D R A F T

FOR DISCUSSION ONLY

# Uniform Health-Care Decisions Act (20XX)

Uniform Law Commission

DRAFTING COMMITTEE MEETING
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September 28, 2022

**Uniform Health-Care Decisions Act (20XX)**

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# Uniform Health-Care Decisions Act (20XX)

## Prefatory Note

This Act modernizes and expands on the Uniform Health-Care Decisions Act promulgated 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 their 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 modernizes the 1993 Act to reflect changes in how health care is delivered, increases in non-traditional familial relationships and living arrangements, the proliferation 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, their 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 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 a patient objects 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 capacity determinations.

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 (20XX)

### Section 1. Title

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

### Section 2. Definitions

In this [act]:

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

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

(3) "Cohabitant" means each of two individuals not married to each other who have been living together as a couple for not less than one year after each has reached the age of majority or been 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. The term does not include a guardian ad litem.

(7) "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.

(8) "Health-care decision" means a decision made by an individual or the

individual's surrogate regarding the individual's health care, including:

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

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

(C) directions to provide, withhold, or withdraw artificial nutrition, hydration, respiration, or other health care.

(9) "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.

(10) "Health-care instruction" means a direction, whether or not in a record, made by an individual that indicates the individual's preference concerning the provision, withholding, or withdrawal of health care. The term includes a direction intended to be effective at a future time if specified conditions arise.

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

(12) "Individual" means an adult or emancipated minor.

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

(14) "Mental health care" means care, treatment, service, or procedure to

maintain, monitor, diagnose, or otherwise affect an individual's mental illness or other emotional, psychological, or social condition.

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

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

(A) an individual related by other law or by blood;

(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.

(17) "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]].

(18) "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.

(19) "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 14 in a timely manner considering the urgency of an individual's health-care situation.

(20) "Record" means information:

(A) inscribed on a tangible medium; or

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

(21) "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 an individual's health care or for overseeing a particular course of treatment.

(22) "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.

(23) "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.

(24) "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.

(25) "Surrogate" means:

(A) an agent;

(B) a default surrogate; or

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

***Legislative Note*:** *If the state has separate terms for and laws authorizing the practice of medicine and osteopathy, remove all brackets from paragraph (17) and insert citations to the appropriate statutes. However, if the practice of osteopathy in the state is included in the term "medicine" and is authorized by the state's law regarding the practice of medicine, the bracketed text related to osteopathy should be deleted.*

**Comment**

This Section begins by defining "advance directive" as either a power of attorney for health care or a health-care instruction. The first appoints an agent to make health-care decisions; the second provides information about an individual's treatment preferences, goals, values, and related wishes to guide future health care decision-making. The term "health-care instruction" includes oral 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.

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.

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 11 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.

This Section defines surrogate to include an agent under a power of attorney for health care, a default surrogate, or a guardian. It also provides definitions to help differentiate these different types of surrogates. 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 successor agents. Second, there is a "guardian", who is appointed by a court under other law. Third, there is a "default surrogate", who is authorized under Section 11 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.

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

The term "health-care decisions" references the definition of "health care". The definition of "health care" is to be given the broadest possible construction. It includes the types of care referred to in the definition of "health-care decision" and to care, including custodial care, provided at a "health-care institution". It also includes alternative medical treatment.

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

This Section also contains several definitions that were not in the original Act. The definition of "lacks 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 definition of "supported decision making," is consistent with the definition of that term in the Guardianship Act.

The phrase "related by other law or by blood" included in the definition of "person interested in the welfare of an individual" and elsewhere in this Act is intended to include relationships created by blood, marriage and adoption as well as by statutes such as the Uniform Parentage Act that allow for the establishment of previously unrecognized child-parent relationships, such as those claimed by de facto parents and same-sex couples.

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.

**Section 3. Presumptions**

(a) This [act] does not affect the right of an individual who does not lack capacity to make a health-care decision for the individual.

(b) Unless an individual has been determined by a court to lack capacity to make the decision, the individual is presumed to have capacity to:

(1) make a health-care decision;

(2) designate or disqualify a default surrogate;

(3) subject to Section 4, make an advance health-care instruction or power of attorney for health care; and

(4) revoke an advance health-care directive.

