

Memorandum 97-4

Health Care Decisions: Uniform Health-Care Decisions Act (Introduction, Advance Health-Care Directives, Miscellaneous Provisions)

At the January meeting, the Commission decided that the next step in the health care decisionmaking study should be an analysis of the Uniform Health-Care Decisions Act (1993), providing a detailed comparison to California law along with recommendations for revision. Assessing existing law primarily involves consideration of (1) the durable power of attorney for health care (DPAHC) in Probate Code Section 4600 *et seq.* and related provisions (such as the registry in Section 4800 *et seq.* and the do not resuscitate orders in Section 4753), (2) the Natural Death Act (NDA) (Health & Safety Code § 7185 *et seq.*, and (3) case law concerning health care decisionmaking by incapacitated adults. Where relevant, we will also consider the law concerning determinations of competency under Probate Code Section 810 *et seq.* and health care decisionmaking by conservators and courts. All of these tasks will not be accomplished in one memorandum or at one meeting. Several important areas such as statutory surrogacy, the statutory form, capacity determinations, and judicial proceedings will be treated in later memorandums.

Commissioners should also keep in mind that, while we are proceeding on the basis of merging the UHCDA into existing law as described above, the issue of the scope of recommended legislation is always before you. It would be possible to adopt the recommendation of the Uniform Commissioners and replace the existing DPAHC with the UHCDA. On the other end of the scale, it would be possible to adopt one or more important aspects of the UHCDA (such as statutory surrogacy) and add them to California law, but not make any significant revisions in the DPAHC or other provisions. Throughout this study we will be faced with some issues of structure and scope:

- If existing California law and the UHCDA provide a rule that is the same in substance but phrased differently, perhaps quite differently, should the existing rule be replaced? Why or why not? Is there a net gain from potential uniformity or a loss from lack of continuity and consistency within California law?

- If existing California law and the UHCDA provide inconsistent rules that do not involve major policies or fundamental structural issues, should we adopt the UHCDA rule?
- The existing rule and the UHCDA provision may be significantly inconsistent or contradictory, creating a tension between the goal of uniformity and natural presumption in favor of the existing California rule.

We have again reproduced the official text of the Uniform Health-Care Decisions Act as an Exhibit so you can get an overview of the uniform act. The following discussion will excerpt relevant portions of the act, but you will find it useful to refer to the original language in context from time to time. We hope not to reproduce the UHCDA every time this subject is on the agenda, so please retain the copy in the Exhibit for future reference.

The UHCDA covers three important types of decisionmaking, the first two of which are currently governed by statute in California: (1) “living wills” pertaining to the expression of patients’ wishes in terminal or permanent unconscious condition (Natural Death Act), (2) durable powers of attorney for health care pertaining to the delegation of health care decisionmaking authority to an agent (attorney-in-fact) with or without guidelines, and (3) statutory surrogacy (also family consent law) which is governed by case law and custom. The Commission has decided to attempt to unify the relevant law to the extent desirable, using the UHCDA as the principal guide, most probably in the Probate Code. The Natural Death Act will be replaced. The existing statutory forms will be reconsidered from the ground up. Execution requirements should be simplified and made consistent and it is hoped that the two-witness rule can be retired in favor of more meaningful execution limitations, although special protections for patients in nursing homes should be retained.

The staff will also be following the efforts of other states. Thus far, only Maine and New Mexico (and maybe Delaware) have enacted the UHCDA. We will mention the variations adopted in these states where relevant. Reports from the home office of the National Conference of Commissioners on Uniform State Laws (NCCUSL) indicate that the act has been introduced in two other states this year; it appears that the act remains alive in Montana.

TERMINOLOGY

We do not want to get bogged down in technical issues concerning definitions at this point, but there are several important terms used in the UHCDA that affect the flavor of the act and must be understood before it can be analyzed. Adoption of several of these terms would represent a significant departure from the way we think about the options under existing California law. Rethinking the terminology should be a useful exercise, but adoption of some of these terms may cause confusion. Perhaps in a state that has little law on the subject, the uniform act would present less of a hurdle, but California has had a Natural Death Act for over 20 years (which was influential in the first Uniform Rights of the Terminally Ill Act) and has had one of the most highly developed durable power of attorney statutes for 15 years. The Health and Safety Code also contains an overlapping procedure for determining consent for patients in long-term care facilities (Section 1418.8) that will not adapt easily to the scheme of the UHCDA. On the other hand, to the extent that UHCDA terms are consistent with language used in the health care community and in federal regulations, it may be beneficial to make the switch because some of the state statutory terminology may have become outmoded.

The following discussion introduces the definitions in the UHCDA, but does not generally attempt to determine whether it should be adopted without modification.

(1) Advance health care directive; Individual instruction; Power of attorney for health care

UHCDA § 1(1) “Advance health-care directive” means an individual instruction or a power of attorney for health care.

Existing California law does not use this term. The uniform act comments reports that the term “appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.” The name of the advance directive document is not too important, but it is probably annoying to the public, not to mention the health care and legal establishments, when the names are changed every 10 years or so. On the other hand, as the function and scope of the instrument is changed, a new name takes on a greater importance, and helps notify potential users that it is a new creature. Individuals will still be

able to execute the familiar Durable Power of Attorney for Health Care, but if the uniform act is followed, there will be a powerful Advance Health-Care Directive form that can be used for the purposes covered by the Natural Death Act and more. *The staff recommends adoption of this term and associated terms.* We make this recommendation even though the terms seem artificial and a bit jargony (but then, so is “power of attorney”), and the distinction between direction and an instruction is not readily apparent, but must be learned. The term “advance health care directive” (we intend to drop the hyphen, if possible) is also a bit wordy. This is recognized implicitly in some UHCDA provisions that omit “advance” and in some UHCDA comments that resort to the more natural “directive.”

Assuming that we adopt the new language, care must be taken to include language in the definition or in another transitional section to cover existing documents such as the declaration under the Natural Death Act (Health & Safety Code § 7186(b)).

UHCDA § 1(9) “Individual instruction” means an individual’s direction concerning a health-care decision for the individual.

This term is somewhat confusing. To say that a person’s instruction is a person’s direction is not very informative. One may also wonder why the act uses both “direction” and “directive.” Read literally, this definition would also include statements in powers of attorney. For now we are working on the assumption that it will all fall into place.

The UHCDA comment is more instructive:

The term “individual instruction” (subsection (9)) includes any type of written or oral direction concerning health-care treatment. The direction may range from a written document which is intended to be effective at a future time if certain specified conditions arise ..., to the written consent required before surgery is performed, to oral directions concerning care recorded in the health-care record. The instruction may relate to a particular health-care decision or to health care in general.

The staff may suggest at a future time that the definition be expanded to include some of the language in this comment.

UHCDA § 1(12) “Power of attorney for health care” means the designation of an agent to make health-care decisions for the individual granting the power.

If the existing durable power of attorney for health care retains something like its current character, this definition will need to be revised.

(2) Agent

UHCDA § 1(2) “Agent” means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power.

Again we are confronted with the issue of what terminology should describe the attorney-in-fact or agent under a power of attorney. For now, the *staff recommends* using “agent” as in the uniform act, since it is generally conceded to be the more user-friendly term. The DPAHC uses both terms, preferring “attorney-in-fact” in statutes that lawyers and judges are most likely to read, and “agent” in warnings and statutory forms that are intended to be read by regular folks.

(3) Capacity

UHCDA § 1(3) “Capacity” means an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.

The UHCDA adopts a simple definition of capacity that is intended to be used and understood without the need for judicial intervention. The definition of “capacity” is fundamental, because it generally determines when the act applies. Two new and highly detailed schemes are provided in existing law for determining capacity. The Due Process in Competence Determinations Act (Prob. Code § 811 and related provisions) (DPCDA) provides a detailed set of rules for determining if a person is of unsound mind or lacks capacity to make a decision, including making medical decisions, in cases where courts are involved. Section 811 specifically provides that it does not affect the nonjudicial procedures for determining capacity in long-term care facilities under Health and Safety Code Section 1418.8 “nor increase or decrease the burdens of documentation on, or potential liability of, physicians and surgeons who, outside the judicial context, determine the capacity of patients to make a medical decision.” Prob. Code § 811(e). Health and Safety Code Section 1418.8(b) provides the following capacity standard: “a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable

to express a preference regarding the intervention.” We do not intend to get into the details of the capacity issues now, but this brief discussion illustrates the sort of issues that must be resolved and make clear that it would not be advisable to simply adopt the UHCDA verbatim.

