114th MAINE LEGISLATURE

SECOND REGULAR SESSION - 1990

Legislative Document **No. 2294**

H.P. 1658 House of Representatives, February 7, 1990

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 26.

Reference to the Committee on Judiciary suggested and ordered printed.

Ed Pert

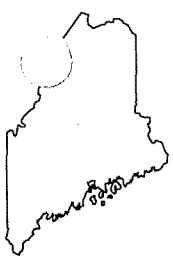
EDWIN H. PERT, Clerk

Presented by Representative MARSANO of Belfast.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

An Act to Provide Authorization to Consent to Health Care.



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

18-A MRSA Art. 5, Pt. 8 is enacted to read:

PART 8

CONSENT TO HEALTH CARE

§5-801. Definitions

As used in this Part, the following terms have the following meanings.

(1) "Adult" means an individual 18 or more years of age.

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

(3) "Health-care provider" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

(4) "Minor" means an individual who is not an adult.

(5) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-801. The age of 18 is bracketed in the definition of an adult (subsection (1)) so that states with a different age for achieving adult status may insert whatever age is appropriate.

Health care (subsection (2)) includes any care, treatment, service or procedure to diagnose or treat a physical or mental condition. The term is broader in scope than medical care and includes care and treatment which is lawful to practice under state law, for instance, nursing care.

Since the definition of health care is broader in scope than medical care, there is a need to limit the coverage of the Act so that the rendition of routine care by family members would not be within its coverage. One limitation on the scope of the Act is found in the definition of a health-care provider in subsection (3). That definition excludes those who are not licensed, certified or otherwise authorized to render health care. Hence, the rendition of simple care by a family member to one who is ill at home would not be covered by this Act while that same treatment would be covered if provided in a hospital.

§5-802. Individuals who may consent to health care

Unless incapable of consenting under section 5-803, an individual may consent to his or her own health care if the individual is:

(1) An adult; or

(2) A minor and

(a) Is emancipated;

(b) Has attained the age of 14 years and, regardless of the source of income, is living apart from the minor's parents or from an individual in loco parentis and is managing the minor's own affairs;

(c) Is or has been married;

(d) Is in the military service of the United States; or

(e) Is authorized to consent to the health care by any other law of this State.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-802. Section 2 [5-802] describes those individuals who may consent to health care for themselves. All adults, unless disqualified by Section 3 [5-803], may consent to health care. These two provisions basically restate the common law with regard to consent by adults. At common law minors were not presumed to be competent to consent to health care. However, there are certain status exceptions, both statutory and common law, which render a minor capable of consenting. Section 2(2) [5-802(2)] is a compilation of the more widely recognized exceptions to the traditional requirement of consent by a parent or guardian which permit a minor, unless disqualified by Section 3 [5-803], to consent to health care for himself as if he were an adult.

The exceptions are based on the assumption that a minor who has made the described decisions or taken the described actions in his life has demonstrated his capacity to make decisions concerning his health care. The emancipated minor exception is widely recognized in case law and in the statutes of more than thirty states. See Wilkins, Children's Rights: Removing the Parental Consent Barriers to Medical Treatment of Minors, 1975 Arizona St. L.J. 31, 59 (1975). Paragraph (2)(b) is an explicit emancipation provision based on objective criteria which will not require a formal adjudication of emancipation. The age is bracketed, but the age of 14 is a reasonable age when coupled with the other requirements of this paragraph.

Other objective criteria which courts and state legislatures have accepted as showing a minor's maturity to make decisions affecting his health, are marriage and service with the armed forces. (See, e.g., Ind. Ann. Stat. 16-8-4-1 (Burns 1973).) Once a minor has satisfied any of these criteria he may consent to health care for himself as if he were an adult.

In addition to the status exceptions permitting consent by minors, many legislatures have created additional exceptions authorizing minors to consent to treatment for specific conditions or diseases without regard to their status. For instance, 45 states presently allow minors to obtain treatment for venereal disease without parental consent. One or more states permit minors to consent to the following forms of health care:

(1) Health care necessary to diagnose or treat pregnancy;

(2) Health care necessary to diagnose or treat venereal disease;

(3) Health care necessary to diagnose or treat alcohol or drug dependency or abuse;

(4) Psychiatric or psychological counseling;

(5) Health care necessary for the performance of an abortion;

(6) Health care necessary for counseling in the use of contraceptive devices; and

(7) Health care necessary for the performance of any type of sterilization.

