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THE NEW UNIFORM HEALTH CARE DECISIONS ACT: 
PAVING A HEALTH CARE DECISIONS 
SUPERHIGHWAY?

CHARLES P. SABATINO*

INTRODUCTION

Advocate directive statutes have become a familiar component of state legislation since 1976 when California enacted the first "living will" statute.1 Today, every state has one or more health care decisions statutes relating to living wills, health care powers of attorney, and other forms of surrogate decisionmaking. All seek to provide a clear pathway for personal control over health care decisionmaking.2 With few exceptions, however, these laws suffer two significant flaws. First, they lack comprehensiveness, addressing only narrow areas of the issue; and second, they are tortuous in formality and procedure.3 In 1985, the Uniform Law Commissioners released the Uniform Rights of the Terminally Ill Act (URTIA),4 hoping to interject some order and simplicity into the picture. Unfortunately, URTIA made only modest progress and failed to offer a simple and comprehensive scheme for decisionmaking.5

In August 1993, after two years of drafting, the Uniform Law Commissioners approved the entirely new Uniform Health Care Decisions Act (UHCDA) to replace URTIA.6 The American Bar Associa-

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3. See David M. English, The UPC and the New Durable Powers, 27 REAL PROP., PROBATE, & TRUST J. 333, 336 (1992) (noting that "[u]niformity, an important goal for ... health powers, is now only a mirage.").
6. UNIFORM HEALTH CARE DECISIONS ACT (1993) (the Act superseded the Commissioners' Model Health-Care Consent Act (1982), the Uniform Rights of the Terminally Ill Act (1985), and the Uniform Rights of the Terminally Ill Act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)) [hereinafter UHCDA].

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tion endorsed the new Act in February 1994. In contrast to the narrowness of URTIA, UHCDA strives to pave a health care decision-making superhighway. This Article describes UHCDA from the point of view of one observer/advisor who had the opportunity to follow the drafting committee's work in progress. It begins with an overview of the basic assumptions underlying the Act and then provides a selective tour of the Act's more important provisions.

I. Basic Assumptions

Three fundamental goals drive nearly every provision of the UHCDA: (1) recognition of individual autonomy; (2) comprehensiveness of decisionmaking options; and (3) simplicity consistent with the way individuals and health care providers actually operate. The drafting committee acted upon these goals to an extent unprecedented in current state legislation. The result is a model act that provides a serious new benchmark for state legislation rather than a rehash of provisions already common in state law.

A. Individual Autonomy

To encourage individual autonomy, the drafters disposed of nearly all restrictions on and preconditions for the operation of advance directives. Thus, an individual may dictate various instructions—regarding treatment wishes or naming an agent for health care decisionmaking—in whatever terms or form the individual chooses. Execution requirements such as witnessing are absent. Also absent are preconditions such as certification of diagnosis of a terminal condition or permanent unconsciousness, the need for life-sustaining procedures, and special rules for nutrition and hydration or pregnancy. This unencumbered approach keeps the focus of decisionmaking where it should be—on discerning what the patient meant by his or her words and instructions, even if they are less than clear, rather than on what the legislature meant by its terms and instructions.

B. Comprehensiveness

The current condition of state health care decisions legislation is fragmented, incomplete, and often inconsistent, both among the

8. See infra notes 29-33 and accompanying text.
states and even within states. The UHCDA drafters sought to combat this confusion by providing a comprehensive statutory scheme. The UHCDA covers in a single statute all forms of advance directives, as well as decisionmaking in the absence of an advance directive. The Act stops short, however, on three important matters. First, it does not address surrogate decisionmaking for minors, although it does cover emancipated minors. Second, it does not clearly address decisionmaking in the absence of both an advance directive and a surrogate authorized under the Act. Finally, it does not expressly address the operation of advance directives in the context of emergency medical services in the home and community.