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

**Comment**

This Section brings together a variety of provisions that were scattered throughout the 1993 Act.

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. It also clearly states that an individual is presumed to have capacity to create or revoke an advance directive and to designate or disqualify a surrogate.

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

(a) The presumption under Section 3(b)(3) regarding the making of a health-care instruction may be rebutted if the individual making the instruction does not have the ability to understand the nature and consequences of a health-care decision in the instruction, including the benefits and risks of the choice expressed in the instruction.

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

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

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

**Comment**

For an advance directive to be valid, the individual making the advance directive must have

capacity to do so at the time the advance directive is created. This Section sets forth how a presumption that an individual has capacity to make an advance directive may be rebutted. What an individual must be able to understand to create an instruction may be different than what the individual must be able to understand to appoint an agent. As a result, it is possible that the individual would be found to lack capacity to do one and not the other. For example, an individual might know that they want their adult child to make health-care decisions for them, and that appointing their adult child as their agent would allow that to happen. At the same time, the individual might not have the ability to understand the risks and benefits of particular health-care treatments. Thus, the individual might be found to lack capacity to make an instruction, but to nevertheless have capacity to create a health-care power of attorney. Similarly, the individual might have capacity to make certain instructions and not others.

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

(a) A determination that an individual lacks capacity to make a health-care decision may be made by any of the following individuals who has contemporaneously examined the individual and is not related to the individual or the individual's surrogate by other law or by blood and is not the individual's or the surrogate's [domestic partner or] cohabitant:

(1) a physician; [or]

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

[(3) the following with training and expertise in the determination of lack of capacity who is licensed or otherwise authorized to practice in this state:

(A) a physician's assistant;

(B) an advanced practice registered nurse; or

(C) a clinical social worker; or]

(4) any responsible health care provider if the individual about whom the determination is to be made is experiencing an urgent health condition that requires that a decision regarding health-care treatment be made without delay, and an individual listed in paragraph (1)[,] [or] (2) [or (3)] is not reasonably available.

(b) The individual making the determination that an individual lacks capacity to make a

health-care decision because of mental illness or cognitive, intellectual, or developmental disability must also have training and expertise in the assessment of functional and cognitive abilities and limitations unless an individual with training and expertise is not reasonably available and the determination is required because the individual about whom the determination is to be made is experiencing an urgent health condition that requires that a decision regarding health-care treatment be made without delay.

(c) A determination made under this section must be made according to accepted standards of medical judgment and to a reasonable degree of medical certainty and must be promptly reflected in a record that:

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

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

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

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

(f) A health-care provider who makes or is informed of a determination that an individual lacks capacity 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, shall promptly reflect the determination or circumstance in the individual's medical record. As soon as reasonably possible, the provider shall also communicate to the individual and, if possible, to the

individual's surrogate:

(1) the determination or circumstance; and

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

(g) If requested by an individual determined to lack capacity to make a health-care decision, the individual's surrogate, a responsible health-care provider, the health-care institution providing health care to the individual, or another person interested in the welfare of the individual, the determination to be effective must be confirmed by another individual described in subsection (a), with the additional training described in subsection (b) if applicable,. The individual making the confirmation may not be:

(1) related by law or by blood to the individual who made the first determination; or

(2) the [domestic partner or] cohabitant of, or employed by, directly supervised by, or otherwise dependent on the individual who made the first determination.

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

*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 determination that an individual lacks capacity even in a non-emergency situation, it should include bracketed paragraph (3) of subsection 4 and include reference to paragraph (3) in paragraph (4).*

**Comment**

This Section sets forth who may determine that a person lacks capacity, and the nature of the determination. Unlike some states that require two persons to make the determination that a person lacks capacity, this provision only requires one unless the individual, their surrogate, or someone interested in the individual's welfare requests a second determination. The Section's primary purposes are to: (1) provide clarity for users (both providers and patients), and (2) create a minimum standard for triggering the authority of a surrogate. A determination that an individual lacks capacity made under this Section is made only for the purposes of this Act, and not for any other purpose.