Paragraph 2(e) of this Act leaves intact those state laws which permit a minor to consent to one or more specific health-care procedures, regardless of whether the minor meets the status exceptions of paragraph 2.

§5-803. Individuals incapable of consenting

An individual otherwise authorized under this Part may consent to health care unless, in the good faith opinion of the health-care provider, the individual is incapable of making a decision regarding the proposed health care.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-803. Section 3 [5-803] uses the phrase incapable of consenting as opposed to incompetency. This choice is deliberate. Incompetency in American law carries the connotation of permanency and is often thought to involve an adjudicative declaration. However, a person may be de jure competent when in fact he is incapable of making a decision regarding his own health care. An otherwise competent adult who has been rendered unconscious in an accident is at that time de facto incompetent or incapable of making a decision regarding proposed health care.

Section 3 [5-803] is phrased negatively as the law presumes that adults, and under certain circumstances minors as well, are capable of making decisions unless there is some determination of a contrary status. The determination called for in Section 3 [5-803] is to be made by the health-care provider, and the standard is whether the individual is incapable of making a decision regarding the proposed health care. If the individual is capable of making a decision, the health-care provider must abide that decision.

Custom suggests and necessity dictates that the initial determination that one is incapable of consenting rest with the health-care provider. Section 3 [5-803] in recognition of necessity legitimates that custom. Unlike the decision to invoke the emergency exception to the requirement of informed consent which has the effect of bypassing consent altogether, a decision that one is incapable of consenting merely shifts the decision regarding the rendition of health care to a third party. This is an important difference for the health-care provider's decision is ex necessitate a "low visibility" one. Any decision to bypass the patient by deciding that he is incapable of making a decision endangers the values of individualism and personal autonomy. What is needed in any such decision is a proper combination of deference to professional judgment and health-care values on the one hand and respect for personal autonomy and individualism on the other. Reposing the ultimate decision to proceed with medical treatment in a third party should assure that values of personal autonomy and individualism receive proper consideration.

The requirement that the individual be incapable of engaging in decision making is consistent with the underlying notion of consent. A unique human characteristic is the power to make decisions. The language of Section 3 [5-803] focuses on the ability of one to make a decision as opposed to the content of a health care decision. A decision to refuse a specific course of treatment may be based on moral or religious grounds. An individual who refuses treatment because he has consistently

relied on prayer for healing in accordance with his religious tradition is capable of making his own health-care decisions. A decision to refuse treatment made under those circumstances should be honored by a health-care provider.

The uncertainties of medical practice and the decision to be made do not make precise statements of the test for determining incapacity easy. However, the context in which the decision is made and the effect of such a decision render the lack of precision less onerous. The health-care provider who decides that one is incapable of consenting must then turn to another who is charged with making the ultimate treatment decision in the best interest of the patient.

§5-804. Individuals who may consent to health care for others

(a) If an individual incapable of consenting under section 5-803 has not appointed a health-care representative under section 5-806 or the health-care representative appointed under section 5-806 is not reasonably available or declines to act, consent to health care may be given:

(1) By a guardian of the individual's person, a representative appointed under section 5-807, or a representative designated or appointed under other law of this State; or

(2) By a spouse, parent, adult child or adult sibling, unless disqualified under section 5-808, if there is no guardian or other representative described in paragraph (1) or the guardian or other representative is not reasonably available or declines to act, or the existence of the guardian or other representative is unknown to the health-care provider.

(b) Consent to health care for a minor not authorized to consent under section 5-802 be given:

(1) By a guardian of the individual's person, a representative appointed under section 5-807, or a representative designated or appointed under other law of this State;

(2) By a parent or an individual in loco parentis, if there is no guardian or other representative described in paragraph (1) or the guardian or other representative is not reasonably available or declines to act, or the existence of the guardian or other representative is unknown to the health-care provider; or

(3) By an adult sibling of the minor, if a parent or an individual in loco parentis is not reasonably available, declines to act, or the existence if the guardian or other representative is unknown to the health-care provider.

(c) An individual delegated authority to consent under section 5-805 has the same authority and responsibility as the individual delegating the authority.

(d) A person authorized to consent for another under this section shall act in good faith and in the best interest of the individual incapable of consenting.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-804. Section 4 [5-804] authorizes designated person to exercise health-care decision-making powers for individuals who cannot consent for themselves and who have not appointed a health-care representative to act on their behalf as authorized in Section 6 [5-806]. If a health-care representative has been appointed and is willing to act, that preempts the operation of this Section.

