or withdrawal of a form of health care, including life-sustaining treatment and mental-health treatment, and the individual's preferences for:

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

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

(3) persons that the individual would or would not like to be consulted regarding health-care decisions for the individual;

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

(5) an individual to serve as an agent or default surrogate.

(b) A health-care provider to whom an individual communicates an instruction under subsection (a) shall record the instruction and the date of the instruction in the individual's medical record.

(c) A health-care instruction that conflicts with a prior health-care instruction, including an instruction reflected in a medical order, revokes the prior 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 indicating preference for care and those which appoint an agent—while recognizing that both may be created by a single document. This Section covers instructions.

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 nomination guarantee that the nominee will be appointed. Rather, in the absence of cause to appoint another, the court would likely select the nominee. Notably, by nominating an agent appointed under a power of attorney for health-care as a guardian, 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 formalities. This reflects the fact that people make instructions in many ways—written, oral, etc.—and limiting their ability to do so by adding procedural requirements might run afoul of long-established rights.

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 recorded a preference inconsistent with a preference stated in a previously executed 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 authorize one or more agents to make a health-care decision for the individual if the individual is determined to lack capacity.

(b) A finding by a court that another person poses a danger to an individual determined to lack capacity disqualifies the other person from acting as an agent for the individual determined to lack capacity even if the court has not imposed a restraining order against the other person.

(c) Unless related to the individual by blood, marriage, [domestic partnership,] or adoption, an owner, operator, or employee of [a residential long-term health-care institution] at which the individual is receiving care cannot be an agent.

(d) A health-care decision made by an agent for an individual under a power of attorney for health care is effective without judicial approval.

(e) A power of attorney for health care must be in a record, signed by the individual granting the power and witnessed by an adult who is:

(1) not the agent appointed by the individual;

(2) not the agent's spouse[ or domestic partner]; and

(3) present when the individual signed the power of attorney or when the individual represented that the power of attorney reflects the individual's wishes.

(f) The witness under subsection (e) shall be considered present if the witness and the individual are:

(1) in the physical presence of each other;

(2) able to see, speak to, and hear each other in real time through electronic means; or

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

(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.

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

***Legislative Note:*** *The state should insert the term used in the state for residential long-term care facilities in subsection (a) and wherever the term appears in this act.*

**Comment**

This Section provides for the second type of advance directive: the power of attorney for health care. It includes execution requirements, as states overwhelming have adopted such requirements. Consistent with concerns about undue barriers to execution, it aims to minimize the burden of execution requirements by requiring only a single witness and allowing witnessing to occur in various ways. However, it requires a witness to discourage forgery and identifies someone who can be asked about what took place should a concern about the validity of the document arise. By contrast, it does not require notarization. A person who is a notary, however, can serve as a witness.

Consistent with the 1993 Act, subsection (c) prohibits owners, operators, or employees of residential health care facilities in which the individual is residing from serving as agent, unless related to the individual. This prohibition reflects the special vulnerability of individuals in residential long-term health-care institutions.

**Section 9. Advance Health-Care Directive for Mental Health Care**

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

(b) A health-care instruction that addresses only mental health care may include:

(1) a statement of the individual's general mental health care philosophy and objectives;

(2) the individual's specific wishes regarding the provision, withholding, or withdrawal of a form of mental health care, including:

(A) the individual's preferences regarding mental health-care professionals, programs, and facilities;

(B) admission to a mental facility, including the length of admission;

(C) a refusal to accept specific types of mental health care, including medications;

(D) the individual's preferences regarding medications; and

(E) the individual's preferences regarding the means of crisis intervention.

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

(d) Appointment by an individual of an agent under a power of attorney for health care that authorizes the agent to make decisions only for the mental health care of the individual does not revoke a prior appointment of an agent under a power of attorney for health care to make other health-care decisions for the individual. The appointment does revoke the prior agent's authority to make mental health-care decisions unless otherwise specified by the subsequent appointment.

(e) Appointment by an individual of an agent under a power of attorney for other health-care decisions subsequent to appointment of an agent authorized only to make mental health-care decisions does not revoke the prior appointment of an agent to make mental health-care decisions unless otherwise specified in the subsequent power of attorney for health care.