The individual making the determination must contemporaneously examine the individual. This

means that their determination 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 potentially out-dated 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.

What constitutes training and expertise for the purposes of this Section should be interpreted broadly. 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 determination should have training as to the legal standards in this Act to be able to assess whether a person's cognitive and functional limitations satisfy that standard. A diagnosis, or a finding that an individual takes a particular medication or is receiving a particular treatment, is not a determination of incapacity. It may be evidence to be taken into consideration as part of an evaluation of incapacity; it is not a substitute for that evaluation.

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

Notably, consistent with the definition of "lacks capacity" in Section 2, an individual might be determined to lack capacity to make certain medical decisions and not others. For example, an individual might be determined to have capacity to set goals for treatment, but not to select among therapies to meet those goals. 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 that the patient lacks capacity.

Similarly, nothing in this Section affects a court's ability to make a determination that an individual lacks capacity. Court proceedings to determine lack of capacity are governed by other law of the state, such as the Guardianship Act or similar state law.

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

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

(1) in a record signed by the individual; or

(2) by any other act clearly indicating that the individual wishes to challenge the

determination, including an oral statement to a health-care provider.

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

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

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

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

(2) the individual shall have the right to be treated as having capacity to make a health-care decision unless:

(A) the objection is withdrawn by the individual;

(B) the court makes a determination under subsection (c) that the individual lacks capacity;

(C) the individual is experiencing a health condition that requires immediate treatment to avoid loss of life or significant injury and the determination that the individual lacks capacity is confirmed by an individual described in Section 5(a) who is not:

(i) related to the individual who made the first determination by other law or by blood; or

(ii) the [domestic partner or] cohabitant of or employed by, directly supervised by, or otherwise dependent on the individual who made the first determination.

(c) An individual determined under Section 5 to lack capacity, a responsible health care provider, the health-care institution providing health care to the individual, or another person interested in the welfare of the individual, may petition the [insert name of the appropriate local court in the state for capacity cases] in the [county] in which the individual resides or is located

to determine whether the individual lacks capacity to make a health-care decision. If a petition is filed under this subsection, the court shall appoint a guardian ad litem to represent the individual in the proceeding. The court shall conduct a hearing on the petition [as soon as possible but not later than [7] days after the petition is filed]. As soon as possible[, but not later than [7] days after the hearing], the court shall determine whether the individual lacks capacity to make a health-care decision. The individual shall be found to lack capacity to make a health-care decision only if the court finds by clear and convincing evidence that the individual lacks capacity to do so.

***Legislative Note****: A state where 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 regarding the timing of a hearing on a petition filed under subsection (c). A state where that is not the case should include the bracketed material and insert what it believes to be an appropriate amount of days.*

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

**Comment**

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

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

A determination that an individual lacks capacity made under subsection (c) is made only for the purposes of this Act, and not for any other purpose.

**Section 7. Health-Care Instruction**

(a) A health-care instruction may include an individual's goals and wishes regarding health care and health-care decisions, including mental-health treatment, and the individual's preferences for:

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

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

(3) individuals who should or should not be consulted regarding health-care decisions for the individual;

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

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

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

(c) A health-care instruction that conflicts with a prior health-care instruction, including an instruction reflected in a medical order, revokes the prior instruction to the extent of the conflict.

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

**Comment**

The Act distinguishes between two types of advance directives—those 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 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 determined to lack capacity.

(b) An agent is disqualified from acting as agent for an individual determined to lack capacity if a court finds that the agent poses a danger to the individual, even if the court has not imposed a restraining order against the agent.

(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 agent unless the owner, operator or employee is related to the individual by other law or by blood or is the [domestic partner or] cohabitant of the individual.

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

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

(1) not the agent appointed by the individual;

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

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

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

individual are:

(1) in the physical presence of each other;

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

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

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

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

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

***Legislative Note:*** *It is intended that the provisions of this act relating to powers of attorney for health care prevail over conflicting provisions in other state law. A state may need to revise its existing law on powers of attorney to avoid conflicting provisions*.

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

**Comment**

This Section provides for the second type of advance directive: the power of attorney for health care, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

authority to make mental health-care decisions unless otherwise specified by the subsequent appointment.