Subsection (a) is concerned with adults and minors authorized to consent under Section 2 [5-802]. It sets forth an order of priority among substitute decision-makers. The first priority is given to individuals appointed by a court, a guardian or an individual appointed under Section 7 [5-807]. The second priority class is the family. Within this class, the spouse, parents, adult children and adult siblings are ranked equally. Any member of the class is authorized to act. Any decision establishing priority among family members would be largely arbitrary. The objective is to have someone who has a close personal relationship with the patient and who will consider his best interest acting for him. If one of those authorized to act disagrees with the decision of another who has been designated a proxy decision maker, that person can seek formal judicial appointment to act for the one incapable of consenting. However, an objector would be required to show that the other authorized decision-maker was not acting in the patient's best interest. (See Section 7 [5-807].)

Subsection (b) authorizes substitute decision-makers for minors who are not authorized to consent under Section 2 [5-802]. The first priority is given to court-appointed officials. If the parents are alive, it is unlikely that there would be a court-appointed guardian and the parents would have first priority. If there is no court-appointed official and if the parents are unavailable, any adult brother or sister of the minor is authorized to make health-care decisions.

Family members authorized to consent for one incapable of consenting under this Section may delegate their decisional authority to another. The person to whom authority is delegated under Section 5 [5-805] has the same priority to act for the patient as the delegating individual.

One authorized by this Section to act for another must act in good faith and in the best interest of the individual incapable of consenting.

§5-805. Delegation of power to consent to health care for another

(a) An individual authorized to consent to health care for another under section 5-804(a)(2), 5-804(b)(2) or 5-804(b)(3) who for a period of time will not be reasonably available to exercise the authority may delegate the authority to consent during that period to another not disqualified under section 5-808. The delegation must be in writing and signed and may specify conditions on the authority delegated. Unless the writing expressly provides otherwise, the delegate may not delegate the authority to another.

(b) The delegate may revoke the delegation at any time by notifying orally or in writing the delegate or the health-care provider.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-805. Section 5 [5-805] permits a limited delegation of authority to consent for another. Family members authorized to consent for another under Section 4 [5-804] may delegate their decisional authority.

This provision should be helpful in situations in which parents want to delegate health-care decision-making to a temporary custodian of their children, for instance when parents plan to be away or when a child is at camp. This Section follows closely Section 5-104 of the Uniform Probate Code.

§5-806. Health care representative: appointment, qualification, powers, revocation and responsibility

(a) An individual who may consent to health care under section 5-802 may appoint another as a health-care representative to act for the appointor in matters affecting the appointors health care.

(b) A health-care representative appointed under this section must be an individual who may consent to health care under section 5-802.

(c) An appointment and any amendment thereto must be in writing, signed by the appointor and a witness other than the health-care representative and accepted in writing by the health-care representative.

(d) The appointor may specify in the writing terms and conditions considered appropriate, including an authorization to the health-care representative to delegate the authority to consent to another.

(e) The authority granted becomes effective according to the terms of the writing.

(f) The writing may provide that the authority does not commence until, or terminates when, the appointor becomes incapable of consenting. Unless expressly provided otherwise, the authority granted in the writing is not affected if the appointor becomes incapable of consenting.

(g) Unless the writing provides otherwise, a health-care representative appointed under this section who is reasonably available and willing to act has priority to act for the appointor in all matters of health care.

(h) In making all decisions regarding the appointor's health care, a health-care representative appointed under this section shall act (1) in the best interest of the appointor consistent with the purposes expressed in the appointment and (2) in good faith.

(i) A health-care representative who resigns or is unwilling to comply with the written appointment may exercise no further power under the appointment and shall so inform (1) the appointor, (2) the appointor's legal representative, if one is known, and (3) the health-care provider, if the health-care representative knows there is one.

(j) An individual who is capable of consenting to health care may revoke (1) the appointment at any time by notifying the health-care representative orally or in writing, or (2) the authority granted to the health-care representative by notifying the health-care provider orally or in writing.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-806. Section 6 [5-806] is designed to extend the concept of patient autonomy by permitting a person to transfer his health-care decision-making power to another. Many individuals who are competent to make health-care decisions nevertheless want to delegate this decisional authority to a

relative or friend. In addition, in the event they are rendered incapable of consenting, many people want the assurance that some other individual whom they trust will make health-care decisions on their behalf.

