D R A F T

FOR DISCUSSION ONLY

Uniform Health-Care Decisions Act (20__)

Uniform Law Commission

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February 9, 2023

Uniform Health-Care Decisions Act (20__)

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Uniform Health-Care Decisions Act (20__)

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, as well as to provide their health-care providers and agent with instructions about the care they do or do not wish to receive. It also authorizes certain people, primarily family members, 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 providers, and provides protection in the form of immunity to both under specified circumstances.

More specifically, 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 changes in how health care is delivered, increases in 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 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 adult Americans have never made one. Without an advance directive, individuals' wishes are less likely to be honored. In addition, their health-care providers, 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 reduce the number of Americans who lack an 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 providers 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 an issue on which state statutes are typically silent: what happens if patients object to a surrogate 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 so that it accounts for the functional abilities of an individual and clarifies that the 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 make 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 to reflect a broader array of relationships and family structures. They also provide additional options to address disagreements among default surrogates who have equal priority.

Sixth, 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 that can be used to guide future health-care decisions. Many commentators have expressed concern that instructions included in advance directives focus exclusively on preferences for particular treatments, and do not provide health-care providers 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 options for individuals to indicate goals and values, in addition to specific treatment preferences.

This Act is intended to supersede the 1993 Act. A state enacting it would repeal that Act or any other statute governing the issues addressed in this Act.

Uniform Health-Care Decisions Act (20__)

Section 1. Title

This [act] may be cited as the Uniform Health-Care Decisions Act (20__).

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.

(3) "Cohabitant" means each of two individuals not married to each other who have been living together as a couple for at least one year after each reached the age of majority or was emancipated.

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

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

(6) "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.

(7) "Has capacity" means not determined or found under Section 4 or 6 to lack capacity. "Had capacity" and "have capacity" have corresponding meanings.

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

(9) “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 provider or health-care institution;

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

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

(10) “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.

(11) “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 specified conditions arise.

(12) “Health-care provider” 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 practice of the physician’s or individual’s profession.

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

(14) “Lack capacity” means is 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.

(15) "Mental health care" means care, treatment, service, or procedure to maintain, monitor, diagnose, or improve an individual's mental illness or other emotional, psychological, or psychosocial condition.

(16) "Nursing home" means a "nursing facility" in 42 U.S.C. § 1396r(a)[, as amended] or "skilled nursing facility" in 42 U.S.C. § 1395i–3(a)[, as amended].

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

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

(A) the spouse, child, parent, or grandparent of the individual, or a descendant of the spouse, child, parent, or grandparent of the individual;

(B) the [domestic partner,]cohabitant[,] or friend of the individual;

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

(D) the individual's surrogate;

(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.

(19) "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]].

(20) “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.

(21) “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 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 15 in a timely manner considering the urgency of an individual’s health-care situation.

(22) “Record” means information:

(A) inscribed on a tangible medium; or

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

(23) “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 for overseeing a particular course of treatment; or

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

(24) “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.

(25) "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.

(26) "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.

(27) "Surrogate" means:

(A) an agent;

(B) a default surrogate; or

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

***Legislative Note*:** *It is the intent of this act to incorporate future amendments to the federal law cited in paragraph (16). 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 recognizes domestic partnerships, include the bracketed text in paragraph 18(B) and wherever the term appears in this act.

If the state has separate terms for and laws authorizing the practice of medicine and osteopathy, remove the brackets in paragraph (19) 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

The 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 designed to provide clarity, and to

indicate that an instruction may include more than one piece of information.

Second, it 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. 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.

Third, it defines an "individual" as an adult or an 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 medical decision-making by or for "mature" minors.

Fourth, it 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. 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 alternate agents. Second, there is a "guardian", who is appointed by a court under other law, but only if the guardian is authorized to make health-care decisions. Third, there is a "default surrogate", who is authorized under Section 12 to make a health-care decision when there is neither an agent nor a guardian willing and able to make a decision. 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.

Fifth, core to the Act's goal of enabling decisions for individuals unable to make decisions for themselves, it defines the terms "has capacity" and "lack capacity." The definition of "lack capacity" is consistent with the functional approach to determining abilities and limitations found in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (2017) ("Guardianship Act").

The Act also contains a variety of definitions that were not in the original Act and that help update the 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, it defines the term "supported decision-making." Notably, this definition is consistent with the definition of that term in the Guardianship Act.

