MEMORANDUM

TO: **Committee to Revise the Uniform Health Care Decisions Act**
FROM: **Nina Kohn, Reporter**
DATE: **November 8, 2021**
RE: **Issues for the Committee's Consideration**

At this week's meeting we will work through the draft section by section. We will also have opportunity to discuss issues that cut across sections. To facilitate that discussion, this memo (1) describes a cross-cutting issue that I would like the Committee to be sure to consider, and (2) highlights key issues and provisions in draft. I welcome discussion of all issues identified in this memo, as well as other issues that participants identify in their review of the draft.

I. Cross-cutting Issue

Locating provider responsibility. In the 1993 Act, certain responsibilities lay with the "supervising physician." In the draft, the term "supervising health-care provider" is used instead to recognize that a patient's primary care provider may not be a physician. Key questions for this Committee include whether: (1) the concept of supervising provider remains useful, (2) the definition of supervising provider in Section 1 is correct, and (3) the places where the supervising health care provider is given extra responsibility are the appropriate ones.

II. Section-by-Section Notes

Section 2. The definitions section contains several definitions that were not in the original act. New definitions include "lacks capacity" and "supported decision-making," both of which mirror definitions in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (UGCOPAA). It also adds a definition of "default surrogate."

In the interest of clarity, the definitions section also revises some definitions from the prior act. For example, the term "individual instruction" is replaced with "health care instruction." Similarly, the term "surrogate," which was previously defined only to apply to what is now called a "default surrogate," is now used to refer to a range of persons with authority to make healthcare decisions for someone else.

Section 3. This section pulls together a variety of provisions that were scattered about the prior act. It also adds a statement that an individual is presumed to have capacity to create or revoke an advance directive, and to designate or disqualify a surrogate.

Section 4. This section is new and, as such, would especially benefit from robust dialogue. It sets forth who may make a determination 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 welfare requests a second determination. This section's primary purpose is to: (1) provide clarity for users (both providers and patients), and (2) create a minimum standard for triggering the authority of a surrogate.

Section 5. This section is also new. It addresses an important question on which the earlier Act was silent: what happens if the individual does not agree with the determination of lack of capacity.

Section 6. The draft aims to clearly distinguish between two types of advance directives—those appointing an agent, and those indicating preference for care—while recognizing that both may be created by a single document. This section covers the health-care instruction. It does not require compliance with formalities for a health care instruction to be valid. This reflects the fact that people make instructions in many ways—written, oral, etc.—and limiting their ability to do so by adding procedural requirements might run afoul of long-established rights as discussed at the last meeting.

The section also provides that the most current instruction governs, regardless of the location of the instruction. For example, if a POLST recorded a preference inconsistent with a preference stated in a previously executed advance directive, the direction in the POLST would govern. Similarly, if the POLST recorded a preference, and an individual subsequently provided a different instruction, the subsequent instruction would govern.

Section 7. This section provides for the second type of advance directive: the power of attorney for healthcare. It includes execution requirements, as states have overwhelming have adopted such requirements. Consistent with observers' 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 many ways.

Section 8. This section governs what are often called "psychiatric advance directives". The draft uses the term "advance directive for mental health care" and thoughts on this terminology are very much welcomed. Since a person may designate an agent to make health care instructions or provide an instruction related to mental health care, in a general power of attorney, this section is unnecessary to empower either. What it does is (1) clarify that a person may make an appointment or instruction exclusively for mental health care; (2) prevent a general advance directive from mistakenly revoking the specific one, and vice versa; and (3) allow an individual to waive their right to challenge a determine of lack of capacity to make mental health decisions (a "Ulysses" type provision).

Section 9. This section is reserved for an optional form, a draft of which was provided in a separate document and which we will discuss at this week's meeting if time permits. Providing such a form is consistent with common state practice.

The proposed form includes two sections designed to reflect a growing concern that people too often provide detailed instructions which 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 their surrogate leeway in following instructions. The latter provision is a simplified version of one in Maryland's short form. If the Committee adopts this approach, input on whether the values identified are the appropriate ones to single out would be particularly helpful.

In reviewing this form, please note that it is designed to simply be a form, not advice. This makes it shorter and simpler than many state statutory short forms. It also avoids providing the problem of the ULC providing advice, including advice which may lack empirical support. Notably, the form could be packaged with advice or other resources by providers or other actors.

Section 10. This section governs default surrogates. In an effort to reflect a broader array of families and support systems, the proposal expands the list of persons on the priority list. Similarly, it groups certain priority groups (e.g., parents and children are given equal priority), recognizing that which generation may be best equipped to serve in this role will vary based on the patient and family structure.

This section also includes two new provisions. Section 10(e) provides a new mechanism for addressing the problem of the equally divided class. Section 10(i) would disqualify certain people from acting as a default surrogate as a matter of law, consistent with suggestions made at a prior meeting.

Section 11. This section governs revocation of advance directives. The draft does not require any minimum capacity to revoke a health care instruction, but does limit revocation of an appointment of an agent by a person who has been determined to lack capacity. This approach aims to balance competing considerations discussed at the last meeting as to whether capacity should be required to revoke an advance directive. Dialogue on whether this approach achieves the right balance is encouraged. The section also adds a provision on disqualification of an agent in Section (e)—comments about the substance of this proposed provision and its location are especially welcomed.

Section 12. The proposed draft deliberately separates the issue of what duties an agent or default surrogate has from what powers such persons have. This section governs duties. It builds on the patient-focused approach of the original Act, but adds Section 12(b) which provides additional guidance as to the factors to be considered.

Section 13. 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. These "hot powers" are ones that participants were divided as to whether to include in the list of agent's powers. This approach aims to find middle ground.

Section 14. This section discusses providers' obligations. This is not a topic that received substantial discussion at past meetings, so a robust dialogue would likely be quite beneficial. For

example, it would be helpful to hear thoughts as to whether the draft properly allocated responsibility among different types of health care providers.

Section 15. This section is consistent with UGCOPAA, and governs the relationship between guardian and health care agent.

Section 16. This section provides immunities for providers. It mirrors language in the previous Act.

Section 17. This section prohibits certain conduct that would undermine the purpose of this act. It largely mirrors language in the prior Act, although (a)(3) is new and the Section clarifies that liability is established through a private right of action under the statute (which was not explicitly stated in the prior Act).

Sections 18-20. These short provisions do not require explanation here. However, we will discuss them as part of our meeting.

Sections 21-26. These are standard ULC provisions that we do not intend to discuss unless anyone has any questions about them.