(f) An individual may elect in an advance health-care directive that addresses only mental health care to waive the individual's rights under Sections 6(b)(2) or 12(b). If the individual waives the individual's rights under this subsection, the advance health-care directive must be in a record and signed and dated by, or at the direction of, the individual creating the directive in the physical presence of at least two adult witnesses, who shall attest that the waiver is voluntary and knowing.

**Comment**

This section governs what are often called "psychiatric advance directives." The use of the term "mental health" instead of "psychiatric" reflects the fact that an individual might wish to write 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. For example, an individual might wish to create an advance directive only for mental health care to govern in the event of an acute mental health crisis, but they might also create one to govern in the event of dementia or another cognitive disability.

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 a person 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—an individual to waive their right to challenge a determine of incapacity to make mental health decisions (a "Ulysses" type provision).

This waiver option is created by subsection (f). That section allows the individual to waive the right under Section 6 to have the individual's challenge of a determination of lack of capacity to make health care decisions prevail in the absence of a court determination. It also allows the individual to waive the right under Section 12 to revoke an instruction for mental health care during a period in which the individual has been determined to lack capacity to make health care decisions. The waiver provision is entirely optional, and thus an individual could create an advance directive for mental health care without including the waiver.

The power of an agent under a power of attorney for mental health care to consent to voluntary admission to a psychiatric facility is governed by Section 14, which governs the powers of an agent.

The list in subsection (b) of issues that can be addressed in an advance directive only for mental health care is not exhaustive.

**Section 10. Optional Form**

The following form may be used to create an advance health-care directive. An individual may complete or modify all or any part of the form.

ADVANCE HEALTH-CARE DIRECTIVE

**Explanation**

You have the right to name someone else to make health-care decisions for you if you cannot make those decisions for yourself. You also have the right to give instructions about your own health care. You can use this form to do one or both of these things. You can also use it to say if you want to be an organ donor when you die.

Using this form is optional. You may use other forms instead or write your wishes in your own words.

* * * * * * * * * * * * * * * * * * * * *

PART 1

This part allows you to name someone else to make health-care decisions for you. You can leave all or part of this part blank.

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I want the following person to make all health-care decisions for me if I cannot make those decisions for myself:

*If you can, give the full name, address, phone number, and email address of the individual you are naming.*

(2) DESIGNATION OF BACK-UP AGENT: I want the following person to make all health-care decisions for me if I cannot make those decisions for myself and my first agent is not willing, able, or reasonably available to make them for me.

*If you can, provide the full name, address, phone number, and email address of the individual you are naming. You may name more than one back-up agent.*

(3) SPECIAL POWERS: My agent may do the following things ONLY if I have initialed or marked them below:

[ ] apply for health insurance and benefits
[ ] consent to my participation in medical research that will not directly benefit me
[ ] admit me to a mental institution
[ ] permanently place me in a nursing home

(4) HEALTH INFORMATION SHARING: My agent may obtain, examine, and share information about my health needs and health care *(please initial or mark one)*:

[ ] whenever my agent reasonably believes it is in my best interest.
[ ] only if I cannot make health-care decisions for myself.

(5) OTHER LIMITS ON 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 as I state here:

*If you do not add any limitations on your agent's power, your agent will have the ability to make all health-care decisions that an agent is permitted to make under State law.*

PART 2

This part allows you to indicate what types of health care you do and do not want. Your doctors and nurses must generally follow these instructions unless you give them different instructions.

You can leave all or some of it blank.

HEALTH-CARE INSTRUCTION

(1) INSTRUCTION ABOUT PRIORITIES: You can use this section to indicate what is important to you, and what is not important to you. This information can help others make decisions for you if you cannot make them for yourself. You may leave all or part of this section blank.

Staying alive as long as possible even if I have substantial physical limitations (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Staying alive as long as possible even if I have substantial mental limitations (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Not being in pain (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Being independent (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Having my family and friends involved in making decisions about my care (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Please feel free to include other values and goals that are important to you here:

(2) INSTRUCTIONS ABOUT LIFE-SUSTAINING CARE

If I have an incurable and irreversible condition that is expected to result in my death in a relatively short time even with treatment, I want (*initial or mark your choices*):

[ ] to remain alive as long as possible
[ ] not to be given health care treatment merely to prolong my life
[ ] not to be given food or liquids through a tube or other means if I can no longer

swallow merely to prolong my life

[ ] other (please write what you want):