(4) Health care; Health-care decision

UHCDA § 1(5) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual’s physical or mental condition.

UHCDA § 1(6) “Health-care decision” means a decision made by an individual or the individual’s agent, guardian, or surrogate, regarding the individual’s health care, including:

- (i) selection and discharge of health-care providers and institutions;
- (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (iii) directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.

“Health care” is to be given the “broadest possible construction” according to the uniform act comment. Compare the definitions from the DPAHC:

Prob. Code § 4609. “Health care” means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition and includes decisions affecting the principal after death.

Prob. Code § 4612. “Health care decision” means consent, refusal of consent, or withdrawal of consent to health care, or a decision to begin, continue, increase, limit, discontinue, or not to begin any health care.

At a later point we will sort out the details of the best definition, but the basic idea behind the uniform act and existing law is to provide a very broad definition of health care.

The staff assumes that whatever broad definition is used, the NDA terms “life-sustaining treatment,” “permanent unconscious condition,” and terminal condition” (Health & Safety Code § 7186) will no longer be needed.

(5) Health-care institution; Health-care provider; Physician; Primary physician, Supervising health-care provider

UHCDA § 1(7) “Health-care institution” means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

UHCDA § 1(8) “Health-care provider” means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

Note that the UHCDA restricts “health-care provider” to an *individual*. It may not be significant, but the DPAHC and the NDA use “person” in their definitions (see Health & Safety Code § 7186(c); Prob. Code § 4615), as did the earlier uniform acts. The UHCDA uses “health care institution” to distinguish entities from individuals. We will need to make sure that these terms are not in conflict with terms used in the DPAHC and other statutes. In some situations, a generic health-care provider may have duties, such as to inform a “supervising health-care provider” of receipt of a communication revoking an advance health-care directive. UHCDA § 3(b).

UHCDA § 1(11) “Physician” means an individual authorized to practice medicine [or osteopathy] under [appropriate statute].

The NDA defines physician as “a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.” (Health & Safety Code § 7186(g).) The Probate Code does not define “physician.” The DPAHC uses the term without defining it or uses the phrase “physician and surgeon” which is a term of art meaning a licensed medical doctor. It would be better to adopt the definition in the NDA and apply it to the DPAHC. The staff believes that the term “physician and surgeon” is awkward when used in these statutes and impairs the readability of already complicated statutes. In some contexts, a literal reading can lead a person to think that two signatures or approvals are required: one from a physician and one from a surgeon. (See, e.g., Prob. Code § 4753(b): “A ‘request to forego resuscitative measures’ shall be a written document, signed by the individual, or a legally recognized surrogate health care decisionmaker and a physician and surgeon, that directs...”) Consistent and comprehensive use of the defined term “physician” as set out in Section 7186(g) should avoid these problems. Further investigation may lead to a

better expression, but *the staff recommends* using the single word “physician.” Nor do we want to get into a dispute over who is qualified to act as a physician under a new act.

UHCDA § 1(13) “Primary physician” means a physician designated by an individual or the individual’s agent, guardian, or surrogate, to have primary responsibility for the individual’s health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

The URTIA used “attending physician,” but the UHCDA finds that

“attending physician” could be understood to refer to any physician providing treatment to the individual, and not to the physician whom the individual, or agent, guardian, or surrogate, has designated or, in the absence of a designation, the physician who has undertaken primary responsibility for the individual’s health care.

UHCDA § 1 comment. Adoption of this term depends in part on the extent to which the surrogacy rules are adopted. It is interesting to note, however, that the concept of the patient designating the responsible physician was in the original 1976 California NDA, which included language defining “attending physician” as the physician “selected by, or assigned to, the patient.” (Former Health & Safety Code § 7187(a).) This phrase was omitted when the NDA was revised in 1991 for greater consistency with the 1989 URTIA. Now the concept is back in the UHCDA definition of “primary physician.”

UHCDA § 1(16) “Supervising health-care provider” means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual’s health care.

According to the UHCDA comment, the “supervising health-care provider” concept “accommodates the circumstance that frequently arises where care or supervision by a physician may not be readily available. The individual’s primary physician is to assume the role, however, if reasonably available.” Thus, for example, a supervising health-care provider is to be given notice of revocation (UHCDA § 3(a)) and must perform certain record-keeping functions (UHCDA § 7).

(6) Reasonably available

UHCDA § 1(14) “Reasonably available” means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient’s health-care needs.

This term is used in the definitions of “primary physician” and “supervising health-care provider” and also plays a crucial role in determining whether a statutory surrogate can act in place of an agent or guardian or a patient-designated or higher-ranking surrogate under UHCDA Section 5.

(7) Surrogate

UHCDA § 1(17) “Surrogate” means an individual, other than a patient’s agent or guardian, authorized under this [Act] to make a health-care decision for the patient.

The UHCDA comments amplifies:

The definition of “surrogate” ... refers to the individual having present authority under Section 5 to make a health-care decision for a patient. It does not include an individual who might have such authority under a given set of circumstances which have not occurred.

As noted above, we are reserving the issues concerning health care decisionmaking by surrogates for a later memorandum.

(8) Miscellaneous Terms

The UHCDA also defines guardian, person, and state. These terms will be superseded by general terms used in the Probate Code.

CREATION AND EFFECT OF ADVANCE HEALTH-CARE DIRECTIVE

Section 2 of the Uniform Health-Care Decisions Act provides the basic rules concerning execution, contents, and the effect of advance health-care directives. The UHCDA is structured so that some rules apply to one or the other class of advance health care directives (individual instructions or powers of attorney), some rules apply to both classes of directives, and some rules depend on whether the directive is written (distinguishing between written individual instructions and powers of attorney, on one hand, and oral individual instructions on the

other). The categories are not mutually exclusive; e.g., written advance directives are subject oral revocation.

Individual Instruction

The UHCDA covers a lot of ground in three short sentences:

UHCDA § 2(a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

California does not generally provide for what the UHCDA calls an “individual instruction” other than through the mechanism of the Natural Death Act, in terminal or permanent unconscious cases, and in the context of appointing and instructing an attorney-in-fact under a DPAHC. (Of course, there are numerous references in the statutory and case law to an individual’s right to determine his or her health care.) It has been reported that people may execute a DPAHC without appointing an attorney-in-fact so that they can use that vehicle to state their health care instructions. It is also possible to appoint an attorney-in-fact in a DPAHC but limit the authority while expressing broad health care instructions. A “living will” may also be given effect by custom without any validating statute. *The staff recommends* adopting the principle of the UHCDA to make the law clearer and easier to use. The instructions option should be clearly implemented as part of a statutory form and enabled for private forms.

The formulation of who may execute a power of attorney (and by analogy, an individual instruction) was given a fair amount of consideration when the Power of Attorney Law was under preparation. Probate Code Section 4120 provides: “A natural person having the capacity to contract may execute a power of attorney.” And Section 4022 defines power of attorney, in part, as an instrument “executed by a natural person having the capacity to contract.” This language makes references to emancipated minors unnecessary, and *the staff recommends* that this approach be continued, although there may be a better way to say it than in Section 4120. The existing PAL does not use the word “adult” except in reference to witness qualifications. See Sections 4122, 4703, 4771 (statutory form). The NDA provides for execution of a declaration governing the withholding or withdrawal of life-sustaining treatment by an “individual of sound mind and 18 or more years of age.” Health & Safety Code § 7186.5(a).

The UHCDA does not directly require that the person executing an advance directive have capacity. However, UHCDA Section 11(b) provides that an “individual is presumed to have capacity ... to give or revoke an advance health-care directive....” The comment states that this is a rebuttable presumption. In addition, health care providers and institutions are protected for acting in good faith and in accordance with generally accepted health care standards for complying with advance directives and “assuming that the directive was valid when made.” UHCDA § 9(a)(3). Both Maine and New Mexico have added requirements that the person executing an individual instruction have capacity. Maine has also limited the effect of oral instructions so that they are valid only if made to a health-care provider or a person who can serve as a surrogate. New Mexico is even more restrictive, validating oral instructions only if made by personally informing a health-care provider. *The staff has not formulated a recommendation on this point, but would like to hear the views of interested persons and groups.*

Power of Attorney Execution and Effect

UHCDA § 2(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal’s later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the principal is receiving care.

Again, the UHCDA provides a very efficient statement of some essential principles governing the durable power of attorney for health care. It is difficult to imagine, however, that we could acceptably replace the much more detailed California rules with such a brief statement, regardless of the virtues of such an approach. The rules in existing law are there because they were determined to be necessary or beneficial at some time in the not too distant past.