It is generally thought that if one cannot or does not exercise his own decisional authority in health-care matters this authority should be placed in the hands of the state (i.e., a court), a health-care provider or the next of kin. Any of these choices may be seen as a restriction on autonomous choice. Leaving this authority in the hands of court when there are other alternatives available is particularly vexing because it allows the state a measure of control over individuals to which it has no obvious moral right and for which it has no special expertise. Section 6 [5-806] provides an alternative. The decision to allow the transfer of authority rests on the principle of the basic human need of self determination and individual autonomy. The patient can designate the person who is to make these health-care decisions. Section 6 [5-806] does not prescribe the nature of the decision-making relationship between the appointing individual and the person appointed. The appointing individual has the opportunity to engage in moral discourse with his agent, and to specify in the document the terms and the conditions of the appointment.

Subsection (h) provides that a health-care representative must act in the best interest of the appointor consistent with the purposes expressed in the appointment and in good faith. Cases often purport to draw a distinction between a best interest and substituted judgment standard. (Compare In re Guardianship of Pescinski, 67 Wis.2d 4, 226 N.W.2d 180 (1975) (best interest) with In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976) (substituted judgment).) Yet the two terms reflect not so much a difference in concept as a difference in emphasis. The standard of best interest is generally thought to incorporate a concept of objective reasonableness with reference to the interests of society and others while the substituted judgment standard focuses on the interest of the particular patient. That the patient may define what is in his best interest and that such a declaration should be accepted by the surrogate decision-maker is well recognized in many adjudicated cases. (See In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) and Eichner v. Dillon, 426 N.Y.S.2d 517 (1981).)

Personal autonomy is the basis for the concept of the health-care representative in Section 6 [5-806]. Where a person appointing a health-care representative has given particular instructions, those instructions should define the best interest of a patient. If no specific directions are given, the more general best interest standard applies.

If the health-care representative cannot in good conscience follow the directions provided by his appointor he must resign or seek relief from that mandate by a court. The health-care representative would be an interested individual entitled to petition a court under Section 7 [5-807]. In the event the health-care representative does not act, consent must be obtained from one of those individuals authorized in Section 4 [5-804] to act for the patient or from a court under Section 7 [5-807].

Section 6 [5-806] is consistent with the [Uniform] Durable Power of Attorney Act. The appointment made under this Section would be given effect without this Act in a jurisdiction which has enacted the Uniform Durable Power of Attorney Act. By incorporating this section into the Act, the power of appointment will be brought to the attention of persons who may not be aware of the [Uniform] Durable Power [of Attorney] Act.

Because the power of appointment is unique, the Conference concluded it was desirable to set forth a suggested form instrument to be used for the appointment of a health-care representative.

Appointment of a Health-care Representative

I, the undersigned, voluntarily appoint_____ whose telephone number and address are: _____
_____
as my health-care representative who is authorized to act for me in all matters of health care, except as otherwise specified below.

This appointment is subject to the following provisions:

_____
_____
_____
_____

This appointment (becomes effective) (remains effective) (terminates) if I later become disabled or incapable of consenting to my health care. I (do) (do not) authorize my health-care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, 19__.

_____
(signed)

_____
(address)

I declare that at the request of the above-named individual making the appointment, I witnessed the signing of this document.

_____
(signed)

_____
(address)

Acceptance by Health-care Representative

I, the undersigned health-care representative, understand that acceptance of this appointment means that I have a duty to act in good faith and in the best interest of the individual appointing me. I further understand that I have a duty to follow any special instructions in the appointment. In the event I cannot do so, I will exercise no further power under the appointment and will inform (i) the individual appointing me, if that individual is capable of consenting, (ii) his/her legal representative, if known to me, and (iii) his/her health-care provider if known to me.

Dated this _____ day of _____, 19__.

_____
(signed)

_____
(address)

§5-807. Court-ordered health care or court-ordered appointment of a representative

(a) A health-care provider or any interested individual may petition the court to (1) make a health-care decision or order health care for an individual incapable of consenting or (2) appoint a representative to act for that individual.

(b) Reasonable notice of the time and place of hearing a petition under this section must be given to the individual incapable of consenting and to individuals in the classes described in section 5-804 who are reasonably available.

(c) The court may modify or dispense with notice and hearing if it finds that delay will have a serious, adverse effect upon the health of the individual.

