117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document **No. 230**

H.P. 182 House of Representatives, January 24, 1995

An Act Adopting the Uniform Health-care Decisions Act.

Reference to the Committee on Judiciary suggested and ordered printed.

JOSEPH W. MAYO, Clerk

Presented by Representative CARLETON of Wells.
Cosponsored by Representatives: BIRNEY of Paris, ETNIER of Harpswell, HARTNETT of Freeport, JOHNSON of South Portland, JOYCE of Biddeford, JOYNER of Hollis, KNEELAND of Easton, LIBBY of Buxton, MAYO of Bath, REED of Falmouth, SIMONEAU of Thomaston, TOWNSEND of Portland, Senators: ABROMSON of Cumberland, LAWRENCE of York, McCORMICK of Kennebec.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 18-A MRSA Art. V, Pt. 8 is enacted to read:

PART 8

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 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.

§5-801. Definitions

As used in this Part, unless the context otherwise indicates, the following terms have the following meanings.

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

(b) "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.

(c) "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.

(d) "Guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual.

(e) "Health care" means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

(f) "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:

(1) Selection and discharge of health-care providers and institutions;

(2) Approval or disapproval of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

(3) Directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care.

(g) "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.

(h) "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.

(i) "Individual instruction" means an individual's direction concerning a health-care decision for the individual.

(j) "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.

(k) "Physician" means an individual authorized to practice medicine under Title 32.

(l) "Power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power.

(m) "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.

(n) "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.

(o) "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.

(p) "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.

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

Comment

The term "advance health-care directive" (subsection (1)) [Me. cite subsection (a)] 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)) [Me. cite subsection (b)] is not limited to a single individual. The Act permits the appointment of co-agents and alternate agents.

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

The definition of "health care" (subsection (5)) [Me. cite subsection (e)] 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)) [Me. cite subsection (f)], and to care, including custodial care, provided at a "health-care institution" (subsection (7)) [Me. cite subsection (g)]. It also includes non-medical remedial treatment such as practiced by adherents of Christian Science.

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

The term "individual instruction" (subsection (9)) [Me. cite subsection (i)] 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 [Me. cite section 5-804], 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)) [Me. cite subsection (j)] 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)) [Me. cite subsection (k)] cross-references the appropriate licensing or other statute.

The Act employs the term "primary physician" (subsection (13)) [Me. cite subsection (m)] 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)) [Me. cite subsection (n)] 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)) [Me. cite subsection (p)]. It appears in the optional statutory form (Section 4) [Me. cite section 5-804] to indicate when an alternate agent may act. In Section 5 [Me. cite section 5-805] 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)) [Me. cite subsection (p)] 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 [Me. cite sections 5-803, 5-805 and 5-807].

The definition of "surrogate" (subsection (17)) [Me. cite subsection (q)] refers to the individual having present authority under Section 5 [Me. cite section 5-805] 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.

§5-802. 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 Part if it complies with this Part, 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 health-care decision the principal could have made while having capacity.

Subsection (b) excludes the oral designation of an agent. Section 5(b) [Me. cite section 5-805, subsection (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 [Me. cite section 5-803].

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 [Me. cite section 5-814].

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)) [Me. cite section 5-805, subsection (g)] or guardians (Section 6(c)) [Me. cite section 5-806, subsection (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 nomination 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.

§5-803. 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) [Me. cite section 5-807, subsection (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.

Subsection (e) establishes a rule of construction permitting multiple advance health-care directives to be construed together in order to determine the individual's intent, with the later advance health-care directive superseding the former to the extent of any inconsistency.

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.

§5-804. Optional form

The following form may, but need not, be used to create an advance health-care directive. The other sections of this Part 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, 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)

_____

(home phone) (work phone)

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)

_____

(home phone) (work phone)

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)

_____

(home phone) (work phone)

(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 [Me. cite section 5-802] 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) [Me. cite section 5-802, subsection (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) [Me. cite section 5-802, subsection (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) [Me. cite section 5-807, subsections (e) to (f)], on the individual's health-care providers. Pursuant to Section 7(d) [Me. cite section 5-807, subsection (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 [Me. cite section 5-812] 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.

§5-805. 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 the surrogate's assumption of authority as promptly as practicable 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) [Me. cite section 5-807, subsection (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) [Me. cite section 5-803, subsection (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 [Me. cite section 5-814], 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 [Me. cite section 5-814].