Who may execute power of attorney. The same issues concerning who may execute a power of attorney that are considered above in connection with individual instructions apply here. There are inconsistencies in existing statutes concerning who can execute particular documents. The goal should be to have uniform rules to the extent possible and appropriate. Section 7186.5(a) in the

NDA, for example, is limited to persons age 18 and over. As noted above, however, the DPAHC, relies on the general power of attorney rules permitting execution by any person with the capacity to contract, thus incorporating the rules concerning emancipated minors. See generally Fam. Code §§ 6500 *et seq.* (minors), 7000 *et seq.* (Emancipation of Minors Law), 7050(e)(1) (consent to medical care), (e)(2) (delegation of power); Prob. Code §§ 4121, 4700. (As noted in an earlier memorandum, the staff does not recommend considering issues relating to health care decisionmaking for unemancipated minors.) The UHCDA refers to “an adult or emancipated minor.” In California, the law relating to emancipated minors should take care of itself, and explicit statutory reference should not be necessary, but in this area of the law, it should be clear and consistent.

Agent’s authority. The standard in the first sentence concerning the basic authority of the agent should not say that the agent can make a decision that the principal “could have made,” but rather “could make,” as in the following rule from the DPAHC (Prob. Code § 4720(b)):

(b) Subject to any limitations in the durable power of attorney, the attorney-in-fact designated in a durable power of attorney for health care may make health care decisions for the principal, before or after the death of the principal, **to the same extent as the principal could make health care decisions if the principal had the capacity to do so**, including the following:

(1) Making a disposition under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

(2) Authorizing an autopsy under Section 7113 of the Health and Safety Code.

(3) Directing the disposition of remains under Section 7100 of the Health and Safety Code.

The staff also thinks that the additional detail of existing law, which dates back to the original California DPAHC enacted on Commission recommendation, should be retained unless there is a convincing reason to eliminate it. We do not believe that it must be continued in this form, but making clear that the attorney-in-fact has authority to make dispositions effective post-death is important and helps link this statute to the others, both substantively and in the minds of the persons who use the statute and forms created to implement it.

Both the UHCDA and the DPAHC overstate the authority of the agent, which is subject to certain limitations expressed elsewhere. Section 13(c) of the UHCDA

provides: “This [Act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.”

Probate Code Section 4722 prohibits authorization of the following in a DPAHC:

- (a) Commitment to or placement in a mental health treatment facility.
- (b) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code).
- (c) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code).
- (d) Sterilization.
- (e) Abortion.

In addition, Section 4723 provides, similarly to the UHCDA:

4723. Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health care pursuant to a durable power of attorney for health care so as to permit the natural process of dying. In making health care decisions under a durable power of attorney for health care, an attempted suicide by the principal shall not be construed to indicate a desire of the principal that health care treatment be restricted or inhibited.

The staff does not intend to review these exceptions at this stage. Consider, however, whether some of these limitations might be unconstitutional. Section 4723 reflects language of the older Natural Death Act and for that reason should be reconsidered. Whether that should be attempted in the course of this study and by the Commission are issues on which the staff would appreciate commentary.

Execution formalities — witnessing. The second sentence of UHCDA requires a power of attorney to be in writing and signed by the principal, but does not require any witnesses or notarization. Note, however, that the “Optional Form” in UHCDA Section 4 encourages the use of witnesses by providing a place for signatures. Obviously there is no limitation on who may be an optional witness. The two-witness requirement is fairly standard for important documents in California. For example, a DPAHC under the general rules may be notarized or signed by two witnesses, whereas the *statutory form* DPAHC requires two witnesses. Compare Prob. Code §§ 4700(b) & 4121(c) with § 4773. The request to

forego resuscitative measures (the DNR “do not resuscitate” form) is signed by the individual (or “legally recognized surrogate health care decisionmaker”) and a physician. Prob. Code § 4753(b). The NDA declaration requires two witnesses.

At the January meeting, the Commission decided to pursue the possibility of eliminating the two-witness requirement. This would mean the elimination of provisions such as the following in the Natural Death Act (Health & Safety Code 7186.5(a)):

The declaration shall be signed by the declarant, or another at the declarant’s direction and in the declarant’s presence, and witnessed by two individuals at least one of whom may not be a person who is entitled to any portion of the estate of the qualified patient upon his or her death under any will or codicil thereto of the qualified patient existing at the time of execution of the declaration or by operation of law.

The Commission also concluded at the January meeting that some protective rules for patients in skilled nursing facilities and long-term health care facilities should probably be retained. See, e.g., Prob. Code § 4701(e).

The uniform act aims to effectuate the individual’s intent without relying too much on execution formalities. The drafters viewed formalities as unnecessarily inhibiting while at the same time doing “little, if anything, to prevent fraud or enhance reliability.” English & Meisel, *Uniform Health-Care Decisions Act Gives New Guidance*, Est. Plan. 355, 358-59 (Dec. 1994). The genuineness of advance directives is bolstered by placing reliance on the health care providers as a general rule, although, as noted, witnesses are encouraged in the form. The act relies on recordkeeping — entering the advance directive in the patient’s health care records — and conformance with medical ethics as affirmative rules to determine and effectuate genuine intent, and provides that anyone

who intentionally falsifies, forges, conceals, defaces, or obliterates an individual’s advance health-care directive or a revocation of an advance health-care directive without the individual’s consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, is subject to liability to that individual for damages of \$[2,500] or actual damages resulting from the action, whichever is greater, plus reasonable attorney’s fees. [UHCDA § 10(b).]

The UHCDA approach was adopted in New Mexico, but Maine has added a two-witness requirement in its version of the UHCDA.

Who may be an agent. The last sentence of UHCDA Section (2)(b) precludes owners, operators and employees of long-term care institutions where the principal is receiving care from acting as agents under a power of attorney unless related by blood, marriage or adoption. Section 4702 in the DPAHC provides a more extensive list of exclusions:

4702. (a) Except as provided in subdivision (b), the following persons may not exercise authority to make health care decisions under a durable power of attorney:

(1) The treating health care provider or an employee of the treating health care provider.

(2) An operator or employee of a community care facility.

(3) An operator or employee of a residential care facility for the elderly.

(b) An employee of the treating health care provider or an employee of an operator of a community care facility or an employee of a residential care facility for the elderly may be designated as the attorney-in-fact to make health care decisions under a durable power of attorney for health care if both of the following requirements are met:

(1) The employee is a relative of the principal by blood, marriage, or adoption, or the employee is employed by the same treating health care provider, community care facility, or residential care facility for the elderly that employs the principal.

(2) The other requirements of this chapter are satisfied.

(c) Except as provided in subdivision (b), if a health care provider becomes the principal's treating health care provider, the health care provider or an employee of the health care provider may not exercise authority to make health care decisions under a durable power of attorney.

(d) A conservator may not be designated as the attorney-in-fact to make health care decisions under a durable power of attorney for health care executed by a person who is a conservatee under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), unless all of the following are satisfied:

(1) The power of attorney is otherwise valid.

(2) The conservatee is represented by legal counsel.

(3) The lawyer representing the conservatee signs a certificate stating in substance:

"I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning his or her rights in connection with this power of

attorney and the applicable law and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this power of attorney.”

This section has been the subject of very careful scrutiny over the years, and was last amended in 1995. *The staff would be reluctant to recommend its replacement by the UHCDA provision, although it is appealingly brief and easy to understand.*

When Agent’s Authority Is Effective

UHCDA § 2(c) Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

This provision adopts a general rule that powers of attorney for health care are “springing powers” — i.e., powers that become effective only when the principal cannot act. Note that the UHCDA permits the power of attorney to provide otherwise. The uniform act comment states:

A principal may provide, however, that the authority of the agent becomes effective immediately or upon the happening of some event other than the loss of capacity but may do so only by an express provision in the power of attorney. For example, a mother who does not want to make her own health-care decisions but prefers that her daughter make them for her may specify that the daughter as agent is to have authority to make health-care decisions immediately. The mother in that circumstance retains the right to later revoke the power of attorney as provided in Section 3.

Probate Code Section 4720(a) adopts a similar approach:

4720. (a) Unless the durable power of attorney provides otherwise, the attorney-in-fact designated in a durable power of attorney for health care who is known to the health care provider to be available and willing to make health care decisions has priority over any other person to act for the principal in all matters of health care decisions, but the attorney-in-fact does not have authority to make a particular health care decision if the principal is able to give informed consent with respect to that decision.