Likewise, it adds several terms designed to recognize a broad array of family and interpersonal arrangements. For example, reflecting the 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 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, with a modification requiring a living-together relationship of at least 1 year precipitated by the need to acknowledge the different purposes of the two acts.

In addition, the 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 provider." A responsible health-care provider is a health-care provider 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 provider. For example, a patient who lacks an existing relationship with a primary care provider (sometimes called a "PCP"), may present needing 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 provider. However, an individual also may have more than one provider who falls into 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 provider" under the 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.

Section 3. Right to Make Health-Care Decision; Presumption of Capacity

(a) An individual is presumed to have capacity to make a health-care decision unless a health-care provider under Section 4 or 5, or a court under Section 6, finds or determines the individual does not understand and appreciate the nature and consequences of the decision, including the primary risks and benefits of the decision.

(b) An individual is presumed to have capacity to make or revoke a health-care instruction unless a health-care provider under Section 4 or 5, or a court under Section 6, finds or determines the individual does not understand and appreciate the nature and consequences of a

health-care decision in the instruction, including the primary risks and benefits of the choices expressed in the instruction.

(c) An individual is presumed to have capacity to make or revoke a power of attorney for health care unless a health-care provider under Section 4 or 5, or a court under Section 6, finds or determines the individual does not understand and appreciate the nature and consequences of appointing an agent under the power of attorney or the identity of, or the general nature of the individual's relationship with, the individual being appointed.

(d) Creating, revoking, or not creating an advance health-care directive does not affect the right of an individual who has capacity to make a health-care decision.

Comment

The Act is not intended to affect the rights of individuals who do not lack capacity to make health-care decisions for themselves and this Section clearly states that.

The Section also clearly states that an individual is presumed to have capacity to make health care decisions, to create or revoke an advance directive, and to designate or disqualify a surrogate.

Section 4. Determination or Finding of Lack of Capacity to Make or Revoke Health-Care Decision or Advance Health-Care Directive

(a) A presumption under Section 3 that an individual has capacity may be rebutted by:

(1) a determination by a court under Section 6 or [cite to the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act or other guardianship statute enacted in the state]; or

(2) a finding made in accordance with accepted standards of medical judgment and to a reasonable degree of medical certainty that the individual lacks capacity by any of the following who has contemporaneously examined the individual and is not the spouse, child, parent, grandparent,[domestic partner,] or cohabitant of the individual or of the individual's

surrogate, or a descendant of the spouse, child, parent, grandparent,[domestic partner,] or cohabitant of the individual or of the surrogate:

(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's assistant;

(ii) an advanced practice registered nurse; or

(iii) a social worker; or]

(D) a responsible health-care provider if:

(i) the individual about whom the finding is to be made is experiencing a health condition requiring that a decision regarding health-care treatment 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.

(b) A finding under subsection (a)(2) must be documented promptly in a record that:

(1) is signed by the individual making the finding; and

(2) states the opinion of the individual making the finding of the cause, nature, extent, and probable duration of the lack of capacity.

(c) A determination or finding under this section may apply to a specified health-care decision, to a specified set of health-care decisions, or to all health-care decisions.

Legislative Note: *If the state decides to include physician's 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 in a non-emergency situation, it should include bracketed subsection (a)(2)(C) and include reference to paragraph (C) in subsection (a)(2)(D).

Comment

This Section sets forth how the presumptions of capacity in Section 3 can be rebutted.

This Section also governs how a determination that an individual lacks capacity is made for the purposes of this Act; it does not govern how such determinations are made for other purposes.

The Section 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 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. Similarly, the individual might have capacity to make certain instructions and not others.

Unlike some states that require two persons to make the determination that a person 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 if the individual, their surrogate, or a person interested in the individual's welfare objects to the first determination.

The individual making the finding must contemporaneously examine the individual. This means that their finding must be based, at least in part, on their own examination of the patient in the patient's current condition. They 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 standards of law in the enacting state.

A finding under this section that an individual lacks capacity must be according to accepted medical standards and to a reasonable degree of medical certainty. As a practical matter, this means that the individual making a finding—especially if it is based on a diagnosis of mental illness or cognitive, intellectual, or developmental disability—will need to have training and expertise in the assessment of functional and cognitive abilities and limitations of persons with similar disabilities.

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. As a practical matter, an individual making the finding 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. 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.