If I am unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible

[ ] not be given health care treatment merely to prolong my life

[ ] not be given food or liquids through a tube or other means if I can no longer swallow merely to prolong my life

[ ] other (please write what you want):

If I have an advanced progressive illness and cannot communicate, care for myself, and recognize family and friends, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible

[ ] not be given health care treatment merely to prolong my life

[ ] not be given food or liquids through a tube or other means if I can no longer swallow merely to prolong my life

[ ] other (please write what you want):

If I have permanent and severe brain damage that prevents me from recognizing and communicating with people I care about, and I am not expected to recover, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible

[ ] not be given health care treatment merely to prolong my life

[ ] not be given food or liquids through a tube or other means if I can no longer swallow merely to prolong my life

[ ] other (please write what you want):

(3) OTHER INSTRUCTIONS

*You can use this section to provide any other information about your goals, values, beliefs, and preferences for treatment about the health care you want or do not want. You can also leave this section blank.*

(4) OPTIONAL GUIDANCE FOR YOUR AGENT:

*Initial or mark your choice if you want to provide your agent with some more guidance about how to use your instructions.*

[ ] My stated preferences are meant to guide whoever is making decisions on my behalf and my doctors and nurses, but I give them permission to be flexible in applying these statements if they think that doing so would be in my best interest.

[ ] My stated preferences are meant to guide whoever is making decisions on my behalf and my doctors and nurses, and I want them to follow my stated preferences exactly as written, even if they think that some alternative is better.

[ ] Other:

*If you want to give your agent, doctors, and nurses other guidance about how to treat your instructions, you use this section to do that.*

PART 3

This part allows you to donate your organs when you die. You can leave all or some of it blank.

DONATION AT DEATH

Upon my death (initial or mark the box that indicates what you want):

[ ] I donate my organs, tissues, and other body parts.

[ ] I donate the following organs, tissues, or body parts only *(list the ones you want to give)*:

[ ] I do not want to use this form to say whether I want to donate my organs, tissues, or body parts.

[ ] I do not want my organs, tissues, or body parts donated to anybody for any reason.

My gift is for the following purposes (initial or mark the box or boxes that indicate what you want):
[ ] Transplant
[ ] Therapy
[ ] Research
[ ] Education

I agree to medical procedures that are necessary to evaluate, maintain, or preserve my organs or tissues so that I can be a donor (initial or mark the box that indicates what you want).
[ ] Yes
[ ] No

PART 4

A guardian is a person appointed by a court to make some or all decisions for someone who cannot make decisions. You can use this part to say who you want to be your guardian if a court finds one needs to be appointed for you. Filling out this part does not mean you want a court to appoint a guardian. You can leave all or some of it blank.

NOMINATION OF GUARDIAN

If a court finds that a guardian needs to be appointed for me, I want the court to choose:

[ ] The agent designated in this form. If that agent is not willing, able, or reasonably available to

act as guardian, I nominate the back-up agents whom I have named, in the order designated.

[ ] The following person:

*If you can, give the full name, address, phone number, and email address of the person you are naming.*

PART 5

SIGNATURES

My name:

My signature:

Date:

Optional: My date of birth:

Optional: My contact information (you may include your address, phone number, email address, or other contact information):

Witness name (a witness is needed if you are using this document to name an agent; the witness cannot be a person you are naming as agent or that person's spouse[ or domestic partner], parent, sibling, child, or grandchild.):

Witness signature:

Witness address (providing the witness's full address is recommended):

Date witness signed:

PART 6

INFORMATION FOR PEOPLE USING THIS ADVANCE HEALTH- CARE DIRECTIVE

**Information for Agents**

If you are named as an agent under this form, you may make a decision for the individual who named you as agent if that individual is unable to make their own decisions. In making decisions, you should follow any instructions the individual has given you, including any listed in this form. If you don't know what the individual would want, you should make the decision that you believe is in the individual's best interest. To figure out what the individual's best interest is, you must consider the individual's (1) personal values and preferences to the extent you know them or could reasonably learn them; and (2) what the individual currently indicates they want, even if these indications are communicated orally rather than in writing.

**Information for Health-Care Providers and Health-Care Institutions**

A copy of this form has the same effect as the original.