It occurs to the staff that Section 4720(a) is susceptible of two interpretations, depending on whether one reads the introductory “unless” clause as overriding the ending “but” clause, or reads the “but” clause as supreme. The Commission Comment makes the intent clear, however:

The power of attorney may, however, give the attorney-in-fact authority to make health care decisions for the principal even though the principal is able to give informed consent, but the power of attorney is always subject to Section 4724 (if principal objects, attorney-in-fact not authorized to consent to health care or to the withholding or withdrawal of health care necessary to keep the principal alive).

The staff is troubled by the notion that a competent individual can effectively delegate present health care decisionmaking authority to another. We would be interested to hear from the experts in the medical field about whether this occurs now, how this works or should work, and whether it is a good policy. The staff suspects that the reason the rule is stated in such a roundabout way is that the law really does not want to permit agents to make decisions for competent patients, but the possibility is recognized as a way to prevent second-guessing of decisions where it is not clear whether the principal was competent.

Agent's Acceptance

The UHCDA does not provide any direct rules concerning the duty of the agent to act or implement any procedures for acceptance of the duties under a power of attorney. The Power of Attorney Law provides that an attorney-in-fact does not have a duty to act unless there is an express agreement in writing to act for the principal. Prob. Code § 4230; see also Section 4720 Comment. The UHCDA commentary to the optional form encourages use of an acceptance in the following terms:

Formal acceptance by an agent has been omitted not because it is an undesirable practice but because it would add another stage to executing an advance health-care directive, thereby further reducing the number of individuals who will follow through and create directives. However, practitioners who wish to adapt this form for use by their clients are strongly encouraged to add a formal acceptance. Designated agents have no duty to act until they accept the office either expressly or through their conduct. Consequently, requiring formal acceptance reduces the risk that a designated agent will decline to act when the need arises. Formal acceptance also makes it more likely that the agent will become familiar with the principal's personal values and views on health care. While the form does not require formal acceptance, the explanation to the form does encourage principals to talk to the person they have named as agent to make certain that the

designated agent understands their wishes and is willing to take the responsibility.

This is a difficult issue to address by statute, as the Commission learned in working on Section 4230 in the PAL. If it is important to implement a principle such as “acceptance through conduct” as advocated in the UHCDA comment, it should be stated in the statute so there is no doubt about the rule’s existence. *The staff would either leave the existing California rule as it is or if a revise it as needed, but not leave the matter to a comment.* The staff does agree that the form, when we get to that stage, should probably not be further complicated by providing for a formal acceptance with attendant warnings. One goal of this project should be to simplify the existing statutory form, replace it with a simple form like that provided in the UHCDA, or leave form drafting to others, such as the California Medical Association.

Determination of Capacity

UHCDA § 2(d) Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician.

This is a practical rule affirming the reality of the physician-patient relationship. In daily experience, the medical professionals will make the necessary capacity determinations and the approach of the UHCDA is to avoid or minimize any need to obtain formal capacity determinations by courts. As with other aspects of the UHCDA, there is a specific record-keeping duty imposed on determinations of capacity and a duty to communicate to the patient and anyone else with decisionmaking authority. See UHCDA § 7(c). Of course, the determination of capacity and other triggering conditions are subject to control in the power of attorney. California does not provide any explicit rule of this nature as far as we are aware; the implicit approach of the DPAHC is to rely on good-faith determinations by the health care provider and attorney-in-fact and confirmation of the identity and status of the attorney-in-fact. (See, e.g., Prob. Code §§ 4750, 4751.). *The staff recommends adoption of the UHCDA rule and its associated recordkeeping and reporting standards.*

Maine clarifies that the determination under its version of UHCDA Section 2(d) must be made by the primary physician “or a court of competent

jurisdiction.” This language recognizes reality, of course, but might be objectionable if it undermines the purpose of the UHCDA to avoid judicial intervention unless necessary.

New Mexico has pulled several of the capacity-related provisions into a single section and cross-refers to it in its Section 2(d). Among other things, that procedure requires determinations of capacity or the existence of other conditions triggering a power of attorney to be made by “two qualified health-care professionals,” one of whom is the primary physician. This is reminiscent of the qualifications applicable under California’s Natural Death Act (Health & Safety Code § 7187.5):

A declaration becomes operative when (a) it is communicated to the attending physician and (b) the declarant is diagnosed and certified in writing by the attending physician and a second physician who has personally examined the declarant to be in a terminal condition or permanent unconscious condition and no longer able to make decisions regarding administration of life-sustaining treatment.

The NDA was amended to state this rule in 1991.

Agent’s Duty To Follow Instructions

UHCDA § 2(e) An agent shall make a health-care decision in accordance with the principal’s individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent’s determination of the principal’s best interest. In determining the principal’s best interest, the agent shall consider the principal’s personal values to the extent known to the agent.

This is, of course, the fundamental rule governing conduct of agents. It is the fiduciary principal adapted to the health care decisionmaking context. Probate Code Section 4720(c) in the DPAHC provides a similar rule:

(c) In exercising the authority under the durable power of attorney for health care, the attorney-in-fact has a duty to act consistent with the desires of the principal as expressed in the durable power of attorney or otherwise made known to the attorney-in-fact at any time or, if the principal’s desires are unknown, to act in the best interests of the principal.

The suggestion was made at the January Commission meeting that if existing law and the UHCDA have inconsistent rules, but other factors are equal, the

presumption should be in favor of adopting the UHCDA language. This is different from our usual approach which favors continuity of existing rules unless there is a reason to change. In this case, the UHCDA provision states directly that the agent determines the principal's best interest and that the principal's values known to the agent are to be considered. This appears to be a more subjective standard than the DPAHC rule requiring the attorney-in-fact to act in the principal's best interests (which could be interpreted as an objective standard) and does not refer to the personal values of the principal. On balance, *the staff prefers the UHCDA rule.*

Judicial Involvement

UHCDA § 2(f) A health-care decision made by an agent for a principal is effective without judicial approval.

This provision implements the same general policy as Section 4900 in the Power of Attorney Law: "A power of attorney is exercisable free of judicial intervention, subject to this part." The UHCDA statement is more direct and applies specifically to health care decisions, whereas the PAL provision is a general rule applying to all powers of attorney, not just health care powers. *The staff thinks it would be beneficial to include the UHCDA rule.*

Nomination of Conservator

UHCDA § 2(g) A written advance health-care directive may include the individual's nomination of a guardian of the person.

Section 4126 in the Power of Attorney Law provides a far more detailed rule applicable to all powers of attorney. *The staff would keep the existing rule but add authority in Section 4126 or elsewhere for nomination of a guardian or conservator by means of a written individual instruction.*

Validating Provision

UHCDA § 2(h) An advance health-care directive is valid for purposes of this [Act] if it complies with this [Act], regardless of when or where executed or communicated.

According to the comment, this provision applies to directives executed before the UHCDA was enacted in the jurisdiction, as well as to instruments executed in other jurisdictions.

California law has detailed and highly confusing transitional provisions concerning the validity of earlier statutory form powers of attorney for health care and other instruments. Sorting through those rules will be left for another time. But as to foreign instruments (there is no rule on oral instructions in existing law), the DPAHC provides:

4653. A durable power of attorney for health care or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, shall be valid and enforceable in this state to the same extent as a durable power of attorney for health care validly executed in this state.

4752. In the absence of knowledge to the contrary, a physician and surgeon or other health care provider may presume that a durable power of attorney for health care or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

Section 4653 requires a determination that an instrument complies with the law of this or some other state or jurisdiction. This is technically broader than the UHCDA rule, which requires compliance with its own requirements, but since the UHCDA execution requirements are so minimal, it is not likely to invalidate foreign state directives in many cases. Still the California rule goes farther and validates instruments that could fail under the UHCDA rule, such as where a technical witnessing rule is not complied with. Note that the NDA provides the same rule concerning withholding or withdrawal of life-sustaining treatment. Health & Safety Code § 7192.5. *The staff sees no reason to retreat from the existing California rule.* It is consistent in spirit with the UHCDA rule and also protects the policy from later amendments that might defeat the UHCDA approach. New Mexico did not include subdivision (h) in its UHCDA; Maine added a provision as in California law making the directive valid if it complies with the law of the state where executed.

On the other hand, some may conclude that the existing policy is too broad and should be reevaluated. The UHCDA rule at least makes sure that its minimal standards are satisfied (although it is not clear at this point that California would adopt the minimal standards as a general rule), whereas the California rule could theoretically avoid any limitations in the interest of granting full comity to standards of other jurisdictions.