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

Notably, consistent with the definition of "lacks capacity" in Section 2, an individual might be determined or found to lack capacity to make certain medical decisions and not others. For example, an individual might be determined or found to have capacity to set goals for treatment, but not to select among therapies to meet those goals. Similarly, a person might have capacity to determine to accept nutrition and hydration and not have capacity to make more complex decisions.

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 or finding that the patient lacks capacity.

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

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

(a) An individual found under Section 4(a)(2) to lack capacity may object to the finding in a record, orally, or by another act.

(b) If the individual objects under subsection (a), the finding is not sufficient to rebut the presumption of capacity in Section 3, and the individual must be treated as having capacity, unless:

(1) the individual withdraws the objection;

(2) the court determines under Section 6 that the individual lacks capacity;

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

(4) the finding is:

(A) not used to withhold or withdraw life-sustaining treatment if the

individual is objecting to the withholding or withdrawal of the treatment; and

(B) confirmed by an individual authorized under Section 4(a)(2) who:

(i) did not make the first finding;

(ii) is not the spouse, child, parent, grandparent,[domestic partner,] or cohabitant of the individual who made the first finding; and

(iii) is not a descendant of the spouse, child, parent, grandparent,[domestic partner,] or cohabitant of the individual who made the first finding; or

(5) the individual, in an advance health-care directive that addresses only mental health care created under Section 9, directs the first finding to be sufficient to rebut the presumption of capacity.

(c) A health-care provider who is informed of an objection under subsection (a) promptly shall:

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

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

Comment

This Section addresses an important question on which the earlier 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(a)(2), 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, there is one caveat to the provision that the finding can be deemed effective if confirmed by another professional: this is not sufficient if the finding would 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 disallow 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.

Section 6. Right to Challenge Finding of Lack of Capacity

(a) An individual found under Section 4(a)(2) to lack capacity, a responsible health-care provider, 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] in the proceeding. 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 individual shall be determined to lack 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 the appointment of legal counsel, if the individual does not have legal counsel, whose primary duty is to represent the individual and the individual's wishes before the court, or a guardian ad litem, whose primary duty is to assist the court by representing the individual's best interests.

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 on a petition filed under subsection (a). A state in which that is not the case should include the bracketed material and insert what it believes to be an appropriate number of days.

Comment

Subsection (a) provides for standing for individuals and others who are found to lack capacity under Section 4(a)(2) 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. 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.

An individual may also challenge a determination of lack of capacity made by a court under Section 4(a)(1). However, the procedure for that challenge is not covered by this Act. Rather, it would be governed by the Guardianship Act, or by the state's own guardianship law.

Section 7. Health-Care Instruction

(a) The preferences in an individual's health care instruction may include:

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

(c) A health-care instruction that conflicts with an earlier health-care instruction, 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 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 any particular set of 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 could run afoul of long-established rights and reduce the likelihood that they 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 a preference inconsistent with a 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 authorize one or more agents to make a health-care decision for the individual if the individual is found or determined under Section 4 or 6 to lack capacity.

(b) An individual is disqualified from acting as agent for an individual found or determined under Section 4 or 6 to lack capacity if the court finds that the first individual poses a danger to the individual found or determined to lack capacity, even if the court does not issue a [restraining order] against the first individual. Advocating for the withholding or withdrawal of health care from the individual is not itself an indication of posing a danger to the individual.

(c) An owner, operator, or employee of a nursing home at which an individual is receiving care is disqualified from acting as agent unless the owner, operator, or employee is the

spouse, child, parent, grandparent,[domestic partner,] or cohabitant of the individual, or a descendent of the spouse, child, parent, [or] grandparent[, or domestic partner] of the individual.

(d) A health-care decision made by an agent 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:

(1) reasonably believes that the act of the individual to create the power of attorney is voluntary and knowing and made without coercion or undue influence;

(2) must not be:

(A) the agent appointed by the individual;

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

(C) if the individual resides in a nursing home, not the owner, operator or employee of the [residential long-term health-care institution]; 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.

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

(1) physically present in the same location;

(2) using an electronic means that allows for real time audio and visual transmission and able to communicate in real time to the same extent as if they 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.

(g) 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 protective orders in place of the bracketed material in subsection (b) and wherever it appears in the act.*

It is intended that a power of attorney under this act prevail over conflicting provisions in other state law. A state may need to revise 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 currently referred to as a health care proxy.