**Comment**

The form includes two sections 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 short 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-being—lacks empirical support. Notably, the form could be packaged with advice or other resources by providers or other actors.

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 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 parts of the form pertaining to donation of bodily organs and tissue.

Part 1, 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 an individual instruction, which cannot possibly anticipate all future circumstances which might arise. Part 1 requires only the designation of a single agent, but with opportunity given to designate a single first alternate, if the individual chooses. As in the 1993 Act, no provision is made in the form for the designation of co-agents in order not to encourage the practice. 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 instrument 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 1(3) and (4) enables the individual to give the agent powers that, under Section 15, require express authorization. For example, under Part 1(4), the individual can make the agent's power

to obtain and disclose medical information immediately effective.

Part 2 of the form enables the individual to provide instructions about specific forms of potential future care, as well as their priorities. Indeed, a key innovation in this section is to allow the individual 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 principals' preferences, values, goals, and wishes, recognizing that an individual cannot possibly anticipate and provide specific instructions for all future circumstances that might arise.

Part 3 of the form provides the individual an opportunity to express an intention to donate bodily organs and tissues at death. It allows an individual to give consent in advance to medical procedures that are necessary to evaluate, maintain or preserve organs or tissues so that the individual can be a donor. In this way, it aims to remove a common barrier to successful organ donation.

**Section 11. 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 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 is authorized to act as a default surrogate for the individual:

(1) an adult who the individual has designated;

(2) the individual's spouse[or domestic partner], unless legally separated;

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

(4) the individual's adult sibling;

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

(6) an adult known to have routinely assisted the individual with supported decision making during the past six months; or

(7) the individual's adult stepchild who the individual actively parented during the stepchild's minor years and with whom the individual has an ongoing relationship.

(c) If no member of any of the classes listed in subsection (b) is reasonably available, an adult who has exhibited special care and concern for the individual, is familiar with the individual's personal values, and is reasonably available may act as a default surrogate.

(d) A default surrogate shall communicate the default surrogate's assumption of authority as promptly as practicable to members of the classes listed in subsection (b) who can be readily contacted.

(e) A member of the class shall inform a responsible health-care provider if more than one member of a class assumes authority to act as a default surrogate and they do not agree on a health-care decision.

(f) A responsible health-care provider shall comply with the decision of a majority of the members of the class who have communicated their views to the provider. The following apply:

(1) If a responsible health-care provider is informed that the class is evenly divided concerning the health-care decision, the provider shall solicit the views of other members of the class who are reasonably available but have not yet communicated their views to the provider. The provider shall comply with the decision of the majority who have communicated their views after the solicitation.

(2) If the class remains evenly divided after additional class members have provided their views, the responsible health-care provider shall solicit the views of members of the next class in priority who are reasonably available and comply with the decision of the majority of the members in the two classes who have communicated their views after the solicitation.

(3) If a responsible health-care provider is informed that the views of the members of the two classes remain evenly divided, those classes and all individuals having lower

priority are disqualified from making the decision and the health-care decision shall be made as provided in other law of this state regarding the treatment of an individual who has been determined to lack capacity.

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

(h) At any time, an individual on behalf of whom a default surrogate purports to exercise authority under this section may disqualify another individual, including a member of the first individual's family, from acting as a default surrogate. The disqualification may be communicated in a record signed by the individual or orally to the individual being disqualified, another individual, or a responsible health-care provider. Disqualification of a default surrogate is effective even if made by an individual who has been found to lack capacity.

(i) A finding by a court that another individual poses a danger to an individual determined to lack capacity disqualifies the other individual from acting as a default surrogate for the individual determined to lack capacity even if the court has not imposed a restraining order against the other individual,

(j) Unless related to the individual by blood, marriage,[ domestic partnership,] or adoption, an owner, operator, or employee of [a residential long-term health-care institution] at which an individual determined to lack capacity is receiving care cannot be a default surrogate.

(k) A responsible health-care provider may require an individual claiming authority to act as a default surrogate under this section to provide a declaration in a record under penalty of perjury stating facts and circumstances reasonably sufficient to establish the authority.

(l) If a responsible health-care provider reasonably determines that an individual who has assumed authority to act as a default surrogate under this section is not willing or able to comply

with the duties under Section 14, the provider may recognize the individual or individuals next in priority under subsection (b) as the default surrogate.

**Comment**

This Section governs default surrogates.