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

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

(g) If an instruction included in an advance health-care directive that addresses only mental health care conflicts with an instruction made in another advance health-care directive, the more recent instruction revokes the prior instruction to the extent of the conflict.

**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.

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

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

The power of an agent under a power of attorney for mental health care to consent to voluntary admission to a psychiatric facility is governed by Section 15, which governs the powers of an agent.

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

**Section 10. Optional Form**

The following form may be used to create an advance health-care directive. An individual may omit, complete, or modify the form.

ADVANCE HEALTH-CARE DIRECTIVE

**Explanation**

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

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

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

Insert your full name and date of birth here. This will help doctors, nurses, and other people involved in your health care identify you.

Name:

Date of birth:

## PART 1

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

### POWER OF ATTORNEY FOR HEALTH CARE

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

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

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

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

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

[ ] apply for health insurance and benefits

[ ] consent to my participation in medical research that 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

[ ] place me in a nursing home if the placement is intended to last more than 90 days and I object to the placement at that time

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

[ ] whenever my agent reasonably believes it is in my best interest

[ ] only if I cannot make health-care decisions for myself

(5) OTHER LIMITS ON AGENT'S AUTHORITY: I give my agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except as I state here:

*If you do not add any limitations here, your agent will be able make all health-care decisions that an agent is permitted to make under State law.*

## PART 2

This part allows you to indicate what your priorities for health care are and the types of health care you do and do not want. Your doctors and nurses must generally follow these instructions unless you give them different instructions. You can leave all or some of it blank.

HEALTH-CARE INSTRUCTION

(1) INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

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

[ ] I want to remain alive as long as possible

[ ] I do not want to be given health care treatment for the sole purpose of prolonging my life

[ ] I do not want to be given food or liquids through a tube or other means for the sole purpose of prolonging my life if I can no longer swallow

[ ] other (please write what you want or do not want):

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

[ ] I want to remain alive as long as possible

[ ] I do not want to be given health care treatment for the sole purpose of prolonging my life

[ ] I do not want to be given food or liquids through a tube or other means for the sole purpose of prolonging my life if I can no longer swallow

[ ] other (please write what you want or do not want):

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

[ ] I want to remain alive as long as possible

[ ] I do not want to be given health care treatment for the sole purpose of prolonging my life

[ ] I do not want to be given food or liquids through a tube or other means for the sole purpose of prolonging my life if I can no longer swallow

[ ] other (please write what you want or do not want):

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

[ ] I want to remain alive as long as possible

[ ] I do not want to be given health care treatment for the sole purpose of prolonging my life

[ ] I do not want to be given food or liquids through a tube or other means for the sole purpose of prolonging my life if I can no longer swallow

[ ] other (please 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. You may leave all or part of this section blank.

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

*your choice*):

[ ] very important
[ ] somewhat important
[ ] not important

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

[ ] very important
[ ] somewhat important
[ ] not important

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

[ ] very important
[ ] somewhat important
[ ] not important

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

[ ] very important
[ ] somewhat important
[ ] not important

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

[ ] very important
[ ] somewhat important
[ ] not important

Please feel free to include here other values and goals that are important to you. 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, values, beliefs, and preferences 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. You can also leave this section blank.*

(4) OPTIONAL GUIDANCE FOR YOUR AGENT:

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

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

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

[ ] Other:

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

PART 3

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

DONATION AT DEATH

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 gift is for only the following purposes (initial or mark the box or boxes that indicate what you want):
[ ] transplant
[ ] therapy
[ ] research
[ ] education
[ ] any lawful purpose

PART 4

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

NOMINATION OF GUARDIAN

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

[ ] The agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the back-up agents whom I have named, in the order designated.