The Section includes execution requirements, as states overwhelmingly have adopted such requirements. However, 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. To discourage forgery it requires a witness and identifies someone who can describe 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. 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 providers. It creates an opportunity for health-care providers to selectively take instruction from the agent whom the provider prefers (e.g., because that agent is easier to reach, is less demanding, asks fewer questions, or is more willing to comply with the provider's own wishes). This can frustrate the ability of agents to effectuate the individual's wishes as required under Section 15. 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 (c) prohibits an owner, operator, or employee of a nursing home in which the individual is residing from serving as agent, unless related to the individual. This prohibition reflects the special vulnerability of individuals in nursing homes.

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.

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

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

(2) the individual's 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 facility, including length of admission;

(C) preferences regarding medications;

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

(E) preferences regarding 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) An individual may direct, in an advance health-care directive that addresses only mental health care, that a single finding that the individual lacks capacity is sufficient under Section 5(b)(5) to rebut the presumption of capacity under Section 3.

(e) If an advance health-care directive includes the direction under subsection (d), the directive must be in a record, signed by the individual creating the directive, and witnessed by at least two adults who:

(1) attest that to the best of their knowledge the direction is voluntary and knowing and made without coercion or undue influence;

(2) must not be:

(i) the agent appointed by the individual;

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

(iii) if the individual resides in a [residential long-term health-care institution] not the owner, operator or employee of the [residential long-term health-care institution]; and

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

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 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. 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. Thus, an individual could have an advance directive only for mental health care and no general advance directive, could have a general advance directive and no advance directive only for mental health care, 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 providers what medication or treatments have had a positive or negative impact in the past. For example, an individual may wish to avoid a treatment method that had side effects that were personally intolerable, or 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—an individual to essentially waive their right to be treated as having capacity pending confirmation of that finding of incapacity by a court or second health-care provider (a "Ulysses" type provision).

This waiver option is created by subsection (d), which allows the individual to agree in advance that a single finding that the individual lacks capacity to make health-care decisions (or to create or revoke an advance directive that only addresses mental health care) prevails in the absence of a court determination or confirmation by a second health-care provider. The waiver option is entirely optional, and thus an individual could create an advance directive that only addresses

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 16, 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. Relationship of Advance Health-Care Directive for Mental Health Care and Other Advance Health-Care Directive

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

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

(c) Appointment by an individual of an agent under a power of attorney for health-care decisions other than mental health-care decisions 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 directive created to only address mental health care and advance directives that are not limited in this way.

Section 11. Optional Form

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

ADVANCE HEALTH-CARE DIRECTIVE

EXPLANATION OF FORM

You can use this form to name someone you want to make health-care decisions for you. This person will only be able to make health care decisions for you if you cannot make them for yourself.

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 when you die.

NAME AND BIRTHDAY

Write your name and date of birth below.

Name:

Date of birth:

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

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

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

(If you can, give the full name, address, phone number, and email address of the individual you are appointing.)

(2) APPOINTMENT OF ALTERNATE AGENT: I want the following person to make health-care decisions for me if I cannot 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 appointing. You can name more than one alternate agent.)

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

( ) consent to my participation in medical research that is allowed by law even if it will not directly benefit me and risks more than a little harm to me

( ) admit me as a voluntary patient to a facility for mental health treatment for no more than (____) days

( ) if I am not terminally ill, place me in a nursing home for more than 100 days even if my needs can be met somewhere else and I object at that time to being placed in the nursing home

(4) HEALTH INFORMATION SHARING: My agent may obtain, examine, and share information about my health needs and health care (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 here, your agent will be able make all health-care decisions that an agent is permitted to make under state law.)

PART 2: HEALTH CARE INSTRUCTION

This part allows you to indicate your priorities for health care and types of health care you do and do not want. You can leave all or some of it blank.

(1) INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

If I have a condition that is not curable and is expected to cause me to die soon even if treated (initial or mark your choices):

( ) I want to receive all medical treatments available to prolong my life

( ) I do not want medical treatment if its only purpose is to prolong my life

( ) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to prolong my life

( ) I want to receive care that will help me be comfortable even if it may shorten my life

( ) other (write what you want or do not want):

If I am unconscious and am not expected to ever be conscious again (initial or mark your choices):

( ) I want to receive all medical treatments available to prolong my life

( ) I do not want medical treatment if its only purpose is to prolong my life

( ) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to prolong my life

( ) I want to receive care that will help me be comfortable even if it may shorten my life

( ) other (write what you want or do not want):

If I have a medical condition that prevents me from communicating with people I care about, care for myself, and recognizing family and friends and I am not expected to recover (initial or mark your choices):

( ) I want to receive all medical treatments available to prolong my life

( ) I do not want medical treatment if its only purpose is to prolong my life

( ) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to prolong my life

( ) I want to receive care that will help me be comfortable even if it may shorten my life

( ) other (write what you want or do not want):

(2) 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.