Subsection (a) authorizes a surrogate to make a health-care decision for a patient if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is not reasonably available.

Subsections (b) and (c) work together to create a priority list for who serves as a default surrogate. At the top of the priority list is a person who the individual has designated. This designation may be 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.

If the individual has not designated a surrogate, or the designee is not reasonably available, subsections (b) and (c) apply 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, it expands the list of persons on the priority list beyond those included in the prior 1993 Act. Similarly, it groups certain priority groups (e.g., parents and children are given equal priority), recognizing that which individual may be best equipped to serve in this role will vary based on the patient and family structure. An individual who has priority under (b)(6) because they have provided the adult with decision-making support may have done so informally, or pursuant to a formal decision-making agreement.

Subsection (d) requires a surrogate who assumes authority to act to promptly notify individuals listed in subsection (b). This notice will enable them to take appropriate action, including to challenge the underlying determination of capacity under Section 6, should the need arise. Section (e) addresses the situation where more than one member of the same class has assumed authority to act as surrogate and a disagreement over a health-care decision arises of which a responsible health-care provider is informed. Should that occur, a responsible health-care provider must comply with the decision of a majority of the members of that class who have communicated their views to the provider. If, however, the members of the class who have communicated their views to the provider are evenly divided concerning the health-care decision, then the provider may look to members of both that class and the members of the next class in priority and comply with the decision of the majority of the members in the combined class. This approach represents a change from the 1993 Act. In that Act, if the class with priority was equally divided, then the entire class was disqualified from making the decision and no individual having lower priority was permitted to act as surrogate. This new approach reduces the likelihood of deadlock and thus the need to seek court intervention.

Subsections (h), (i), and (j) disqualify certain people from acting as a default surrogate, either

because of the individual's stated wishes or as a matter of law. Subsection (h) permits an individual to disqualify any other individual from acting as the individual's default surrogate. Section (i) 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 (j) disqualifies an owner, operator, or employee of a residential long-term health-care institution at which a patient is receiving care from acting as the patient's surrogate unless related to the individual. This disqualification is similar to that for appointed agents.

Subsection (k) permits a responsible health-care provider to require an individual claiming the right to act as surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A responsible health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as surrogate.

Subsection (l) allows a health-care provider to take direction from an individual of lower priority than the one who originally assumed authority to act as a default surrogate if the person who originally assumed authority fails to make decisions consistent with the agent's fiduciary duty and the decision-making standards set forth in Section 15. In determining whether to look to a person of lower priority to make such decisions, a responsible provider working in an institution that has an Ethics Committee may wish to consult that committee.

**Section 12. Revocation of Advance Health-Care Directive**

(a) An individual who has not been determined to lack capacity may revoke the designation of an agent under a health-care power of attorney:

(1) in a record signed by the individual;

(2) by orally informing a responsible health-care provider; or

(3) by any act that provides clear and convincing evidence of the individual's intent to revoke the designation.

(b) Unless waived under Section 9(f), an individual may revoke a health-care instruction in whole or in part at any time and in any manner that communicates the individual's intent to revoke the instruction.

(c) An advance health-care directive that conflicts with a prior advance health-care directive revokes the prior directive to the extent of the conflict.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a prior appointment of a spouse [or domestic partner] as agent for an individual unless otherwise specified in the decree or in the individual's health-care directive appointing the agent.

**Comment**

This Section governs revocation of advance directives. It allows a wide variety of acts to constitute revocation.

Subsection (b) provides that an individual may revoke any portion of a health care instruction at any time and in any manner that communicates an intent to revoke. However, a more restrictive standard applies to the revocation an appointment of an agent: the revocation must be in writing, provided orally to a responsible health-care provider, or be done in a way that provides clear and convincing evidence of intent to revoke the appointment. Thus, an oral declaration made to someone other than a responsible health-care provider would not revoke the advance directive unless, under the circumstances, it showed clear and convincing evidence of intent to revoke.

The lower standard of proof to revoke a health-care instruction helps ensure that creating a health-care instruction does not interfere with an individual's preexisting right to refuse or consent to treatment. Requiring clear and convincing evidence to revoke an instruction would run the risk of individuals receiving care that is inconsistent with their expressed preferences at the time of treatment.