1. Minors.—As to minors, the drafters concluded: “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.” This explanation, however, is equally persuasive as an argument for why a uniform act should apply to minors. For example, the Illinois Health Care Surrogate Act covers decisionmaking for adults and minors in a single statute. As a practical matter, it is a formidable and complex challenge to cover the full range of possible health care decisions, parental and custodial arrangements, and levels of maturity of minors under one act. The drafting committee wisely left it to another day. Nevertheless, it is up to the Uniform Law Commissioners to make sure that the issue is not lost. A separate uniform act on health care decisionmaking for minors should be seriously considered.

2. No Advance Directive or Surrogate.—As to decisionmaking in the absence of both an advance directive and a natural surrogate, the time may not be ripe for a national model. There are simply no viable models or innovative precedents in place to draw from, other than resorting to guardianship.

3. Emergency Medical Services.—The Act’s principles certainly apply in concept to emergency medical services. However, special protocols and protections are needed to enable emergency medical services

10. See English, supra note 3, at 336.
11. See supra note 3.
12. Id. § 2(a).
14. However, the Act focuses solely on decisions to terminate life support under narrowly defined circumstances. Id.
15. A guardian’s authority to make health care decisions is determined by the terms of the judicial appointment. See supra note 3.
personnel to withhold resuscitation in emergencies. Because state legislators have only just begun to address this situation through legislation and regulation, the drafters concluded that it was premature to codify protocols or guidelines in model legislation.16

C. Simplicity

Simplicity is evident throughout UHCDA, especially in the Act's relative brevity and in the elimination of formalities for the execution of advance directives. Without the commentary, the Act is barely 3500 words, or about half the length of the 1993 Maryland Health Care Decisions Act.17 Predictably, some will criticize the Act for dismissing widely used formalities such as witnessing protocols and witness restrictions. However, the drafters were motivated by the fact that less than twenty percent of the adult public has made use of advance directives, despite their nearly twenty years of existence.18 If the formalities and other protective measures discourage the majority of adults from using advance directives, then their value is doubtful at best.

II. Section 1—Definitions

Seventeen definitions comprise section 1 of the Act. Most are familiar, but many have benefited from a fair amount of streamlining. The Act uses the term “advance health-care directive” as a generic term covering both an “individual instruction” and a “power of attorney for health care.”19 The term “health care” is sweeping in scope, meaning “any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual’s physical or mental condition.”20 A “health-care decision” reiterates this broad sweep and...
expressly includes the selection and discharge of providers as well as directions regarding artificial nutrition and hydration.\textsuperscript{21}

There are three possible decisionmakers for an individual who lacks "capacity": an "agent" designated in a power of attorney;\textsuperscript{22} a "guardian" who has been granted authority by the court to make health care decisions;\textsuperscript{23} and a "surrogate," who is any one of several default family or friend decisionmakers identified in section 5 of the Act.\textsuperscript{24}

"Capacity" is defined as "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."\textsuperscript{25} This definition strives to keep capacity determinations situation-specific, rather than global, by focusing on one particular health care decision at a time. A separate section of the Act establishes a rebuttable presumption of capacity and reiterates the preeminent right of an individual to make health care decisions while having capacity to do so.\textsuperscript{26}

A novel term used in the Act is that of "supervising health-care provider" which 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."\textsuperscript{27} The term ensures that someone with authority can assume responsibility for certain matters when the primary physician is unavailable. Such matters include responding to revocations of advance directives under section 3, accepting the oral designation of a surrogate by a patient under section 5, informing the patient of a surrogate decision before implementing it under section 7, and documenting information in the medical record regarding a patient's advance directives or surrogate, as required by section 7.\textsuperscript{28}

\textsuperscript{21} See id. § 1(6)(i), (iii). A "health-care decision" also includes "approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate." Id. § 1(6)(ii).

\textsuperscript{22} Id. § 1(2).

\textsuperscript{23} Id. § 1(4).

\textsuperscript{24} See id. § 1(17) & cmt. By including a guardian as one of three possible decisionmakers, the Act clearly downplays the use of guardianship and seeks to keep decision-making out of the courts absent a real controversy.