(d) The court may order health care, appoint a representative to make a health-care decision for the individual incapable of consenting to health care with such limitations on the authority of the representative as it considers appropriate, or order any other appropriate relief in the best interest of that individual, if it finds:

(1) A health-care decision is required for the individual;

(2) The individual is incapable of consenting to health care; and

(3) There is no individual authorized to consent or an individual authorized to consent to health care is not reasonably available, declines to act, or is not acting in the best interest of the individual in need of health care.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-807. Section 7 [5-807] is designed to operate in two basic situations. The first is that in which an individual is in need of health care and incapable of consenting and there is no one to act on his behalf. It is not infrequent that a person admitted to a hospital has no known relatives or friends. The second is that in which one authorized to act is not acting in the best interest of the individual who is incapable of consenting. If the parents of a minor refuse medical treatment because of the parents' religious convictions courts have not hesitated to take the decision-making authority from the parent[s] when the child's life is endangered.

The removal of a parent's power to consent is generally taken pursuant to state child neglect statutes. However, in some instances courts simply assume the decision-making authority under the parens patriae doctrine. Section 7 [5-807] provides for the same kind of relief that is provided in the child neglect statutes. Section 7 [5-807] provides a certain and expeditious means for removing one authorized to consent who is not acting in the best interest of a patient. The Act does not attempt to define best interest. There is a developing body of law on that question; however, its contours are not yet clear. (See M. Wald, State intervention on Behalf of "Neglected" Children: A Search for Realistic Standards, 27 Stan.L.Rev. 985, 1031-1033 (1975).

Any health-care provider or any individual is given standing to petition for the appointment of a competent representative to consent to the rendition of health care. A court acting pursuant to this Section is authorized to order health care or to appoint a competent representative who is authorized to make health-care decisions. This Section does not displace any other state procedures designed to accomplish the same result. Because most states have existing mechanisms to address these questions, the purely procedural portions of Section 6 [5-806], subsections (b) through (d) are bracketed. They may be deleted from the Act without destroying its integrity.

§5-808. Disqualification of authorized individuals

(a) An individual who may consent to health care for that individual under section 5-802 may disqualify others from consenting to health care for that individual.

(b) The disqualification must be in writing, signed by the individual, and designate those disqualified.

(c) A health-care provider who knows of a written disqualification may not accept consent to health care from a disqualified individual.

(d) An individual who knows he [that that individual] has been disqualified to consent to health care for another may not act for the other under this Part.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-808. A full recognition of individual autonomy requires not only that one be authorized to appoint his health-care representative but that he also be authorized to say whom he does not want to act for him. Section 8 [5-808] permits this disqualification. A patient may not want to go through the formality of appointing a Section 6 [5-806] health-care representative but may well wish to exclude certain persons from acting on his behalf.

One who is disqualified under Section 8 [5-808] has no authority to act. However, unless that disqualification is known to a health-care provider, he may nevertheless rely on an authorization from one who is disqualified. (See Section 9 [5-809].)

§5-809. Limitations of liability

(a) A health-care provider acting or declining to act in reliance on the consent or refusal of consent of an individual who he [the health-care provider] believes in good faith is authorized by this Part or other law of this State to consent to health care is not subject to criminal prosecution, civil liability, or professional disciplinary action on the ground that the individual who consented or refused to consent lacked authority or capacity.

(b) A health-care provider who believes in good faith an individual is incapable of consenting under section 5-803 is not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to follow that individual's direction.

(c) A person who in good faith believes he [that that person] is authorized to consent or refuse to consent to health care for another under this Part or other law of this State is not subject to criminal prosecution or civil liability on the ground he [that person] lacked authority to consent.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-809. Under Section 9 [5-809], the health-care provider is permitted to rely on the consent of an individual whom he believes in good faith is authorized to consent to health care. In meeting this standard under the Act, a health-care provider could not close his eyes to the truth, of course, but to prescribe an affirmative requirement of detailed investigation would make reliance impossible.

Similarly, a health-care provider who makes a determination that one is incapable of consenting and thus calls in a third-party decision maker is not subject to liability for discharging his obligation in good faith.

An individual acting for another is in every sense of the word a fiduciary and has those obligations which a fiduciary owes his ward. The immunity provided in this section does not protect a substitute decision maker from negligence or other breach of duty but only from acting without authority if he in good faith believes that he is authorized to give consent.

§5-810. Availability of medical information

An individual authorized to consent to health care for another under this Part has the same right as does the individual for whom the representative is acting to receive information relevant to the contemplated health care and to consent to the disclosure of medical records to a contemplated health-care provider. Disclosure of information regarding contemplated health care to an individual authorized to consent for another is not a waiver of an evidentiary privilege.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-810. An individual authorized to consent for another stands in the shoes of the patient when making health-care decisions. The individual authorized to consent is entitled to receive information relevant to the proposed health care whether or not that is allowable under any other provision of state law. This Section guarantees that right but makes no attempt to define the scope of disclosure required.