By contrast, requiring clear and convincing evidence of a revocation of an appointment of an agent does not run the same risk, and helps guard against the possibility that an individual who lacks capacity to make their own health-care decisions will have no one available to make those decisions when it is not entirely clear that is what they would have wanted. This higher standard is also justified by the risk of a false revocation of an agent's designation or of a misinterpretation or miscommunication of a principal's statement communicated through a third party. For example, without this higher standard, an individual motivated by a desire to gain control over a patient might be able to assume authority to act as agent by falsely informing a health-care provider that the principal no longer wishes the previously designated agent to act but instead wishes to appoint the individual.

**Section 13. Duty to Communicate Revocation or Disqualification**

A health-care provider or surrogate who is informed of a revocation of an advance health-care directive or disqualification of an agent or default surrogate shall promptly communicate the fact of the revocation or disqualification to a responsible health-care provider and to an administrator with responsibility for medical records of the health-care institution providing

health care to the individual.

**Comment**

**Section 14. Duties of Agent and Default Surrogate**

(a) An agent or default surrogate is a fiduciary.

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

(c) In determining the individual's best interest, among other factors, an agent or default surrogate shall consider the individual's:

(1) personal values, preferences, and goals to the extent known to or reasonably ascertainable by the agent or default surrogate; and

(2) contemporaneous expressions, including nonverbal expressions.

**Comment**

This section governs duties of an agent or default surrogate. It builds on the patient-focused approach of the original Act but adds subsection (b) which provides additional guidance as to the factors to be considered when making a health-care decision.

**Section 15. Powers of Agent and Default Surrogate**

(a) Except as provided in subsection (c), the power of an agent or default surrogate commences when a determination is made under Section 5 that the individual lacks capacity. The

power ceases if the individual is subsequently determined not to lack capacity, or a challenge is made under Section 6 to the determination of lack of capacity. If the power ceases because a challenge is made under Section 6 to the termination of lack of capacity, the power resumes if a court subsequently determines that the person lacks capacity.

(b) Subject to subsection (d), an agent or default surrogate has the power to make a health care decision for the individual.

(c) An agent or default surrogate has the power to request, receive, examine, and copy, and consent to the disclosure of, medical and other health-care information about the individual making the appointment if the individual would have the right to request, receive, examine, copy, or disclose that information. If the advance health-care directive so provides, this power commences upon appointment.

(d) An agent or default surrogate has the following powers only if specifically authorized by an individual in an advance health-care directive:

(1) apply for public or private health insurance and benefits;

(2) consent to the individual's participation in medical research that:

(i) does not provide direct benefit to the individual and poses more than minimal risk to the individual; and

(ii) is authorized by an approved institutional review board and consistent with relevant state and federal regulations if the research includes a clinical trial or experimental treatment;

(3) consent to voluntary admission of the individual to a mental facility for the number of days specified in the directive or, if no number is specified, for up to [14] days; and

(4) consent to placement in a health-care institution where the placement is

intended to be permanent even if it is made over the individual's objection.

**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 default surrogate is not authorized to make decisions for an individual unless the individual lacks capacity to make those decisions for themselves. Thus, the power to consent to health care—or refuse consent to 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 provider to provide the care the agent thinks best in the particular situation.

The power to obtain and disclose the individual's health-care information, by contrast, can commences upon appointment if the individual has so specified in an advance directive. The rationale for allowing immediate power 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 (e.g., if the person lacks 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 information.

Subsection (d) sets forth powers (other than the power to immediately access and disclose records) that an agent has if explicitly granted by the terms of the power of attorney for health care. These include the power to consent to medical research that does not provide direct benefit to the individual and poses more than minimal risk to the individual. By comparison, an agent can consent to medical research that provides a direct benefit to the individual and poses only minimal risk without explicit authorization.

As noted in Section (d)(2)(ii), the power of an agent authorized to consent to medical research that poses more than minimal risk and is not directly beneficial to the individual is not unlimited: the research must still be authorized by an approved institutional review board and consistent with relevant state and federal regulations if the research includes a clinical trial or experimental treatment. This language is based on language from some state statutes, including one in New Hampshire, which require the experimental treatment to "be authorized by an institutional review board and be consistent with the relevant state and federal regulations, including 45 CFR part 46, subpart A (the "Common Rule"), and 21 CFR parts 50 and 56, as applicable".