\textsuperscript{25} Id. § 1(3).

\textsuperscript{26} See id. § 11.

\textsuperscript{27} Id. § 1(16).

\textsuperscript{28} See id. § 1(16) cmt.
III. SECTION 2—ADVANCE HEALTH CARE DIRECTIVES

This compact section sets forth nearly all the operating principles for advance directives under the Act.

A. Individual Instruction

One of the most significant departures from the prevailing approach is the provision of an “individual instruction.” The term replaces the more limited, stand-alone concept of a “living will.” Unlike living wills, which are typically limited to end-of-life decisions, an “instruction” may relate to any aspect of one’s health care under any circumstances that the maker chooses to specify. Another important difference is that an instruction may be oral as well as written.

Written instructions may be in any form and require no witnesses or other formality, although the sample advance directive form in section 4 encourages the use of witnesses. Oral instructions are likewise free of any required formalities except that a supervising health care provider must record an oral instruction in the medical record. By recognizing oral instructions, the Act affirms the legitimacy and value of direct communication between doctor and patient. Unfortunately, this policy dissipates the incentive to create a formal directive. “Why bother, if I can just tell my physician?” In addition, although an oral instruction is recorded by the doctor in the medical record, it is unlikely that such notes will be as readily recognizable or as portable as a separate, formal instruction. Thus, oral instructions may be lost in the system or misinterpreted by the ultimate decisionmaker.

B. Agent

Section 2(b) establishes a person’s broad power to delegate to an agent, under a power of attorney for health care, the authority “to make any health-care decision the principal could have made while having capacity.” Unlike the individual instruction, the power of attorney must be in writing and signed by the individual. No witnessing or other formality is required. In the name of simplicity and personal autonomy, the drafters had considered eliminating any limitations whatsoever on the choice of agent. After considerable deliberation:

29. Id. § 2(a).
30. Id.
31. See id.
32. Id.
33. Id. § 7(b).
34. Id. § 2(b).
35. Id.
ation, however, they concluded that persons in long-term care residential settings were uniquely vulnerable and in need of special protection against decisionmakers who could have a fundamental conflict of interest by virtue of their connection to the institution. Thus, unless related to the principal by blood, marriage, or adoption, section 2(b) precludes owners, operators, or employees of residential long-term health care institutions from serving as agents.36

C. Orally Designated Surrogate

The welcome simplicity of the power of attorney for health care is unfortunately confounded by a concept that underlies section 5 of the Act. Specifically, section 5(b) authorizes an individual to "designate any individual to act as surrogate by personally informing the supervising health-care provider."37 The orally designated surrogate has decisionmaking priority over all others when there is no advance directive or guardian authorized to make health care decisions.38

There may be little difference between an orally designated surrogate and an agent under a written power of attorney. They are both, at heart, agency relationships. However, the oral designation is not treated as such under the Act's definitions,39 perhaps because the law frowns upon the notion of an oral power of attorney. Yet, under the Act, only three differences are apparent between the two. First, an agent under a written power of attorney for health care has priority over an orally designated surrogate.40 Second, the authority of an orally designated surrogate is trumped by a guardian.41 This is not so with an agent's authority, unless the court expressly authorizes the guardian to override the agent.42 Third, when an orally designated surrogate assumes authority, the surrogate has a duty to communicate this fact to the patient's spouse, adult children, parents, and brothers and sisters "who can be readily contacted."43 The agent has no such duty.

Inclusion of the orally designated surrogate may be commended as a serious attempt to acknowledge the way decisions are actually made. It is far more likely that a patient will say, "Doc, if anything

36. See id. § 2(b).
37. Id. § 5(b).
38. See id.
39. See supra notes 22-24 and accompanying text.
40. See UHCDA § 5(a).
41. Id.
42. Id. § 6(a), (b).
43. Id. § 5(d).
happens to me, talk to my daughter, Mary. I trust her," than for the patient to execute a written power of attorney. On the other hand, the oral designation causes the same problems that an oral instruction causes, only worse. It has always been difficult to explain powers of attorney for health care to the general public and to convince people to use them. With an orally designated surrogate in the picture, the explanation of those vehicles becomes doubly confusing, and the arguments for using them less convincing. The response is likely to be, "Why bother using a written power, when I can simply mention my choice of decisionmaker to my doctor on the morning of surgery?"