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

( ) very important

( ) somewhat important

( ) not important

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

( ) very important

( ) somewhat important

( ) not important

Being free from significant pain is (initial or mark your choice):

( ) very important

( ) somewhat important

( ) not important

Being independent is (initial or mark your choice):

( ) very important

( ) somewhat important

( ) not important

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

( ) very important

( ) somewhat important

( ) not important

You can indicate other values and goals that are important to you below. This can include things you want and things you do not want:

(3) OTHER INSTRUCTIONS

You can use this section to provide any other information about your goals, preferences, values, and wishes for treatment about the health 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.

(4) OPTIONAL ADDITIONAL GUIDANCE FOR YOUR AGENT

Initial or mark your choice if you want to provide your agent with more guidance.

( ) The instructions I stated in this document should guide the person making decisions for me, but I give that person permission to be flexible in applying these statements if they think it would be in my best interest based on what they know about me.

( ) The instructions I stated in this document should guide the person making decisions for me, and I want them to follow them exactly as written if possible, even if they think something else is better.

( ) Other (You can use this section to tell your agent more about how to treat your instructions.):

PART 3: ORGAN DONATION

This part allows you to donate your organs when you die. If you do not want to use this form to make a donation, you can leave it blank.

Even if procedures necessary to evaluate, maintain, or preserve my organs, tissues, or other body parts conflict with other instructions I have put in this form or another document, upon my death (initial or mark the box that indicates what you want):

( ) I donate my organs, tissues, and other body parts, except for those listed below (if you do not list any, all can be donated):

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

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

My organs, tissues, and body parts may be used for (initial or mark the box or boxes that indicate what you want):
( ) transplant
( ) therapy
( ) research
( ) education
( ) all of the above

PART 4: SIGNATURES

My name:

My signature:

Date:

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

(A witness is needed if you are using this form to name an agent. The witness cannot be a person you are naming as agent or that person's spouse[, domestic partner,] or cohabitant. If you live in a nursing home, the witness cannot be an employee, operator or owner of the home):

Witness name:

Witness signature (only sign as a witness if you believe the person above is voluntarily making this advance directive):

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

Date witness signed:

PART 5: INFORMATION FOR AGENTS

If this form appoints you as an agent, you may make decisions about health care for the person who appointed you when they cannot make their own. If making a decision for the person, you should follow any instructions the person gave, including any in this form. If you don't know what the person would want, you should make the decision that you think is in the person's best interest. To figure out what the individual's best interest is, you must consider the individual's values, preferences, and goals if you know them or can learn them. You should also consider any behaviors or communications from the person that indicate what they currently want.

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

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 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-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 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 16, 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 part 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 principal's 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. 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 Uniform Organ Donation Act.

Of course, this is only one way an individual can make such a gift. Failure to complete this portion does not preclude a 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).

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 who the individual has designated in an advance health-care directive or in another manner;

(2) the individual's spouse[or domestic partner], unless a petition for annulment, divorce, dissolution of marriage, legal separation, or termination has been filed and not dismissed or withdrawn, or 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) who 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 member of a class who assumes authority to act as default surrogate shall communicate the assumption of authority as promptly as practicable to other members who can be readily contacted in the same class and in classes with higher priority listed in subsection (b) and to a responsible health-care provider.

(d) A responsible health-care provider 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.

(e) If a responsible health-care provider reasonably determines that an individual who has assumed authority to act as a default surrogate is not willing or able to comply with a duty under Section 17 or fails to do so in a timely manner, the provider may recognize the individuals next in priority under Section 12(b) as the default surrogates.

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

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 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, it expands the list of persons on the priority list beyond those included in the 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 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 this 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 to reduce barriers to execution of powers of attorney for healthcare elsewhere in this Act.

By adopting a priority list, this 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 providers. If health-care providers 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 provider to recognize a surrogate other than one with top priority under the limited circumstances set forth in subsection (n).

Subsection (c) 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 to the underlying finding of capacity under Section 4, should the need arise.

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

Subsection (e) 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 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 provider 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 has assumed authority under Section 12(c) shall inform a responsible health-care provider if two or more members of the class have assumed authority to act as default surrogates and the members do not agree on a health-care decision.