**Section 16. Duties of Health-Care Provider, Responsible Health-Care Provider, and Health-Care Institution**

(a) Before implementing a health-care decision made for an individual by a surrogate, a responsible health-care provider, if possible, shall promptly communicate to the individual the decision made and the identity of the person making the decision.

(b) A responsible health-care provider shall promptly, if known to the provider, record in an individual's medical record the existence or revocation of an advance health-care directive for the individual, or the designation or disqualification of a surrogate for the individual. If evidence of the directive, revocation, designation or disqualification is in a record, the provider shall request a copy and upon receipt arrange for the copy to be recorded in the individual's medical record.

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

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

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

(3) a health-care decision for the individual made by the individual's surrogate to the same extent as if the decision had been made by the individual at a time when the individual was not determined to lack capacity.

(d) A health-care provider or a health-care institution may refuse to implement the terms of a health-care instruction or health-care decision:

(1) because 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; or

(2) compliance would:

(A) require the provision of medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution;

(B) require the use of a form of care or treatment that is not available to the provider or institution; or

(C) violate a court order or other law.

(e) A health-care provider or health-care institution that refuses to implement an instruction or decision under subsection (d) shall:

(1) promptly inform, if possible, the individual and the individual's surrogate of the refusal;

(2) immediately make all reasonable efforts to effect the transfer of the individual to another health-care provider or health-care institution that is willing to comply with the instruction or decision; and

(3) provide continuing care to the individual until a transfer under paragraph (2) is made.

(f) A health-care provider or health-care institution may not require or prohibit the creation or revocation of an advance health-care directive as a condition for providing health care to an individual.

**Comment**

This Section discusses providers' obligations.

Subsection (a) further reinforces the Act's respect for patient self-determination by requiring a responsible health-care provider, if possible, to promptly 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 (b), which requires a responsible health care provider to reflect the existence or revocation of an advance directive in a patient's medical record, is designed to reduce the risk that a health-care provider 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 (c) requires health-care providers and institutions to comply, absent an exception in subsection (d), with a patient's individual instruction and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient. A health-care provider 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 (d) sets forth limited situations in which a responsible health-care provider may lawfully refuse to comply with a health-care instruction or decision. 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. It is also permitted if compliance would require the provision of medically ineffective health care or health care contrary to generally accepted health-care standards, require the use of a form of care or treatment that is not available to the provider or institution, or violate a court order or other law. "Medically ineffective health care", as used in this section, means treatment which would not offer the patient any significant benefit.

Subsection (e) sets forth obligations for a health-care provider or institution that declines to comply with an individual instruction or health-care decision. The first is to promptly communicate the refusal to the patient, if possible, and to any person then authorized to make health-care decisions for the patient. The second is to (unless the patient refuses) immediately make all reasonable efforts to effect the transfer of the individual to another health-care provider or health-care institution that is willing to comply with the instruction or decision. The third is to provide continuing care to the patient until a transfer can be effected. Subsection (h), forbidding a health-care provider 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)).

**Section 17. Decisions by Guardian**

(a) A guardian shall comply with the instructions of the individual subject to guardianship

and may not revoke the individual's advance health-care directive unless the court appointing the guardian expressly authorizes 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 the decision of the guardian appointed for the individual.

**Comment**

This Section is consistent with the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act, adopted by the Uniform Law Commission in 2017. It governs the relationship between guardian and health care agent.

**Section 18. Immunities**

(a) A health-care provider or health-care institution acting in good faith and in accordance with generally accepted health-care standards applicable to the provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying with a health-care decision of a person who the provider or institution reasonably believes has authority to make the decision for an individual, including a decision to withhold or withdraw health care;

(2) refusing to comply with a health-care decision of a person based on a reasonable belief that the person lacked authority to make the decision; or

(3) complying with an advance health-care directive that the provider or institution reasonably believes was valid when created and reasonably believes has not been revoked by the individual who created the directive or a court.

(b) An agent or default surrogate, or a person with a reasonable belief that the person 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 the

duties set forth in Section 14.

**Comment**

This Section provides immunities for providers, agents, and default surrogates.

Subsection (a) provides immunity to a health-care provider who complies with an instruction of an individual who lacks authority to provide that instruction if the provider is acting in good faith and reasonably believes the person has such authority. Similarly, it provides immunity to a provider acting in good faith who refuses to comply with an instruction by an individual who does have such authority if the provider reasonably believes that individual does not have authority to make it.