[ ] The following person:

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

PART 5

SIGNATURES

My name:

My signature:

Date:

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

Witness name (a witness is needed if you are using this 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.):

Witness signature:

Witness name:

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

Date witness signed:

PART 6

INFORMATION FOR PEOPLE USING THIS ADVANCE HEALTH- CARE DIRECTIVE

**Information for Agents**

If you are named as an agent under this form, you may make a decision for the individual who named you as agent if that individual is unable to make their own decisions. You also have the ability to obtain and share the individual's health information when the individual is unable to make their own decisions, or earlier if the individual explicitly gave you that ability in this form. In making decisions, you should follow any instructions the individual has provided, including any listed in this form. If you don't know what the individual would want, you should make the

decision that you believe is in the individual's best interest. To figure out what the individual's best interest is, you must consider the individual's (1) personal values and preferences to the extent you know them or could reasonably learn them; and (2) what the individual currently indicates they want, even if these indications are communicated orally rather than in writing.

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

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

**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 15, require express authorization. For example, under Part 1(4), the individual can make the agent's power to obtain and disclose medical information immediately effective.

Part 2 of the form enables the individual to provide instructions about specific forms of potential future care, as well as their priorities. Indeed, a key innovation in this 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.

**Section 11. Default Surrogate**

(a) A default surrogate may make a health-care decision for an individual who lacks capacity to make health-care decisions and for whom an agent or guardian has not been appointed to make health-care decisions 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 is not disqualified under subsections (h), (i) or (j) is authorized to 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;

(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) known to have routinely assisted the individual with supported decision making during the past 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 default surrogate shall communicate the default surrogate's assumption of authority as promptly as practicable to other members in the same class and members in classes with higher priority listed in subsection (b) who can be readily contacted.

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

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

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

after the solicitation.

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

(h) If a responsible health-care provider is informed that the views of the members of the two classes providing their views under subsection (g) remain evenly divided, those classes and all individuals having lower priority are disqualified from making the decision and the health-care decision shall be made as provided in other law of this state regarding the treatment of an individual who has been determined to lack capacity.

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

(j) At any time, an individual may disqualify another individual from acting as default surrogate for the first individual. The disqualification may be communicated in a record signed by the first individual or by verbal or nonverbal communication 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 to lack capacity.

(k) An individual is disqualified from acting as a default surrogate for an individual determined to lack capacity to make health-care decisions if a 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 has not imposed a restraining order against the individual being disqualified. A decision by a potential default surrogate to withdraw or withhold health care

from an individual, by itself, is not an indication that the potential default surrogate poses a danger to the individual.

(l) 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 related to the individual by other law or by blood or is the cohabitant [or domestic partner] of the individual.

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

(n) If a responsible health-care provider reasonably determines that an individual who has assumed authority to act as a default surrogate under this section is not willing or able to comply with the duties under Section 14, the provider may recognize the individual or individuals next in priority under subsection (b) as the default surrogate.

**Comment**

This Section governs default surrogates.

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

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

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

because of the individual's stated wishes or as a matter of law. Subsection (j) permits the individual to disqualify any other individual from acting as the individual's default surrogate. Subsection (k) 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 (l) 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 (m) permits a responsible health-care provider to require an individual claiming the right to act as default surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A responsible health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as default surrogate.

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

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

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

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

(1) in a record signed by the individual; or

(2) by any other act clearly indicating that the individual intends to revoke the designation, including an oral statement to a health-care provider.,

(b) Unless waived under Section 9(f), an individual may revoke a health-care instruction in whole or in part:

(1) in a record signed by the individual; or

(2) by any other act clearly indicating that the individual intends to revoke the

instruction, including an oral statement to a health-care provider.

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

(d) A prior appointment of a spouse [or domestic partner] as agent for an individual is, unless otherwise provided in the individual's health-care directive appointing the agent, 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].

**Comment**

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

Subsection (a) allows an individual to revoke an appointment of an agent or designation of a default surrogate 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. For example, the individual might not be able to understand a complex medical decision but know that they no longer want their sister, who they previously appointed but with whom they subsequently had a falling out, to make decisions for them.

Subsection (b) provides that an individual may revoke any portion of a health care instruction at any time and in any manner that clearly communicates an intent to revoke.

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

Subsection (e) 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 13. Portability of Advance Health-Care Directive**

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

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

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

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

**Comment**

This Section governs the portability of advance directives, something especially important for individuals who travel, move, or live in multiple jurisdictions.

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

(a) An agent or default surrogate is a fiduciary when exercising or purporting to exercise powers authorized under Section 15.