DECISIONMAKER'S RIGHT TO INFORMATION

UHCDA § 8. Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information.

Under the UHCDA, an agent, guardian, or surrogate stands in the shoes of the patient and has full access to patient records unless the right is restricted by an advance directive.

Section 4721 in the DPAHC provides the same right, but in different terms:

4721. Except to the extent the right is limited by the durable power of attorney for health care, an attorney-in-fact designated to make health care decisions under a durable power of attorney for health care has the same right as the principal to receive information regarding the proposed health care, to receive and review medical records, and to consent to the disclosure of medical records.

In effect, the UHCDA rule is broader because it applies one rule to all types of persons authorized to make decisions under the act and the “unless” clause is not limited to powers of attorney. Read literally, the UHCDA rule would seem to permit an oral individual instruction (a type of advance directive) to limit the ability of an agent under a power of attorney or a court-appointed conservator to obtain records. This is probably consistent with the revocation rules under Section 4727, which allow a principal to revoke a DPAHC or the attorney-in-fact’s authority either orally or in writing. For this purpose, the principal is presumed to have capacity. But we doubt that existing law would allow a conservatee to preclude access to medical records by a conservator. *The staff believes that a broader rule will be needed to cover the expanded concept of advance health care directives, but that the UHCDA does not make some necessary distinctions. We will do more research on the issue and consider alternatives when we prepare a draft statute for Commission consideration. We will also consider the impact of other rules, such as Health and Safety Code Section 123100 which distinguishes between the individual’s right to his or her own records and the right of “persons having responsibility for decisions respecting the health of others.” The latter class “in general” has “access to*

information on the patient's condition and care," whereas individuals have a right to "complete information respecting his or her condition and care."

As time permits, we will present the other major parts of the UHCDA — relating to surrogacy, the "optional" form, and the obligations and immunities of health care providers. After preliminary policy decisions and directions are made, the staff will be in a position to put a rough draft together for more detailed consideration.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

UNIFORM HEALTH-CARE DECISIONS ACT

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS ONE-HUNDRED-AND-SECOND YEAR
IN CHARLESTON, SOUTH CAROLINA
JULY 30 - AUGUST 6, 1993



WITH PREFATORY NOTE AND COMMENTS

Approved by the American Bar Association
Kansas City, Missouri, February 7, 1994

UNIFORM HEALTH-CARE DECISIONS ACT

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UNIFORM HEALTH-CARE DECISIONS ACT

PREFATORY NOTE

Since the Supreme Court's decision in *Cruzan v. Commissioner, Missouri Department of Health*, 497 U.S. 261 (1990), significant change has occurred in state legislation on health-care decision making. Every state now has legislation authorizing the use of some sort of advance health-care directive. All but a few states authorize what is typically known as a living will. Nearly all states have statutes authorizing the use of powers of attorney for health care. In addition, a majority of states have statutes allowing family members, and in some cases close friends, to make health-care decisions for adult individuals who lack capacity.

This state legislation, however, has developed in fits and starts, resulting in an often fragmented, incomplete, and sometimes inconsistent set of rules. Statutes enacted within a state often conflict and conflicts between statutes of different states are common. In an increasingly mobile society where an advance health-care directive given in one state must frequently be implemented in another, there is a need for greater uniformity.

The Health-Care Decisions Act was drafted with this confused situation in mind. The Act is built around the following concepts. *First*, the Act acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. An individual's instructions may extend to any and all health-care decisions that might arise and, unless limited by the principal, an agent has authority to make all health-care decisions which the individual could have made. The Act recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.

Second, the Act is comprehensive and will enable an enacting jurisdiction to replace its existing legislation on the subject with a single statute. The Act authorizes health-care decisions to be made by an agent who is designated to decide when an individual cannot or does not wish to; by a designated surrogate, family member, or close friend when an individual is unable to act and no guardian or agent has been appointed or is reasonably available; or by a court having jurisdiction as decision maker of last resort.

Third, the Act is designed to simplify and facilitate the making of advance health-care directives. An instruction may be either written or oral. A power of attorney for health care, while it must be in writing, need not be witnessed or acknowledged. In addition, an optional form for the making of a directive is provided.

Fourth, the Act seeks to ensure to the extent possible that decisions about an individual's health care will be governed by the individual's own desires concerning the issues to be resolved. The Act requires an agent or surrogate authorized to make health-care decisions for an individual to make those decisions in accordance with the instructions and other wishes of the individual to the extent known. Otherwise, the agent or surrogate must make those decisions in accordance with the best interest of the individual but in light of the individual's personal values known to the agent or surrogate. Furthermore, the Act requires a guardian to comply with a ward's previously given instructions and prohibits a guardian from revoking the ward's advance health-care directive without express court approval.

Fifth, the Act addresses compliance by health-care providers and institutions. A health-care provider or institution must comply with an instruction of the patient and with a reasonable interpretation of that instruction or other health-care decision made by a person then authorized to make

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health-care decisions for the patient. The obligation to comply is not absolute, however. A health-care provider or institution may decline to honor an instruction or decision for reasons of conscience or if the instruction or decision requires the provision of medically ineffective care or care contrary to applicable health-care standards.

Sixth, the Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

The Health-Care Decisions Act supersedes the Commissioners' Model Health-Care Consent Act (1982), the Uniform Rights of the Terminally Ill Act (1985), and the Uniform Rights of the Terminally Ill Act (1989). A state enacting the Health-Care Decisions Act which has one of these other acts in force should repeal it upon enactment.

SECTION 1. DEFINITIONS. In this [Act]:

- (1) "Advance health-care directive" means an individual instruction or a power of attorney for health care.
- (2) "Agent" means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power.
- (3) "Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.
- (4) "Guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual.
- (5) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition.
- (6) "Health-care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, including:
 - (i) selection and discharge of health-care providers and institutions;
 - (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
 - (iii) directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.
- (7) "Health-care institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.
- (8) "Health-care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.
- (9) "Individual instruction" means an individual's direction concerning a health-care decision for the individual.
- (10) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
- (11) "Physician" means an individual authorized to practice medicine [or osteopathy] under [appropriate statute].
- (12) "Power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power.
- (13) "Primary physician" means a physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.
- (14) "Reasonably available" means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs.

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(15) "State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(16) "Supervising health-care provider" means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual's health care.

(17) "Surrogate" means an individual, other than a patient's agent or guardian, authorized under this [Act] to make a health-care decision for the patient.

Comment

The term "advance health-care directive" (subsection (1)) appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.

The definition of "agent" (subsection (2)) is not limited to a single individual. The Act permits the appointment of co-agents and alternate agents.

The definition of "guardian" (subsection (4)) recognizes that some states grant health-care decision making authority to a conservator of the person.

The definition of "health care" (subsection (5)) is to be given the broadest possible construction. It includes the types of care referred to in the definition of "health-care decision" (subsection (6)), and to care, including custodial care, provided at a "health-care institution" (subsection (7)). It also includes non-medical remedial treatment such as practiced by adherents of Christian Science.

The term "health-care institution" (subsection (7)) includes a hospital, nursing home, residential-care facility, home health agency or hospice.

The term "individual instruction" (subsection (9)) includes any type of written or oral direction concerning health-care treatment. The direction may range from a written document which is intended to be effective at a future time if certain specified conditions arise and for which a form is provided in Section 4, to the written consent required before surgery is performed, to oral directions concerning care

recorded in the health-care record. The instruction may relate to a particular health-care decision or to health care in general.

The definition of "person" (subsection (10)) includes a limited liability company, which falls within the category of "other legal or commercial entity."

Because states differ on the classes of professionals who may lawfully practice medicine, the definition of "physician" (subsection (11)) cross-references the appropriate licensing or other statute.

The Act employs the term "primary physician" (subsection (13)) instead of "attending physician." The term "attending physician" could be understood to refer to any physician providing treatment to the individual, and not to the physician whom the individual, or agent, guardian, or surrogate, has designated or, in the absence of a designation, the physician who has undertaken primary responsibility for the individual's health care.

The term "reasonably available" (subsection (14)) is used in the Act to accommodate the reality that individuals will sometimes not be timely available. The term is incorporated into the definition of "supervising health-care provider" (subsection (16)). It appears in the optional statutory form (Section 4) to indicate when an alternate agent may act. In Section 5 it is used to determine when a surrogate will be authorized to make health-care decisions for an individual, and if so, which class of individuals has authority to act.