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 in order 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 who has been 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 was reasonably available and authorized to act.

**Section 19. Prohibited Conduct; Damages**

(a) A person may not:

(1) intentionally falsify, conceal, deface, or obliterate an advance health-care directive or revocation of an advance health-care directive without the consent of the individual who created or revoked the directive;

(2) coerce or fraudulently induce an individual to create, revoke, or refrain from creating or revoking an advance health-care directive; or

(3) intentionally withhold knowledge of the existence or revocation of an advance health-care directive from a responsible health care provider or health-care institution providing health care to the individual who created or revoked the directive.

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

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

(d) This section does not preclude other remedies available under other law.

**Comment**

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

The legislature of an enacting state will have to determine the amount of damages which needs to be authorized in order to encourage the level of potential private enforcement actions necessary to effect 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.

**Section 20. Effect of Copy**

A copy of an advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate in a record has the same effect as the original.

**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 providers or may be receiving care at a location distant from that where the original is kept. To facilitate prompt and informed decision making, this section provides that a copy of a health-care direction, revocation of a health-care direction, or designation or disqualification of a surrogate in a record has the same effect as the original.

A copy can include an electronic copy.

**Section 21. Construction**

(a) Death of an individual resulting from the withholding or withdrawal of 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 to the contrary.

(b) This [act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other law of this state.

**Comment**

**Section 22. Judicial relief**

(a) The court may enjoin or order the implementation of a health-care decision made on behalf of an individual or order other equitable relief on petition of:

(1) the individual;

(2) the individual's surrogate;

(3) a health-care provider or health-care institution, providing health care to the individual; or

(4) another person interested in the welfare of the individual.

(b) 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 determined 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 person has authority to act as surrogate or whether a surrogate's purported decision on behalf of a patient is consistent with the surrogate's underlying duties.

The court 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 also limited to those with a direct interest in an individual's health care.

The final portion of this section has been placed in brackets in recognition of the fact that states vary widely in the extent to which they codify procedural matters in a substantive act.

**Section 23. Transitional Provisions**

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

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

**Section 24. 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 25. Relation to Electronic Signatures in Global and National Commerce Act**

This [act] modifies, limits, or supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001 et seq.[, as amended], but does not modify, limit or supersede Section 7001(c), or authorize electronic delivery of any of the notices described in Section 7003(b).

***Legislative Note:*** *It is the intent of this act to incorporate future amendments to the cited federal law. 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.*

**Comment**

This is a standard section in Uniform Law Commission Acts that provides an express defense for this Act against preemption by the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §§ 7001 et seq. ("E-Sign"). E-Sign, enacted into federal law in 2000, governs the legal validity of electronic records and signatures in private and

governmental transactions in the United States. In most circumstances, it applies to permit electronic signatures to satisfy the statute of frauds even in states that otherwise retain paper or manual signature requirements. 15 U.S.C. § 7001. E-sign expressly permits states to "modify, limit, or supersede" its requirements if (a) the state law is consistent with E-sign and (b) the state law makes "specific reference" to E-sign. 15 U.S.C. § 7002(a). This Act has provisions that permit electronic records and signatures to be used. Consequently, this provision is the "specific reference" required to ensure that these provisions are covered by the non-preemption provision of E-sign. The probability of conflict preemption for this Act is very unlikely but this standard section satisfies the express technical requirements of E-sign to qualify for non-preemption, so it provides even greater assurance that the Act is not preempted by federal law. This provision also makes clear that this Act does not attempt to modify, limit, or supersede provisions of E-sign that permit states to continue to require non-electronic records and signatures in certain situations. These situations include certain consumer contracts, notices to cancel important services (such as utilities and health insurance), and notices of product recalls. 15 U.S.C. §§ 7001(c), 7003(b). Since this Act does not apply to those situations, these disclaimers are not essential, but they are included anyway to protect against confusion and because this is a standard Uniform Law Commission provision.

**Section 26. Saving Provision**

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

**Comment**

**[Section 27. 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 28. Repeals; Conforming Amendments**

(a) The [cite to 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 conforming revisions are required by this act.*

**Comment**

**Section 29. Effective Date**

This [act] takes effect . . .