D. Triggers

The individual has the right to specify when an advance directive becomes effective and how trigger conditions, if any, are to be determined.\textsuperscript{44} If the individual provides no alternative direction, then a power of attorney for health care becomes effective upon the person's loss of capacity as determined by the primary physician.\textsuperscript{45} No concurrence or other secondary opinions are required.

E. Standard for Decisionmaking

A standard for decisionmaking first appears in subsection (e), applicable to an agent.\textsuperscript{46} The agent must follow the principal's instructions and other expressed wishes to the extent known to the agent. Otherwise, the agent must act in the principal's best interest as determined by the agent, taking into account the principal's "personal values" to the extent known to the agent.\textsuperscript{47} The drafters chose not to develop a set of required factors for determining "best interest" because they believed it more patient-centered to grant the agent "discretion to ascertain and weigh the factors likely to be of importance to the principal."\textsuperscript{48}

F. Court Involvement

The drafters intended to keep most health care decisions out of court. Subsection (f) states simply: "A health-care decision made by

\textsuperscript{44} See id. § 2(c), (d).
\textsuperscript{45} Id.
\textsuperscript{46} See id. § 2(e). A standard for decisionmaking appears again in § 5(f), applicable to surrogates, and again indirectly in § 6(a), applicable to guardians.
\textsuperscript{47} See id. § 2(e).
\textsuperscript{48} Id. § 2(e) cmt. The decision not to enumerate factors for determining 'best interest' contrasts markedly to the approach used in the 1993 Maryland Health Care Decisions Act which enumerates seven factors. See Md. Code Ann., Health-Gen. § 5-601(e) (1994).
an agent for a principal is effective without judicial approval."49 Section 2(g) permits an individual to nominate a guardian of the person in any written advance directive.50 The comment to the subsection states the drafters' hope that "the mere nomination of the agent [as guardian] will reduce the likelihood that a guardianship could be used to thwart the agent's authority."51

G. Out-of-State Directives

The final principle established in section 2 concerns the validity of out-of-state advance directives and directives made prior to the date of enactment.52 Such concerns arise under most advance directive legislation because of wide variations in required formalities or other rules. Under the UHCDA, the concerns are virtually eliminated because formalities and restrictive rules are almost nonexistent. Section 2(h) simply states that if a directive complies with the Act, then the directive is valid no matter where or when executed.53

IV. Section 3—Revocation

Having decided to recognize maximum flexibility in creating advance directives, the drafters faced a conundrum in formulating rules for revocation. If they applied the same flexibility to revocation, recognizing any expression of an intent to revoke as valid, then the authority of a written directive could be undermined by anyone's oral claim that the individual had revoked the directive. To meet the challenge, the drafters established two rules under section 3. First, an agent's designation under a power of attorney may be revoked only by "a signed writing or by personally informing the supervising healthcare provider."54 The same rule applies to the revocation of an orally designated surrogate.55 Second, for all other advance directives, written or oral, any action "that communicates an intent to revoke" is sufficient to effect a revocation.56 Section 3 also sets forth the duty of interested parties to communicate the fact of revocation to health

49. UHCDA § 2(f). The same principle of decisionmaking without judicial approval reappears in § 5(g) with respect to surrogates, and in § 6(c) with respect to guardians.
50. See id. § 2(g).
51. Id. § 2(g) cmt.
52. Id. § 2(h).
53. Id.
54. Id. § 3(a).
55. See id. § 5(h).
56. Id. § 3(b).
care providers, revocation as a matter of law by divorce or legal separation, and partial revocations.\textsuperscript{57}