(b) A responsible health-care provider shall comply with the decision of a majority of the members of the class with higher priority who have communicated their views to the provider.

(c) If a responsible health-care provider is informed that the members of the class are evenly divided concerning the health-care decision, the provider shall make a reasonable effort to 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, after the solicitation, shall comply with the decision of a majority of the members who have communicated their views to the provider.

(d) If the class remains evenly divided after additional class members have provided their views under subsection (c), a responsible health-care provider shall make a reasonable effort to solicit the views of members of the next class in priority, if any, who are reasonably available and, after the solicitation, comply with the decision of a majority of the members in the two classes who have communicated their views to the provider

(e) If a responsible health-care provider is informed that the views of the members of the two classes providing their views under subsection (d) remain evenly divided, the health-care decision shall be made as provided in other law of this state regarding the treatment of an individual who has been found or determined under Section 4 or 6 to lack capacity.

Comment

This Section 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. If the disagreement persists, however, the decision will be made as provided by other law of the state governing incapacity issues.

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 default surrogate. This new approach reduces the likelihood of deadlock and thus the need to seek court intervention.

Nothing in this Section requires a health-care provider to affirmatively seek out all members of a class.

Section 14. Disqualification to Act as Default Surrogate

(a) At any time, an individual for whom health-care decisions would be made may disqualify another individual from acting as default surrogate for the first individual. The disqualification may 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 provider. Disqualification under this subsection is effective even if made by an individual who has been found or determined under Section 4 or 6 to lack capacity to make health-care decisions.

(b) An individual is disqualified from acting as a default surrogate for an individual found or determined under Section 4 or 6 to lack capacity to make health-care decisions if the court finds that the potential default surrogate poses a danger to the individual for whom health-care decisions would be made, even if the court does not impose a [restraining order] against the individual being disqualified. Advocating for the withholding or withdrawal of health care from an individual does not itself indicate that the potential default surrogate poses a danger to the individual.

(c) An owner, operator, or employee of a [residential long-term health-care institution] at which an individual is receiving care is disqualified from acting as a default surrogate for the individual unless the owner, operator, or employee is the spouse, child, parent, grandparent[, domestic partner,] or cohabitant of the individual, or a descendant of the spouse, child, parent, [or] grandparent[, or domestic partner] of the individual.

(d) An individual who refuses to provide a timely declaration under Section 12(d) is disqualified from acting as default surrogate.

Comment

This Section disqualifies certain people from acting as a default surrogate, either because of the individual's stated wishes or as a matter of law. Subsection (a) permits the individual to disqualify any other individual from acting as the individual's default surrogate. This ability is not conditioned on the individual having capacity; individuals without capacity may have a strong sense that they do not feel comfortable with a particular person making decisions for them, and the Act takes the position that such opinions should be respected regardless of the individual's cognitive disability. Subsection (b) 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 (c) 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 (d) disqualifies an individual who has refused to provide the written declaration required under Section 12(d) in a timely manner.

Section 15. Revocation

(a) Unless found or determined to lack capacity to do so under Section 4 or 6, an individual may revoke the designation of an agent under a power of attorney for health care, the designation of a default surrogate, or a health-care instruction in whole or in part. The revocation must be by any act clearly indicating that the individual intends to revoke the designation or instruction, including an oral statement to a health-care provider.

(b) An advance health-care directive that conflicts with an earlier advance health-care

directive revokes the earlier directive to the extent of the conflict.

(c) Unless otherwise provided in the 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 by:

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

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

(3) [abandonment] of the individual for more than one year by the individual's spouse[or domestic partner].

Legislative Note: *The state should insert the term used in the state for abandonment in the first set of brackets in subsection (c)(3).*

Comment

This Section governs revocation of advance directives, including advance directives for mental health care. It allows a wide variety of acts to constitute revocation.

Subsections (a) and (b) allow an individual to revoke an appointment of an agent, the designation of a default surrogate, or a health-care instruction so long as they do not lack capacity to revoke it. It is possible that an individual would lack 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 (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, then both are effective.

Subsection (d) revokes the appointment of a spouse or domestic partner under certain situations in which the would-be agent's relationship to the principal has changed since the appointment was made.

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 no state is 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 or rely on it if the person does not have good cause to believe that the directive is invalid or has been revoked.