Subsection (f) imposes on surrogates the same standard for health-care decision making as is prescribed for agents in Section 2(e) [Me. cite section 5-802, subsection (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)) [Me. cite section 5-802, subsection (f)] or guardians (Section 6(c)) [Me. cite section 5-806, subsection (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) [Me. cite section 5-802, subsection (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) [Me. cite section 5-809, subsection (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.

§5-806. 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) [Me. cite section 5-807, subsections (e) and (f)], by an individual's health-care providers. Subsection (a) extends this principle to guardians by requiring 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)) [Me. cite section 5-802, subsection (f)] or surrogates (Section 5(g)) [Me. cite section 5-805, subsection (g)].

§5-807. 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 that 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 that 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) [Me. cite section 5-802, subsections (c) and (d)] and 5(a) [Me. cite section 5-805, subsection (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)).

§5-808. 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.

§5-809. 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 Part 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.

§5-810. Statutory damages

(a) A health-care provider or institution that intentionally violates this Part 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.

§5-811. Capacity

(a) This Part 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.

§5-812. 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.

§5-813. Effect of Part

(a) This Part 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 Part 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 Part 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 Part 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 Part 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 Part does not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a mental health-care institution.

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.

§5-814. 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 5-805, subsection (b) or (c), the court may enjoin or direct a health-care decision or order other equitable relief.

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 [Me. cite section 5-805] 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) [Me. cite section 5-802, subsection (e)] and 5(f) [Me. cite section 5-805, subsection (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.

§5-815. Uniformity of application and construction

This Part must be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject matter of this Part among states enacting it.

§5-816. Short title

This Part may be cited as the Uniform Health-care Decisions Act.

§5-817. Effective date

This Part takes effect on October 1, 1995.

PART B

Sec. B-1. 18-A MRSA §5-209, sub-§(c), as amended by PL 1991, c. 719, §1, is further amended to read:

(c) The guardian is empowered to facilitate the ward's education, social or other activities and to give or withhold consents or approvals related to medical, health or other professional care, counsel, treatment or service for the ward. The guardian is empowered to withhold or withdraw life-sustaining treatment when the ward is in a terminal condition or persistent vegetative state ~~as defined in section 5-701 with respect to qualified patients~~. A guardian is not liable by reason of such giving or withholding of consent for injury to the ward resulting from the negligence or acts of 3rd persons unless it would have been illegal for a parent to have so given or withheld consent. A guardian may consent to the marriage or adoption of the ward.

Sec. B-2. 18-A MRSA §5-312, sub-§(a), ¶(3), as amended by PL 1991, c. 719, §2, is further amended to read:

(3) A guardian may give or withhold consents or approvals related to medical or other professional care, counsel, treatment or service for the ward. The guardian is empowered to withhold or withdraw life-sustaining treatment when the ward is in a terminal condition or persistent vegetative state ~~as defined in section 5-701 with respect to qualified patients~~ provided, however, that the guardian shall honor any effective ~~living will declaration~~ advance health-care directive executed by the ward pursuant to section ~~5-702~~ 5-802.

Sec. B-3. 18-A MRSA §5-506, sub-§(a), as enacted by PL 1991, c. 719, §3, is amended to read:

(a) A durable health care power of attorney is a durable power of attorney by which a principal designates another as attorney-in-fact to make decisions on the principal's behalf in matters concerning the principal's medical or health treatment and care. An attorney-in-fact designated under a durable health

care power of attorney may be authorized to give or withhold consents or approvals relating to any medical, health or other professional care, counsel, treatment or service of or to the principal by a licensed or professional certified person or institution engaged in the practice of, or providing, a healing art, including life-sustaining treatment when the principal is in a terminal condition or a persistent vegetative state as ~~these terms are defined in section 5-701~~.

Sec. B-4. 18-A MRSA Art. V, Pt. 7, as amended, is repealed.

Sec. B-5. 29-A MRSA §1403, as enacted by PL 1993, c. 683, Pt. A, §2 and affected by Pt. B, §5, is amended to read:

§1403. Advance health-care directive

Subject to available funding, the Secretary of State shall make ~~living will~~ advance health-care directive forms available in offices of the Bureau of Motor Vehicles. The form must be in substantially the form provided in Title 18-A, section ~~5-702~~ 5-804 and with the addition of ~~a title at the top of the form to read "LIVING WILL" and~~ the following information at the end: "Completion of this form is optional."

STATEMENT OF FACT

This bill replaces the Uniform Rights of the Terminally Ill Act with the Uniform Health-care Decisions Act.