V. SECTION 4—OPTIONAL FORM

Section 4 provides a single, multipurpose advance directive form that is entirely optional. The drafters' goals of simplicity and comprehensiveness met their toughest test in this section because the goals compel contradictory approaches to form drafting—one, brevity, and the other, great detail.\textsuperscript{58}

The form has four parts. Individuals may use any or all of the four parts and may modify or supplement them as they wish. Part one designates an agent under a power of attorney for health care. Part two allows the individual to give instructions about the individual's health care, focusing primarily on end-of-life decisions.\textsuperscript{59} Two basic end-of-life options are offered in paragraph six of the form:

(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.\textsuperscript{60}

The next paragraph allows individuals to refine their instruction one step further by specifically addressing 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).\textsuperscript{61}

\textsuperscript{57} Id. § 3(c), (d).
\textsuperscript{58} See id. § 4. While the form is more readable than most of its statutory brethren, it unfortunately was not subjected to a formal reading level evaluation, a process that should be routine in all advance directive drafting.
\textsuperscript{59} Id. Check-list approaches to end-of-life instructions inevitably cause concern about whether individuals really know what they are saying when they initial the boxes. This form raises the same concerns, although it fares better than most.
\textsuperscript{60} Id. § 4, \textsuperscript{1} 6.
\textsuperscript{61} Id. § 4, \textsuperscript{1} 7.
Paragraph (8) of the form accommodates any special instructions about pain relief, with the default instruction dictating that "treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death."62 The final paragraph invites any supplemental or substitute instructions, noting that the writer may add additional sheets of paper if needed.63

Part three provides an opportunity to express an intention to donate bodily organs and tissues at death. The drafters' decision to include this component recognizes that anatomical gift designations are essentially another form of advance directive and merit inclusion, or at least consideration, in a comprehensive health care instruction. Nevertheless, part three further illustrates the difficulty of creating a universal form. The Patient Self-Determination Act64 requires most providers to give patients information about advance directives at the stressful time of admission to a health care facility.65 Some providers, hospitals in particular, are especially reluctant to provide patients with an advance directive form that asks not only for instructions about terminating treatment, but also for permission to harvest their organs. Such a form may give the wrong impression at the wrong time.

The simple answer to those providers is to change the form. The Act is emphatic about the right to modify the form or use any other form of advance directive.66 The simple answer, however, must be tempered by the fact that statutory forms tend to become fixed realities with an identity and a life of their own that is resistant to change.

Part four of the form provides a space for the individual to designate a primary physician, and an alternate, if the individual wishes to do so.67 This provision is rare among most statutory forms today, but was viewed by the drafters as an important component of the decision-making options over which the individual may exercise control.

VI. Section 5—Decisions by Surrogate

Section 5 provides a legal framework for health care decisionmaking on behalf of patients who lack advance directives and guardians.

62. Id. § 4, ¶ 8.
63. Id. § 4, ¶ 9.
66. The prefatory language to the optional form in the UHCDA § 4 states: "The following form may, but need not, be used to create an advance health-care directive . . . . An individual may complete or modify all or any part of the following form."
67. UHCDA § 4 pt. 4.
This is by far the most commonly occurring situation today because so few patients have advance directives.\textsuperscript{68}

A. Ranking

After recognizing the authority of an orally designated surrogate, section 5 affirms the legitimacy of close family decisionmaking by providing a list of authorized surrogates in the following order of priority: (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; or (4) an adult brother or sister.\textsuperscript{69}

The section also recognizes the legitimacy of a close friend as surrogate if none of the above family members are available:

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.\textsuperscript{70}

No special procedure is required to establish the status of any surrogate relationship, although the Act authorizes providers to require, at their discretion, “a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.”\textsuperscript{71} The only limitation on who may act as surrogate is the same as that applied to agents.\textsuperscript{72} Unless related to the patient, a surrogate may not be an owner, operator, or employee of a residential long-term health care institution.\textsuperscript{73}