The definition of "supervising health-care provider" (subsection (16)) accommodates the circumstance that frequently arises where care

or supervision by a physician may not be readily available. The individual's primary physician is to assume the role, however, if reasonably available. For the contexts in which the term is used, see Sections 3, 5, and 7.

The definition of "surrogate" (subsection

(17)) refers to the individual having present authority under Section 5 to make a health-care decision for a patient. It does not include an individual who might have such authority under a given set of circumstances which have not occurred.

SECTION 2. ADVANCE HEALTH-CARE DIRECTIVES.

(a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the principal is receiving care.

(c) Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

(d) Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician.

(e) An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(f) A health-care decision made by an agent for a principal is effective without judicial approval.

(g) A written advance health-care directive may include the individual's nomination of a guardian of the person.

(h) An advance health-care directive is valid for purposes of this [Act] if it complies with this [Act], regardless of when or where executed or communicated.

Comment

The individual instruction authorized in subsection (a) may but need not be limited to take effect in specified circumstances, such as if the individual is dying. An individual instruction may be either written or oral.

Subsection (b) authorizes a power of attorney for health care to include instructions regarding

the principal's health care. This provision has been included in order to validate the practice of designating an agent and giving individual instructions in one document instead of two. The authority of an agent falls within the discretion of the principal as expressed in the instrument creating the power and may extend to any

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health-care decision the principal could have made while having capacity.

Subsection (b) excludes the oral designation of an agent. Section 5(b) authorizes an individual to orally designate a surrogate by personally informing the supervising health-care provider. A power of attorney for health care, however, must be in writing and signed by the principal, although it need not be witnessed or acknowledged.

Subsection (b) also limits those who may serve as agents to make health-care decisions for another. The subsection addresses the special vulnerability of individuals in residential long-term health-care institutions by protecting a principal against those who may have interests that conflict with the duty to follow the principal's expressed wishes or to determine the principal's best interest. Specifically, the owners, operators or employees of a residential long-term health-care institution at which the principal is receiving care may not act as agents. An exception is made for those related to the principal by blood, marriage or adoption, relationships which are assumed to neutralize any consequence of a conflict of interest adverse to the principal. The phrase "a residential long-term health-care institution" is placed in brackets to indicate to the legislature of an enacting jurisdiction that it should substitute the appropriate terminology used under local law.

Subsection (c) provides that the authority of the agent to make health-care decisions ordinarily does not become effective until the principal is determined to lack capacity and ceases to be effective should the principal recover capacity. A principal may provide, however, that the authority of the agent becomes effective immediately or upon the happening of some event other than the loss of capacity but may do so only by an express provision in the power of attorney. For example, a mother who does not want to make her own health-care decisions but prefers that her daughter make them for her may specify that the daughter as agent is to have authority to make health-care decisions immediately. The mother in that circumstance

retains the right to later revoke the power of attorney as provided in Section 3.

Subsection (d) provides that unless otherwise specified in a written advance health-care directive, a determination that a principal has lost or recovered capacity to make health-care decisions must be made by the primary physician. For example, a principal might specify that the determination of capacity is to be made by the agent in consultation with the primary physician. Or a principal, such as a member of the Christian Science faith who relies on a religious method of healing and who has no primary physician, might specify that capacity be determined by other means. In the event that multiple decision makers are specified and they cannot agree, it may be necessary to seek court instruction as authorized by Section 14.

Subsection (d) also provides that unless otherwise specified in a written advance health-care directive, the existence of other conditions which affect an individual instruction or the authority of an agent must be determined by the primary physician. For example, an individual might specify that an agent may withdraw or withhold treatment that keeps the individual alive only if the individual has an incurable and irreversible condition that will result in the individual's death within a relatively short time. In that event, unless otherwise specified in the advance health-care directive, the determination that the individual has that condition must be made by the primary physician.

Subsection (e) requires the agent to follow the principal's individual instructions and other expressed wishes to the extent known to the agent. To the extent such instructions or other wishes are unknown, the agent must act in the principal's best interest. In determining the principal's best interest, the agent is to consider the principal's personal values to the extent known to the agent. The Act does not prescribe a detailed list of factors for determining the principal's best interest but instead grants the agent discretion to ascertain and weigh the factors likely to be of importance to the principal. The legislature of an enacting jurisdiction that

wishes to add such a list may want to consult the Maryland Health-Care Decision Act, Md. Health-Gen. Code Ann. § 5-601.

Subsection (f) provides that a health-care decision made by an agent is effective without judicial approval. A similar provision applies to health-care decisions made by surrogates (Section 5(g)) or guardians (Section 6(c)).

Subsection (g) provides that a written advance health-care directive may include the individual's nomination of a guardian of the person. A nomination cannot guarantee that the nominee will be appointed but in the absence of cause to appoint another the court would likely select the nominee. Moreover, the mere nomi-

nation of the agent will reduce the likelihood that a guardianship could be used to thwart the agent's authority.

Subsection (h) validates advance health-care directives which conform to the Act, regardless of when or where executed or communicated. This includes an advance health-care directive which would be valid under the Act but which was made prior to the date of its enactment and failed to comply with the execution requirements then in effect. It also includes an advance health-care directive which was made in another jurisdiction but which does not comply with that jurisdiction's execution or other requirements.

SECTION 3. REVOCATION OF ADVANCE HEALTH-CARE DIRECTIVE.

(a) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.

(b) An individual may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) A health-care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(e) An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

Comment

Subsection (b) provides that an individual may revoke any portion of an advance health-care directive at any time and in any manner that communicates an intent to revoke. However, a more restrictive standard applies to the revocation of the portion of a power of attorney for health care relating to the designation of an agent. Subsection (a) provides that an individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider. This higher standard is justified by the risk of a false revocation of an agent's designation or of a misinterpretation or miscommunication of a

principal's statement communicated through a third party. For example, without this higher standard, an individual motivated by a desire to gain control over a patient might be able to assume authority to act as agent by falsely informing a health-care provider that the principal no longer wishes the previously designated agent to act but instead wishes to appoint the individual.

Subsection (c) requires any health-care provider, agent, guardian or surrogate who is informed of a revocation to promptly communicate that fact to the supervising health-care provider and to any health-care institution at

which the patient is receiving care. The communication triggers the Section 7(b) obligation of the supervising health-care provider to record the revocation in the patient's health-care record and reduces the risk that a health-care provider or agent, guardian or surrogate will rely on a health-care directive that is no longer valid.

determine the individual's intent, with the later advance health-care directive superseding the former to the extent of any inconsistency.

Subsection (e) establishes a rule of construction permitting multiple advance health-care directives to be construed together in order to

The section does not specifically address amendment of an advance health-care directive because such reference is not necessary. Subsection (b) specifically authorizes partial revocation, and subsection (e) recognizes that an advance health-care directive may be modified by a later directive.

SECTION 4. OPTIONAL FORM. The following form may, but need not, be used to create an advance health-care directive. The other sections of this [Act] govern the effect of this or any other writing used to create an advance health-care directive. An individual may complete or modify all or any part of the following form:

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) select or discharge health-care providers and institutions;
- (c) approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration,

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as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

(name of individual you choose as agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box , artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(10) Upon my death (mark applicable box)

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only

(c) My gift is for the following purposes (strike any of the following you do not want)

- (i) Transplant
- (ii) Therapy
- (iii) Research
- (iv) Education

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(11) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

(date)	(sign your name)
(address)	(print your name)
(city) (state)	

(Optional) SIGNATURES OF WITNESSES:

First witness	Second witness
(print name)	(print name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)

Comment

The optional form set forth in this section incorporates the Section 2 requirements applicable to advance health-care directives. There are four parts to the form. An individual may complete all or any parts 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 and the designation of a primary physician.

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 (1) of the power of attorney for health care form requires only the designation of a single agent, but with opportunity given to designate a single first alternate and a single second alternate, if the individual chooses. 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 (2) of the power of attorney for health care form grants the agent authority to make all health-care decisions for the individual subject to any limitations which the individual may state in the form. Reference is made to artificial nutrition and hydration and other forms of treatment to keep an individual alive in order to ensure that the individual is aware that those are forms of health care that the agent would have the authority to withdraw or withhold absent specific limitation.

Part 1 (3) of the power of attorney for health care form provides that the agent's authority becomes effective upon a determination that the individual lacks capacity, but as authorized by Section 2(c) a box is provided for the individual to indicate that the authority of the agent takes effect immediately.