(c) An advance health-care directive or a revocation of a directive may not be denied legal effect or enforceability solely because it is in electronic form. If this [act] requires a signature on a directive or revocation, an electronic signature satisfies the requirement.

(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 it is in electronic form.

(e) 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 directives, something especially important for individuals who travel, move, or live in multiple jurisdictions. The Section allows an advance directive to be valid if it complied with the procedural and substantive requirements of the state in which the individual was physically located at the time they created it or in the state in which the document is presented. It also provides for a presumption of validity so that a health-care provider is not required to look behind the document unless they have actual notice of its invalidity. Finally, if the document contains a choice-of-law provision, that 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 to or reasonably ascertainable by the agent or default surrogate. If there is no direction 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.

(c) In determining the individual's best interest, an agent or default surrogate shall give primary consideration to the individual's contemporaneous communications, including verbal and nonverbal expressions.

(d) An agent or default 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 revocation or disqualification to a responsible health-care provider.

Comment

Once an individual 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.

Subsections (b) and (c) provide guidance as to the factors to be considered when making a health-care decision under this 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 often referred to as a "substituted judgment" standard, in that the surrogate is substituting the preferences of the individual for the surrogate's own preferences, which might be different. Notably, the preferences need not have been expressed exclusively prior to the onset of lack of capacity. Contemporaneous expressions may also be considered.

Subsection (c) spells out factors to be taken into account in determining an individual's best interest. The emphasis on considering the individual's contemporaneous expressions

Section 18. Powers of Agent and Default Surrogate

(a) Except as provided in subsection (d), the power of an agent or default surrogate commences when the individual is found under Section 4(a)(2) or is determined by a court to lack capacity to make a health-care decision. The power ceases if the individual later is found or determined to have capacity to make a health-care decision, or the individual makes an objection under Section 5 to the finding of lack of capacity under Section 4(a)(2). If the power ceases because an objection is made under Section 5, the power resumes if a court later determines that the person lacks capacity to make a health-care decision.

(b) Subject to subsection (f) and Section 19(a) and (b), an agent or default surrogate may make a health-care decision for the individual.

(c) An agent or default surrogate may request, receive, examine, and 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 disclose the information.

(d) The power of attorney for health care may provide that the power of an agent under subsection (c) commences upon appointment.

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

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

(1) consent to have the individual participate in medical research that does not

provide direct benefit to the individual and creates a risk of more than minimal harm to the individual, but is otherwise authorized by law;

(2) consent to voluntary admission of the individual to a facility for mental health treatment for not longer than the number of days specified in the directive or, if no number is specified, for no more than [14] days; or

(3) consent to placement of the individual, if not terminally ill, in a nursing home if the placement is intended to be for more than [100] days and an alternative living arrangement is reasonably feasible.

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 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 of an agent to obtain and disclose the individual's health-care information, by contrast, can commence 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 (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 (e) 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 in order to accelerate eligibility for Medicaid or other means-tested benefits. Subsection (e), moreover, merely permits the surrogate to apply for benefits; it does not create any duty for the surrogate to do so.

Subsection (f) 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 (f)(2), 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 law. Thus, an agent may never consent to the individual's participation in research not permitted under 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 19. Limitation on Powers

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

(1) the treatment is not necessary to sustain the individual's life;

(2) the individual has expressly authorized the 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:

(i) given a direction inconsistent with withdrawal; or

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

(b) A default surrogate does 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 would be prohibited from making that decision or would only be able to make that decision with specific court authorization. This provision is designed to prevent the default surrogate option from becoming an end-run around protections for individuals with disabilities that can be found in state's 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 only be legally permitted 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 can be provided to an individual who has not appointed an agent.

Section 20. Co-Agents and Alternate Agents

(a) A power of attorney for health care may designate two or more individuals to act as co-agents. Unless the power of attorney provides otherwise, each co-agent may exercise independent authority.

(b) A power of attorney for health care may designate one or more alternate agents to act if an agent resigns, dies, becomes disqualified, is not reasonably available, or is otherwise unwilling or unable to serve as agent. Unless the power of attorney provides otherwise, an alternate agent:

(1) has the same authority as the original agent; and

(2) may act only if all predecessor agents have resigned, died, become disqualified, are not reasonably available, or are otherwise unwilling or unable to act as agent.

Comment

Section 17 allows an individual to appoint more than one individual to serve as an agent. Where co-agents are appointed, Section 17(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 lawfully 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.