(b) An agent or default surrogate shall make a health-care decision in accordance with the instructions of the individual included in an advance health-care directive and other wishes of the individual to the extent known to or reasonably ascertainable by the agent or default surrogate. If the instructions or wishes of the individual regarding a health-care decision are not known or reasonably ascertainable by the agent or default surrogate, the agent or default surrogate shall make the decision in accordance with the agent's or default surrogate's determination of the individual's best interest.

(c) In determining the individual's best interest, an agent or default surrogate shall give primary consideration to the individual's:

(1) personal values, preferences, and goals to the extent known to or reasonably

ascertainable by the agent or default surrogate; and

(2) contemporaneous 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 fact of 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 on whose behalf they are acting. This means that the agent or default surrogate must exercise reasonable care, diligence, and prudence in acting on behalf of the individual.

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

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

(a) Except as provided in subsection (c), the power of an agent or default surrogate commences when a determination is made by a court or under Section 5 that the individual lacks capacity to make a health-care decision. The power ceases if the individual is subsequently determined not to lack capacity to make a health-care decision, or a challenge is made under Section 6 to the determination of lack of capacity. If the power ceases because a challenge is made under Section 6, the power resumes if a court subsequently determines that the person lacks capacity to make a health-care decision.

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

(c) An agent or default surrogate has the power to request, receive, examine, and copy, and consent to the disclosure of, medical and other health-care information about the individual making the appointment if the individual would have the right to request, receive, examine, copy,

or disclose that information. If the advance health-care directive so provides, the power commences upon appointment.

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

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

(2) consent to participation in medical research that does not provide direct benefit to the individual, creates a risk of more than minimal harm to the individual, and is otherwise authorized by law;

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

(4) consent to placement in a nursing home if the placement is intended to be for more than [100] days and is made over the individual's objection.

(e) If an individual has a long-term disability requiring routine treatment by artificial nutrition, hydration, or respiration 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 and the individual has not:

(i) given an instruction that is inconsistent with withdrawal of treatment; and

(ii) recently communicated, by verbal or nonverbal expression, a desire for

artificial nutrition, hydration, or respiration.

(f) A default surrogate does not have the power to 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 only be made by a guardian if the court appointing the guardian specifically authorizes the guardian to make the health-care decision.

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

As noted in Section (d)(2), 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".

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

Subsection (f) 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 (f) 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 (f) 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 16. Co-agents and Successor 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 otherwise provides, each co-agent may exercise independent authority.

(b) A power of attorney for health care may designate one or more successor 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 otherwise provides, a successor agent:

(1) has the same authority granted to 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.

**Section 17. Duties of Health-Care Provider, Responsible Health-Care Provider, and Health-Care Institution**

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

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

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

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

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

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

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

(1) because the instruction or decision is contrary to a policy of the health-care

institution providing health care to the individual 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; or

(2) compliance would:

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

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

(C) violate a court order or other law.

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

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

(2) immediately make all reasonable efforts to 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 (d)(1), provide continuing care to the individual until a transfer under paragraph (2) is made; and

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

(f) A health-care provider or health-care institution may not require or prohibit the

creation or revocation of an advance health-care directive as a condition for providing health care.

**Comment**

This Section discusses providers' obligations.

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

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

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

Section (d) sets forth limited situations in which a responsible health-care provider may lawfully refuse to comply with a health-care instruction or decision. Failure to comply is permitted if the instruction or decision is contrary to a policy of the health-care institution providing health care to the individual which is expressly based on reasons of conscience and the policy was timely communicated to the individual who gave the instruction or about whom the decision was to be made or to the individual's surrogate. It is also permitted if compliance would require the provision of medically ineffective health care or health care contrary to generally accepted health-care standards, require the use of a form of care or treatment that is not available to the provider or institution, or violate a court order or other law. "Medically ineffective health care", as used in this section, means treatment which would not offer the patient any significant benefit.

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

Subsection (f), forbidding a health-care provider or institution to condition provision of health care on execution, non-execution, or revocation of an advance health-care directive, tracks the provisions of the federal Patient Self-Determination Act (42 U.S.C. 1395cc(f)(1)(C) (Medicare); 42 U.S.C. § 1396a(w)(1)(C) (Medicaid)).