In case of disagreement among surrogates of equal priority, the Act establishes majority rule.\textsuperscript{74} If the surrogates are evenly divided, however, the process comes to a halt.\textsuperscript{75} This leaves guardianship as the last resort.\textsuperscript{76} It is noteworthy that, while the majority rule approach is commonly used in state surrogate consent statutes, there is little or no evidence that it provides a workable solution. Query how many health care providers will proceed with a termination of treatment if even one of a group of authorized surrogates expresses strong

\begin{footnotes}
\item[68] See supra note 18 and accompanying text.
\item[69] UHCDA § 5(b).
\item[70] Id. § 5(c).
\item[71] Id. § 5(j).
\item[72] See supra note 36 and accompanying text.
\item[73] UHCDA § 5(i).
\item[74] Id. § 5(e).
\item[75] Id. (“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.”).
\item[76] Id. § 5(e) cmt.
\end{footnotes}
opposition. It may be that legislators find majority rule appealing as a sound legal notion, although in the grit and mire of health decision-making, only consensus-building may actually work. This is one area that cries out for further research into decision-making processes, including the use of ethics committees and other dispute resolution mechanisms.

The remaining components of section 5 reiterate the substituted judgment/best interests standard for decisionmaking and the authority of surrogates to act without judicial approval. Subsection (h) recognizes a right that is certainly implied in many advance directive laws, but which deserves to be made explicit, that is, a right to disqualify any person from acting as one's surrogate, either by a signed writing or by personally informing the supervising health care provider.

B. Scope of Surrogate's Authority

Perhaps the most remarkable feature of the surrogate provisions is what they do not include. Nowhere does the section place any limitations or preconditions on the range of decisions, including decisions about life support, that may be made by a surrogate on behalf of a patient who has been determined by the primary physician to lack capacity. Once again the Act rejects the protective approach found in most surrogate statutes today, and instead, places substantial faith in the authority of surrogates as the best way to reinforce patient autonomy.

VII. Section 6—Decisions by Guardians

This brief section emphasizes the Act's intent to give priority in health care decisionmaking to an agent over a guardian and to bind a guardian to a ward's advance directive unless the appointing court expressly authorizes otherwise. If a guardian with health care decisionmaking authority does, in fact, assume the decisionmaking role, section 6 clarifies that the guardian can make health care decisions without returning to the court for judicial approval of specific deci-

77. See supra notes 47-48 and accompanying text.
78. See UHCD A § 5(f), (g).
79. Id. § 5(h).
80. One possible limitation, however, is included as an optional provision in § 13(e) of the Act. The optional language recognizes a limitation on an agent's or surrogate's authority to admit an individual to a mental health institution, absent express authorization. Id. § 13(e). The comment to § 13(e) recognizes that states may have such limitations already operative in separate mental health commitment statutes, but that they may wish to address the issue in this Act. Id. § 13(e) cmt.
81. Id. § 6(a), (b).
sions. The comment recognizes that “[c]ourts 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.”

**VIII. Section 7—Obligations of Health Care Provider**

This section spells out certain notification and recording obligations of providers. The heart of the section, however, is the provider’s obligation to comply with an individual’s advance directive. The basic mandate of section 7(d) requires the provider to comply with an individual instruction of the patient; comply with a reasonable interpretation of that instruction by an authorized agent, surrogate, or guardian; and comply with a health care decision made by an authorized agent, surrogate, or guardian.

Two exceptions may arise to vitiate this mandate. First, like most advance directive statutes, the UHCDA includes a conscience exception, but with fairly stringent requirements. Both individuals and institutions may raise conscience objections to the mandate. In the case of institutions, the objection is considered valid only 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.