Part 1 (4) of the power of attorney for health care form directs the agent to make health-care decisions in accordance with the power of attorney, any instructions given by the individual in Part 2 of the form, and the individual's other wishes to the extent known to the agent. To the extent the individual's wishes in the matter are not known, the agent is to make health-care decisions based on what the agent determines to be in the individual's best interest. In determining the individual's best interest, the agent is to consider the individual's personal values to the extent known to the agent. Section 2(e) imposes this standard, whether or not it is included in the form, but its inclusion in the form will bring it to the attention of the individual granting the power, to the agent, to any guardian or surrogate, and to the individual's health-care providers.

Part 1 (5) of the power of attorney for health care form nominates the agent, if available,

able, and willing to act, otherwise the alternate agents in order of priority stated, as guardians of the person for the individual. This provision is included in the form for two reasons. First, if an appointment of a guardian becomes necessary the agent is the one whom the individual would most likely want to serve in that role. Second, the nomination of the agent as guardian will reduce the possibility that someone other than the agent will be appointed as guardian who could use the position to thwart the agent's authority.

Because the variety of treatment decisions to which health-care instructions may relate is virtually unlimited, Part 2 of the form does not attempt to be comprehensive, but is directed at the types of treatment for which an individual is most likely to have special wishes. Part 2(6) of the form, entitled "End-of-Life Decisions", provides two alternative choices for the expression of wishes concerning the provision, withholding, or withdrawal of treatment. Under the first choice, the individual's life is not to be prolonged if the individual has an incurable and irreversible condition that will result in death within a relatively short time, if the individual becomes unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or if the likely risks and burdens of treatment would outweigh the expected benefits. Under the second choice, the individual's life is to be prolonged within the limits of generally accepted health-care standards. Part 2(7) of the form provides a box for an individual to mark if the individual wishes to receive artificial nutrition and hydration in all circumstances. Part 2(8) of the form provides space for an individual to specify any circumstance when the individual would prefer not to receive pain relief. Because the choices provided in Parts 2(6) to 2(8) do not cover all possible situations, Part 2(9) of the form provides space for the individual to write out his or her own instructions or to supplement the instructions given in the previous subparts of the form. Should the space be insufficient, the individual is free to add additional pages.

The health-care instructions given in Part 2 of

the form are binding on the agent, any guardian, any surrogate, and, subject to exceptions specified in Section 7(e)-(f), on the individual's health-care providers. Pursuant to Section 7(d), a health-care provider must also comply with a reasonable interpretation of those instructions made by an authorized agent, guardian, or surrogate.

Part 3 of the form provides the individual an opportunity to express an intention to donate bodily organs and tissues at death. The options provided are derived from a suggested form in the Comment to Section 2 of the Uniform Anatomical Gift Act (1987).

Part 4 of the form provides space for the individual to designate a primary physician should the individual choose to do so. Space is also provided for the designation of an alternate primary physician should the first designated physician not be available, able, or willing to act.

Paragraph (12) of the form conforms with the provisions of Section 12 by providing that a copy of the form has the same effect as the original.

The Act does not require witnessing, but to

encourage the practice the form provides space for the signatures of two witnesses.

The form does not require formal acceptance by an agent. Formal acceptance by an agent has been omitted not because it is an undesirable practice but because it would add another stage to executing an advance health-care directive, thereby further reducing the number of individuals who will follow through and create directives. However, practitioners who wish to adapt this form for use by their clients are strongly encouraged to add a formal acceptance. Designated agents have no duty to act until they accept the office either expressly or through their conduct. Consequently, requiring formal acceptance reduces the risk that a designated agent will decline to act when the need arises. Formal acceptance also makes it more likely that the agent will become familiar with the principal's personal values and views on health care. While the form does not require formal acceptance, the explanation to the form does encourage principals to talk to the person they have named as agent to make certain that the designated agent understands their wishes and is willing to take the responsibility.

SECTION 5. DECISIONS BY SURROGATE.

(a) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

- (1) the spouse, unless legally separated;
- (2) an adult child;
- (3) a parent; or
- (4) an adult brother or sister.

(c) If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate his or her assumption of authority as promptly as practica-

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ble to the members of the patient's family specified in subsection (b) who can be readily contacted.

(e) If more than one member of a class assumes authority to act as surrogate, and they do not agree on a health-care decision and the supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

(f) A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

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

(h) An individual at any time may disqualify another, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health-care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the patient is receiving care.

(j) A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

Comment

Subsection (a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law.

While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, subsection (b) affirms the principle of patient autonomy by allowing an individual to designate a surrogate by personally informing the supervising health-care provider. The supervising health-care

provider would then, in accordance with Section 7(b), be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a).

If an individual does not designate a surrogate or if the designee is not reasonably available, subsection (b) applies a default rule for selecting a family member to act as surrogate. Like all default rules, it is not tailored to every situation, but incorporates the presumed desires of a majority of those who find themselves so situated. The relationships specified in subsection (b) include those of the half-blood and by adoption, in addition to those of the whole blood.

Subsection (c) permits a health-care decision to be made by a more distant relative or unrelated adult with whom the individual enjoys a

close relationship but only if all family members specified in subsection (b) decline to act or are otherwise not reasonably available. Consequently, those in non-traditional relationships who want to make certain that health-care decisions are made by their companions should execute powers of attorney for health care designating them as agents or, if that has not been done, should designate them as surrogates.

Subsections (b) and (c) permit any member of a class authorized to serve as surrogate to assume authority to act even though there are other members in the class.

Subsection (d) requires a surrogate who assumes authority to act to immediately so notify the members of the patient's family who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a guardian or the commencement of judicial proceedings under Section 14, should the need arise.

Subsection (e) addresses the situation where more than one member of the same class has assumed authority to act as surrogate and a disagreement over a health-care decision arises of which the supervising health-care provider is informed. Should that occur, the supervising 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 the members of the class who have communicated their views to the provider are evenly divided concerning the health-care decision, however, then the entire class is disqualified from making the decision and no individual having lower priority may act as surrogate. When such a deadlock arises, it may be necessary to seek court determination of the issue as authorized by Section 14.

Subsection (f) imposes on surrogates the

same standard for health-care decision making as is prescribed for agents in Section 2(e). The surrogate must follow the patient's individual instructions and other expressed wishes to the extent known to the surrogate. To the extent such instructions or other wishes are unknown, the surrogate must act in the patient's best interest. In determining the patient's best interest, the surrogate is to consider the patient's personal values to the extent known to the surrogate.

Subsection (g) provides that a health-care decision made by a surrogate is effective without judicial approval. A similar provision applies to health-care decisions made by agents (Section 2(f)) or guardians (Section 6(c)).

Subsection (h) permits an individual to disqualify any family member or other individual from acting as the individual's surrogate, including disqualification of a surrogate who was orally designated.

Subsection (i) 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 patient by blood, marriage, or adoption. This disqualification is similar to that for appointed agents. See Section 2(b) and Comment.

Subsection (j) permits a supervising health-care provider to require an individual claiming the right to act as surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A supervising health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as surrogate, and Section 9(a) protects a health-care provider or institution from liability for complying with the decision of such an individual, absent knowledge that the individual does not in fact have such authority.

SECTION 6. DECISIONS BY GUARDIAN.

- (a) A guardian shall comply with the ward's individual instructions and may not revoke the ward's advance health-care directive unless the appointing court expressly so authorizes.
- (b) Absent a court order to the contrary, a health-care decision of an agent takes precedence over that of a guardian.
- (c) A health-care decision made by a guardian for the ward is effective without judicial approval.

Comment

The Act affirms that health-care decisions should whenever possible be made by a person whom the individual selects to do so. For this reason, subsection (b) provides that a health-care decision of an agent takes precedence over that of a guardian absent a court order to the contrary, and subsection (a) provides that a guardian may not revoke the ward's power of attorney for health care unless the appointing court expressly so authorizes. Without these subsections, a guardian would in many states have authority to revoke the ward's power of attorney for health care even though the court appointing the guardian might not be aware that the principal had made such alternate arrangement.

The Act expresses a strong preference for honoring an individual instruction. Under the Act, an individual instruction must be honored by an agent, by a surrogate, and, subject to exceptions specified in Section 7(e)-(f), by an individual's health-care providers. Subsection (a) extends this principle to guardians by requir-

ing that a guardian effectuate the ward's individual instructions. A guardian may revoke the ward's individual instructions only if the appointing court expressly so authorizes.