**Section 18. Decisions by Guardian**

(a) A guardian shall comply with the instructions of the individual subject to guardianship and may not revoke the individual's advance health-care directive unless the court appointing the guardian expressly 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*:** *A state should amend its guardianship laws to conform with this provision to avoid conflicting provisions*.

**Comment**

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

**Section 19. Immunities**

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

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

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

(3) complying with an advance health-care directive that the provider or institution reasonably believes is valid; or

(4) determining that an individual who might otherwise be authorized to act as an agent or default surrogate is not willing or able to do so.

(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 the duties under Section 14.

**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 11(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 20. Prohibited Conduct; Damages**

(a) A person may not:

(1) intentionally falsify, conceal, deface, or obliterate an advance health-care

directive or revocation of an advance health-care directive without the consent of the individual who created or revoked the directive;

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

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

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

(c) An individual who made 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 17(c) 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 also recover reasonable attorney's fees, court costs, and other reasonable litigation expenses.

(e) This section does not supersede or preclude other causes of action or remedies available under other law.

**Comment**

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

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 21. Effect of Copy**

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 in a record has the same effect as the original.

**Comment**

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

**Section 22. Construction**

(a) 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.

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

**Section 23. Judicial relief**

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

(1) enjoin implementation of a health-care decision made by an agent or default surrogate on behalf of the individual upon a finding that the decision is inconsistent with the duties under Section 14 or the powers under Section 15;

(2) enjoin an agent from making a health-care decision for the individual upon 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 duties under Section 14; or

(C) poses a danger to the individual;

(3) enjoin another individual from acting as a default surrogate upon a finding that the other individual's designation as a default surrogate was not in compliance with Section 11 or the other individual:

(A) is unable or unwilling to comply with the duties under Section 14; or

(B) poses a danger to the first individual;

(4) order the implementation of a health-care decision made by and for the individual if the individual does not lack capacity to make the decision; or

(5) order the 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) 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 24. 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 if it complied with the law of the state in which it was created at the time of creation.

(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 prior to [the effective date of this [act]] may continue to act as default surrogate until the individual for whom the individual 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 advance 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 25. 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 26. Relation to Electronic Signatures in Global and National Commerce Act**

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

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

**Comment**

This is a standard section in Uniform Law Commission Acts that provides an express defense for this Act against preemption by the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §§ 7001 et seq. ("E-Sign"). E-Sign, enacted into federal law in 2000, governs the legal validity of electronic records and signatures in private and governmental transactions in the United States. In most circumstances, it applies to permit electronic signatures to satisfy the statute of frauds even in states that otherwise retain paper or manual signature requirements. 15 U.S.C. § 7001. E-sign expressly permits states to "modify, limit, or supersede" its requirements if (a) the state law is consistent with E-sign and (b) the state law makes "specific reference" to E-sign. 15 U.S.C. § 7002(a). This Act has provisions that permit electronic records and signatures to be used. Consequently, this provision is the "specific reference" required to ensure that these provisions are covered by the non-preemption provision of E-sign. The probability of conflict preemption for this Act is very unlikely but this standard

section satisfies the express technical requirements of E-sign to qualify for non-preemption, so it provides even greater assurance that the Act is not preempted by federal law. This provision also makes clear that this Act does not attempt to modify, limit, or supersede provisions of E-sign that permit states to continue to require non-electronic records and signatures in certain situations. These situations include certain consumer contracts, notices to cancel important services (such as utilities and health insurance), and notices of product recalls. 15 U.S.C. §§ 7001(c), 7003(b). Since this Act does not apply to those situations, these disclaimers are not essential, but they are included anyway to protect against confusion and because this is a standard Uniform Law Commission provision.

**[Section 27. Severability**

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

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

**Section 28. Repeals; Conforming Amendments**

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

(b) . . .

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

*A state should examine its statutes to determine whether 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 18 {Decisions by Guardian} and other provisions of this act relating to guardians, and other provisions of this act.*

**Section 29. Effective Date**

This [act] takes effect . . .