The second exception permits individual providers and institutions to decline to comply with an individual instruction or decision “that requires medically ineffective health care or health care contrary to generally accepted health-care standards.” The term “medically ineffective” is not defined by the Act, so whether it adds anything beyond the already fluid meaning of “generally accepted health-care standards” is doubtful. Had the drafters chosen to define “medically ineffective,” they would have opened a definitional mire because the term is subject to differing and volatile views that trigger debate over

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82. Id. § 6(c).
83. Id. § 6 cmt.
84. Id. § 7(d).
85. Id. § 7(e).
86. Id.
87. Id. § 7(f).
larger issues of rationing, resource allocation, and definitions of futile treatment.\textsuperscript{88}

If the provider or institution asserts either exception, it must fulfill three attendant responsibilities: (1) inform the patient and surrogate promptly; (2) provide continuing care until a transfer can be effected; and (3) "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."\textsuperscript{89} Despite the obligation to "make all reasonable efforts," the provision still leaves individuals vulnerable to noncomplying providers in locales in which transfer to another provider is difficult or impossible. The drafters had considered mandating an ultimatum—either transfer the patient or comply with the advance directive/surrogate decision—but rejected such a mandate in deference to provider concerns.\textsuperscript{90}

\section*{IX. Other Matters}

The remaining sections of the Act address several other issues:

- \textit{Immunities}. The Act provides broad protection from liability for actions taken in good faith by both providers and persons acting as agents or surrogates.\textsuperscript{91}

- \textit{Statutory Damages}. An individual may seek statutory damages against a provider who intentionally violates the Act or who commits certain intentional acts, such as falsifying or forging an advance directive or a revocation of an advance directive.\textsuperscript{92} Minimum statutory damages are left to the discretion of adopting states.\textsuperscript{93} The drafters chose not to include criminal penalties out of a recognition that prosecutions are unlikely to occur.\textsuperscript{94} Unless the civil damages are substantial, they likewise are unlikely to be used.\textsuperscript{95}

- \textit{Judicial Relief}. A brief and limited judicial relief provision authorizes those with a direct interest in a patient's care (i.e., the patient,
agent, guardian, surrogate, health care provider, or institution involved with the patient’s care) to seek injunctive or other equitable relief as needed. The comment urges legislators to cross-reference the section to the state’s rules on expedited proceedings or rules on proceedings affecting incapacitated persons.

- **Effect of the Act and Other Administrative Provisions.** Several boilerplate provisions, common to advance directive laws, relate to matters such as presumptions of the intent of individuals who have not completed any advance directive, a prohibition against treating a death resulting from compliance with the Act as a suicide or homicide, the disavowal of mercy killing, assisted suicide, and euthanasia, and the recognition of copies of advance directives.

### Conclusion

The Uniform Health Care Decisions Act represents a quantum leap in thinking since the enactment of the now-defunct URTIA in terms of scope, flexibility, comprehension, and affirmation of personal autonomy. Despite the flaws described in this Article, it offers a clear vision of the direction in which health care decisions legislation needs to move. If not a health care decisions superhighway, the Act is at least an avenue for patient autonomy. Some will criticize it as an aberration that tramples the protections currently afforded vulnerable persons. But those criticisms go to the Act’s basic assumptions, not to its structure and operation. If one agrees with its assumptions, one must admit that it remains remarkably true to its premises. The Act arrives on the scene, however, at a time in which most states have already embraced one or more statutory schemes governing advance directives. Fewer have surrogate or family consent statutes.

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96. *Id.* § 14.  
97. *Id.* § 14 cmt. The comment also refers legislators to the National Center for State Courts, Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases (2d ed. 1992)  
98. UHCDA § 13(a). The 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.” *Id.*  
99. *Id.* § 13(b). Such a death does not “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.” *Id.*  
100. *Id.* § 13(c).  
101. *Id.* § 12. “A copy of a written advance health-care directive . . . has the same effect as the original.” *Id.*  
legislative change is not easy for a state in this posture. Perhaps the most compelling fact in favor of acceptance of the UHCDA is the fragmentation, complexity, and variability of state health decisions law. Confusion, is, after all, the *raison d'être* of uniform acts.