Uniform Law Commission

M E M O R A N D U M

TO: **Committee to Amend or Revise the Uniform Health-Care Decisions Act**

FROM: **Nina Kohn, Reporter**
Nora Winkelman, Chair

DATE: **May 28, 2021**

RE: **Summary of Issues**

As you know, the Uniform Law Commission (ULC) Executive Committee accepted last year's Study Committee recommendations and appointed a drafting committee to move forward with this project. Thank you for agreeing to participate. Your insights, opinions and recommendations will be extremely valuable to the drafting of a product that we can all be proud of and one that we hope will be accepted by and adopted by States across the country.

At our initial meeting on June 3 – which will be conducted over Zoom – we will review the process moving forward for those of you who are not familiar with the ULC's drafting practices and procedures, including the character and likely timing of future meetings, before moving on to the issues outlined in this memo.

We are not expecting to come to conclusions about the specific provisions or approaches outlined below at this meeting. Rather, we intend to lay out for you the issues and topics the draft is intended to address, answer any questions you have, and consider any specific recommendations that you might have at this juncture.

We are particularly interested in soliciting your thoughts on including provisions regarding how a determination that a person cannot make healthcare decisions for themselves should be made. We are also interested in any lessons you might share based on your experience with the move to the use of electronic advance directives and health-care powers of attorney during the pandemic. Both of these issues are discussed in more detail below. We hope the discussion on these and other issues raised in this memo will give the Reporter the guidance she needs to create a first draft over the course of the next few months for your consideration at a meeting in the Fall.

Below are the highlights of some of the major issues the Committee will consider as part of its work revising the Act. For a more in-depth review of them, we turn your attention to the copy of the Study Committee's final report being circulated with this memo.

Capacity Trigger. The current version of the Uniform Health-Care Decisions Act (Act) does not wade too deeply into the question of how and who makes a determination that a patient lacks capacity to make health-care decisions.

- Should the new Act include procedures for determining whether an individual lacks capacity to make their own decisions, thus triggering the authority of an agent appointed by a power of attorney for health care or an agent selected in accordance with the state's default surrogate list. If so, what should they be? In this regard, we anticipate that the Act will incorporate an acknowledgment that the fact that a patient uses support (i.e., technical assistance or help from another person), in other areas of the patient's life or in making health-care decisions, does not mean the patient lacks capacity.

- Should the new Act include a specified degree of confidence (i.e., probable, clear and convincing evidence) that the standard used by a health-care provider for determining incapacity is met before a surrogate is authorized to make decisions.

- Should the patient be informed of a determination of incapacity and what should the consequences if the patient objects to the determination?

Execution requirements, including provisions for electronic documents. The Act, which was adopted by the ULC in 1993 (six years before promulgation of the Uniform Electronic Transactions Act), does not address the effectiveness of, or include rules governing the use of, electronic documents and signatures. Moreover, we have learned many lessons from state laws and executive orders issued during the COVID-19 pandemic that were adopted and issued to facilitate the use of electronic documents that should be incorporated into a new Act.

- What are the best practices for the use, execution and revocation of electronic advance directives and how can the new Act encourage and facilitate the use of these practices?.

- What provisions can the new Act include that would seek to avoid problems that can arise with the use of electronic advance directives?

- Should the execution requirements be relaxed so that advance directives and health-care powers of attorney can be easier to use (i.e., eliminating the need for witnesses and/or notarization).

Default surrogates: priority for appointment. The Study Committee recommendations include the expansion of the list of individuals who can act as default surrogates as the current list does not reflect the current reality of many family structures and patient preferences.

- Should the list include grandparents, grandchildren, nearest kin, etc.?

- Should the new Act give priority to certain persons unrelated to the patient (e.g., unmarried cohabitants, persons who provide decision-making support, etc.).

- What provisions can we incorporate into the new Act to better meet the needs of a patient for whom none of the individuals on the priority list are "reasonably available" (i.e., the "un-befriended patients")?

Default surrogates: disagreement among surrogates of equal priority. The current Act directs a health-care provider to comply with a decision articulated by the majority of the class of surrogates authorized by the Act when an individual unable to make decisions has not appointed an agent or surrogate. If the class of surrogates is divided, then no one is authorized to make the decision without a court order – obviously a cumbersome and expensive proposition. The Study Committee recommended changing this construct.

- What are the best practices for resolving disagreement among a class of default surrogates and how can the new Act encourage the use of these practices?

- Are approaches to this issue used in other states better than the approach in the current Act? If so, what are they?

- Should the Act replace the current the "majority vote" approach with something more practical?

Relationship between advance directives and Physician Orders for Life-Sustaining Treatment (POLST). Since the adoption of the Act in 1993, medical orders known as POLST have become widely used in many states. They are typically created by a medical provider in consultation with a significantly frail or ill patient for end-of-life planning and are meant to supplement, rather than supplant, a health-care advance directive or power of attorney. However, some confusion has arisen as to the relationship between a health-care advance directive and a POLST when both are available for a particular patient. The Study Committee recommended that we clarify the relationship between and among designations and instructions that may be included in a power of attorney for health care or other advance directive and those found in a POLST.

- Should the designation of a surrogate in a valid power of attorney for health-care always trump the statement in a POLST that someone else is a surrogate?

- What should be the circumstances, if any, under which treatment preferences in a valid power of attorney for health care or other advance directive will trump inconsistent preferences set forth in a POLST.

- What should be the legal effect of the revocation by a patient of a power of attorney for health care or another advance directive on instructions included in a POLST (e.g., should a provider disregard a statement on a POLST that a certain person is the health care agent if the patient revokes the advance directive or power of attorney appointing the preferred agent)?

Psychiatric Advance Directives. The current Act authorizes the inclusion of mental health treatment preferences in either a health-care power of attorney or an advance directive. However, the National Alliance on Mental Illness (NAMI) supports the use of a separate psychiatric advance directive, or PAD, because of the unique issues of mental health care and treatment. As of 2019, approximately one-half of the states have statutes that authorize and govern PADs.

- Is there a particular state's legislation we can look to as a model for authorizing and governing PADs? Alternatively, are there best practices we should incorporate?

- How can a new Act avoid problems that have arisen, or may arise, with the use of psychiatric advance directives?

- Is there language in psychiatric advance directives that should be avoided to help eliminate unnecessary stigma?

Other issues. The Study Committee recommended that a drafting committee also tackle a myriad of miscellaneous – but no less important – issues in a new Act. These include:

- Whether an agent or surrogate named under a health-care power of attorney should be permitted to apply for government health-care benefits for the principal and, if so, whether this power should be explicitly stated or should it be the default.

- Whether a new Act should include additional grounds for disqualifying agents and default surrogates.

- Whether additional qualifications should be placed on an agent's or surrogate's ability to consent to mental health treatment for individuals who may not be in the category of patients who have or need a psychiatric advance directive.

- Can the statutory form be revised to make it more accessible to diverse populations?

- Should oral designations of surrogates be honored and, if so, under what conditions?