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

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

(b) A responsible health-care provider who makes or is informed of a determination or 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, promptly shall:

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

(2) if possible, communicate to the individual and the individual's surrogate the determination, finding or circumstance and that the individual may object to the determination or finding.

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

(1) document the information promptly in the individual's medical record; and

(2) if evidence of the directive, revocation, 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.

(d) Except as provided in subsections (e) and (f), a health-care provider 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 to the same extent as if the decision had been made by the individual at a time when the individual had capacity.

(e) A health-care provider or a health-care institution may refuse to provide 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 health care to the individual that 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;

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

(3) compliance would:

(A) require the provider or institution to provide care that is contrary to

generally accepted health-care standards applicable to the provider or institution; or

(B) violate a court order or other law.

(f) A health-care provider or health-care institution that refuses care under subsection (e)(1) or (2) shall:

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

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

(3) if the refusal is made under subsection (e)(1), provide medically appropriate care to the individual until a transfer under paragraph (2) is made; and

(4) if the refusal is made under subsection (e)(2), provide continuing care to the individual until a transfer under paragraph (2) is made or it reasonably appears transfer cannot be made not later than [10] days after the refusal.

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 (c), 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 (d) requires health-care providers and institutions to comply, absent an exception in subsection (e), 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 (e) 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 care that is contrary to accepted medical standards. This would include care that is medically ineffective health care (i.e., care that does not offer any significant chance of improving the individual's health or avoiding harm to the individual). In addition, it is permitted if compliance would 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.

Subsection (f) 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 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.

Section 22. Decision by Guardian

(a) A guardian shall comply with the direction of the individual subject to guardianship and may not refuse to comply with or revoke the individual's advance health-care directive, unless 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 the decision of the guardian appointed for the individual.

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

Comment

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

Section 23. Immunity

(a) A health-care provider 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 of a person based on a reasonable belief that the person 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 or capacity to make the decision;

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

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

(b) An agent or default surrogate, or an individual with a reasonable belief that they are 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.

Comment

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

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. It also provides immunity to a provider who, acting in good faith, 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(n).

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 24. Prohibited Conduct; Damages

(a) A person may not:

(1) intentionally falsify an advance health-care directive;

(2) intentionally conceal, deface, obliterate, or delete an advance health-care directive or revocation of an advance health-care directive without consent of 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;

(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; 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 by 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) An individual who makes a health-care instruction, or the individual's estate, has a cause of action against a health-care provider or health-care care institution that intentionally violates Section 18(d) for statutory damages of $[50,000] or actual damages resulting from the violation, whichever is greater.

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

(e) This section does not supersede or preclude another cause of action or a remedy 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 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 highly subjective and has been heartily 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 vigorously arguing that "As a matter of doctrine, undue influence fails to meet any standard of clarity, fairness, or predictability that a legal doctrine should satisfy"). 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 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).

The legislature of an enacting state will have to determine the amount of damages which should 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.

As set forth in Subsection (e), this Act does not limit any claims that would exist under other law of this state, including tort liability for medical malpractice. Thus, although subsection (b) only provides for actual damages or statutory damages, punitive damages might be available under

other state law.

Section 25. Effect of Copy; Certification of Physical Copy

(a) A physical or electronic copy of an advance health-care directive, revocation of an advance health-care directive, or 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 in electronic form or the revocation in electronic form of a directive 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 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. The Section also recognizes the growing use of documents in electronic form.

Section 26. 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 to the contrary.

(d) 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.

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.*

Section 27. Judicial Relief

(a) On petition of an individual, the individual's surrogate, a health-care provider 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(c);

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

(C) poses a danger to the individual;

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

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

(B) poses a danger to the first individual;

(4) order implementation of a health-care decision made by and for the individual if the individual has not been found or determined under Section 4 or 6 tot lack capacity to make the decision; or

(5) order implementation of a health-care decision made by an agent or default

surrogate who is acting in compliance with the powers and duties of the agent or default surrogate.

(b) Advocating for the withholding or withdrawal of health care from an individual is not itself an indication that an agent or default surrogate poses a danger to the individual.

(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 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 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 as a result are 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.

Section 28. Transitional and Saving Provisions; Interpretation

(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 complied at the time of creation with the law of the state in which it was created.

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

(d) 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 no longer lacks capacity or the default surrogate is disqualified, whichever occurs first.

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

Comment

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

Section 29. 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 30. 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 31. 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.

Section 32. Effective Date

This [act] takes effect . . .