Courts have no particular expertise with respect to health-care decision making. Moreover, the delay attendant upon seeking court approval may undermine the effectiveness of the decision ultimately made, particularly but not only when the patient's condition is life-threatening and immediate decisions concerning treatment need to be made. Decisions should whenever possible be made by a patient, or the patient's guardian, agent, or surrogate in consultation with the patient's health-care providers without outside interference. For this reason, subsection (c) provides that a health-care decision made by a guardian for the ward is effective without judicial approval, and the Act includes similar provisions for health-care decisions made by agents (Section 2(f)) or surrogates (Section 5(g)).

SECTION 7. OBLIGATIONS OF HEALTH-CARE PROVIDER.

- (a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.
- (b) A supervising health-care provider who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, or a designation or disqualification of a surrogate, shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and if one is furnished shall arrange for its maintenance in the health-care record.
- (c) A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the

authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's health-care record and communicate the determination to the patient, if possible, and to any person then authorized to make health-care decisions for the patient.

(d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:

- (1) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and
- (2) comply with a health-care decision for the patient 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.

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:

- (1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;
- (2) provide continuing care to the patient until a transfer can be effected; and
- (3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

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

Comment

Subsection (a) further reinforces the Act's respect for patient autonomy by requiring a supervising 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.

The recording requirement in subsection (b) reduces the risk that a health-care provider or institution, or agent, guardian or surrogate, will rely on an outdated individual instruction or the decision of an individual whose authority has

been revoked.

Subsection (c) imposes recording and communication requirements relating to determinations that may trigger the authority of an agent, guardian or surrogate to make health-care decisions on an individual's behalf. The determinations covered by these requirements are those specified in Sections 2(c)-(d) and 5(a).

Subsection (d) requires health-care providers and institutions to comply 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 patient's rights to autonomy and self-determination and validate and seek to effectuate the substitute decision making authorized by the Act.

Not all instructions or decisions must be honored, however. Subsection (e) authorizes a health-care provider to decline to comply with an individual instruction or health-care decision for reasons of conscience. Subsection (e) also allows a health-care institution to decline to comply with a health-care instruction or decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to an individual then authorized to make health-care decisions for the patient.

Subsection (f) further authorizes a health-care provider or institution to decline to comply with an instruction or decision that requires the provision of care which would be medically ineffective or contrary to generally accepted health-care standards applicable to the provider or

institution. "Medically ineffective health care", as used in this section, means treatment which would not offer the patient any significant benefit.

Subsection (g) requires a health-care provider or institution that declines to comply with an individual instruction or health-care decision 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 provider or institution also must provide continuing care to the patient until a transfer can be effected. In addition, unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, the health-care provider or institution must immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

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

SECTION 8. HEALTH-CARE INFORMATION. Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information.

Comment

An agent, guardian, or surrogate stands in the shoes of the patient when making health-care decisions. To assure fully informed decision making, this section provides that a person who is then authorized to make health-care decisions

for a patient has the same right of access to health-care information as does the patient unless otherwise specified in the patient's advance health-care directive.

SECTION 9. IMMUNITIES.

(a) A health-care provider or institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or institution is not subject to

civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying with a health-care decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw health care;

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

(3) complying with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated.

(b) An individual acting as agent or surrogate under this [Act] is not subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith.

Comment

The section grants broad protection from liability for actions taken in good faith. Subsection (a) permits a health-care provider or institution to comply with a health-care decision made by a person appearing to have authority to make health care decisions for a patient; to decline to comply with a health-care decision made by a person believed to be without authority; and to assume the validity of and to comply with an advance health-care directive. Absent bad faith or actions taken that are not in accord with generally accepted health-care standards, a health-care provider or institution has no duty to investigate a claim of authority or the validity of an advance health-care directive.

Subsection (b) protects agents and surrogates acting in good faith from liability for making a health-care decision for a patient. Also protected from liability are individuals who mistakenly but in good faith 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 surrogate unaware that a family member having a higher priority was reasonably available and authorized to act.

SECTION 10. STATUTORY DAMAGES.

(a) A health-care provider or institution that intentionally violates this [Act] is subject to liability to the aggrieved individual for damages of \$[500] or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health-care directive or a revocation of an advance health-care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, is subject to liability to that individual for damages of \$[2,500] or actual damages resulting from the action, whichever is greater, plus reasonable attorney's fees.

Comment

Conduct which intentionally violates the Act and which interferes with an individual's autonomy to make health-care decisions, either personally or through others as provided under the Act, is subject to civil damages rather than criminal penalties out of a recognition that prosecutions are unlikely to occur. The legislature of an enacting state will have to determine the

amount of damages which needs to be authorized in order to encourage the level of potential private enforcement actions necessary to effect compliance with the obligations and responsibilities imposed by the Act. The damages provided by this section do not supersede but are in addition to remedies available under other law.

SECTION 11. CAPACITY.

(a) This [Act] does not affect the right of an individual to make health-care decisions while having capacity to do so.

(b) An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive, and to designate or disqualify a surrogate.

Comment

This section reinforces the principle of patient autonomy by providing a rebuttable presumption that an individual has capacity for all

decisions relating to health care referred to in the Act.

SECTION 12. EFFECT OF COPY. A copy of a written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original.

Comment

The need to rely on an advance health-care directive may arise at times when the original is inaccessible. 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 valid written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original.

SECTION 13. EFFECT OF [ACT].

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

(b) Death resulting from the withholding or withdrawal of health care in accordance with this [Act] does not for any purpose 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.

(c) This [Act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.

(d) This [Act] does not authorize or require a health-care provider or institution to provide health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

[(e) This [Act] does not authorize an agent or surrogate to consent to the admission of an individual to a mental health-care institution unless the individual's written advance health-care directive expressly so provides.]

[(f) This [Act] does not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a [mental health-care institution under appropriate statute].]

UNIFORM HEALTH-CARE DECISIONS ACT

§ 15

Comment

Subsection (e) is included to accommodate the legislature of an enacting jurisdiction that wishes to address in this Act rather than by separate statute the authority of an agent or surrogate to consent to the admission of an individual to a mental health-care institution. In recognition of the principle of patient autonomy, however, an individual may authorize an agent or surrogate to consent to an admission to a mental health-care institution but may do so only by express provision in an advance health-care directive. Subsection (e) does not address the authority of a guardian to consent to an

admission, leaving that matter to be decided under state guardianship law.

All states surround the involuntary commitment process with procedural safeguards. Moreover, state mental health codes contain detailed provisions relating to the treatment of individuals subject to commitment. Subsection (f) is included in the event that the legislature of an enacting jurisdiction wishes to clarify that a general health-care statute such as this Act is intended to supplement and not supersede these more detailed provisions.

SECTION 14. JUDICIAL RELIEF. On petition of a patient, the patient's agent, guardian, or surrogate, a health-care provider or institution involved with the patient's care, or an individual described in Section 5(b) or (c), the [appropriate] court may enjoin or direct a health-care decision or order other equitable relief. A proceeding under this section is governed by [here insert appropriate reference to the rules of procedure or statutory provisions governing expedited proceedings and proceedings affecting incapacitated persons].

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, the members of a class of surrogates authorized to act under Section 5 may be evenly divided with respect to the advisability of a particular health-care decision. In that circumstance, authorization to proceed may have to be obtained from a court. Examples of other legitimate issues that may from time to time arise include whether an agent or surrogate has authority to act and whether an agent or surrogate has complied with the standard of care imposed by Sections 2(e) and 5(f).

This section has a limited scope. The court under this section may grant only equitable relief. Other adequate avenues exist for those

who wish to pursue money damages. The class of potential petitioners is also limited to those with a direct interest in a patient's health care.

The final portion of this section has been placed in brackets in recognition of the fact that states vary widely in the extent to which they codify procedural matters in a substantive act. The legislature of an enacting jurisdiction is encouraged, however, to cross-reference to its rules on expedited proceedings or rules on proceedings affecting incapacitated persons. The legislature of an enacting jurisdiction which wishes to include a detailed procedural provision in its adoption of the Act may want to consult Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases (2d ed. 1992), published by the National Center for State Courts.

SECTION 15. UNIFORMITY OF APPLICATION AND CONSTRUCTION. This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject matter of this [Act] among States enacting it.

SECTION 16. SHORT TITLE. This [Act] may be cited as the Uniform Health-Care Decisions Act.

SECTION 17. SEVERABILITY CLAUSE. If any provision of this [Act] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

SECTION 18. EFFECTIVE DATE. This [Act] takes effect on

SECTION 19. REPEAL. The following acts and parts of acts are repealed:

- (1)
- (2)
- (3)