In many cases, proper diagnosis and treatment require that medical information must be passed from one doctor or hospital to another. Because of the confidential or privileged nature of much of this information, the patient's consent is necessary before the information can be disclosed. (61 Am.Jur.2d Physicians & Surgeons Section 101 (1972) and 20 A.L.R.3d 1109 (1968).) To the extent that the patient has a right which can be waived, an individual acting on his behalf has the same right of waiver. The Act does not determine whether confidential information or a privilege exists in the first instance.

§5-811. Effect on existing state law

(a) This Part does not affect the law of this State concerning an individual's authorization to make a health-care decision for himself [that individual] or another to withdraw or withhold medical care necessary to preserve or sustain life.

(b) This Part does not affect the requirements of any other law of this State concerning consent to observation, diagnosis, treatment, or hospitalization for a mental illness.

(c) This Part does not authorize an individual to consent to any health care prohibited by the laws of this State.

(d) This Part does not affect any requirement of notice to others of proposed health care under any other law of this State.

(e) This Part does not affect the laws of this State concerning (1) the standard of care of a health-care provider

required in the administration of health care, (2) when consent is required for health care, (3) informed consent for health care, or (4) consent to health care in an emergency.

(f) This Part does not prevent an individual capable of consenting to health care for himself [that individual] or another under this Part, including those authorized under sections 5-804, 5-805, and 5-806, from consenting to health care administered in good faith pursuant to religious tenets of the individual requiring health care.

UNIFORM PROBATE CODE COMMENT*

SECTION 5-811. Section 11 [5-811] contains important limitations. It is written to make clear that this Act does not intrude into areas of the law where its operation would be inappropriate.

The law with respect to the withdrawal of life support systems in the case of the terminally ill is changing rapidly. At least 10 states have Natural Death Acts and there have been several court decisions concerning the issue of termination of treatment. Nothing in this Act changes existing law in that regard. All proxy decision makers are charged with acting in the best interest of the patient who is incapable of consenting. If a patient had appointed a health-care representative and had made known his wish that life support systems be withdrawn in the event of terminal illness, many courts would consider that evidence conclusive of the patient's best interest. However, this Act does not provide an answer to the question of what is in the patient's best interest in such a circumstance.

Subsection (b) provides that the Act will not override the operation of mental health codes. All states require that commitment proceedings be surrounded with stringent procedural safeguards which must be adhered to before an individual can be involuntarily committed. Subsection (b) makes it clear that this Act does not allow any individual authorized to consent for another to bypass those commitment statutes under the guise of a voluntary commitment. In addition, subsection (b) prohibits this Act from being used to authorize forcible drug medication unless in conformity with other proper procedural requirements.

Subsection (c) is written to make it clear that this Act does not authorize one to consent to medical procedures which are prohibited by law.

The Supreme Court [of the United States] has held in Belloti v. Baird, 443 U.S. 622 (1979) that minors are entitled to consent to an abortion without parental consent. That holding is recognized in Section 2 [5-802] which permits minors to consent

to health care which is otherwise authorized by law. However, the Supreme Court [of the United States] held in the case of H. L. v. Matheson, 450 U.S. 398, 101 S.Ct. 1164 (1981) that a state requirement of notice to parents does not violate the constitutional rights of a minor. Subsection (d) is written to ensure that state statutes, such as the Utah statute under review in Matheson, are not affected by this Act.

This Act is narrow in scope. It is not concerned with the standard of care required of health-care providers. It is not concerned with whether, how and under what circumstances consent to health care is required. Nor is it an informed consent statute. As outlined in the Prefatory Note, this statute is basically a procedural one and matters of state substantive law are unchanged.

Section 2 [5-802] of this Act limits health-care providers to those who are licensed, certified or otherwise authorized to provide health care. Practitioners of religious healing, for instance, Christian Science Practitioners are not licensed, certified or authorized by the state but practice as a matter of the free exercise of religion. Yet spiritual healing is a well recognized form of health care and there is no intention to make this religious activity illegal by the operation of this Act. There is no intention to prevent an individual capable of consenting to health care from consenting for another or himself to spiritual healing which is health care administered in good faith pursuant to religious tenets of the individual requiring health care as a matter of free exercise of religion. Certainly those practitioners of religious healing should not be required to seek state authorization to practice their faith. Hence, subsection (f) is an express savings clause to permit one to consent to spiritual healing as health care.

§5-812. Severability

If any provisions of this Part or the application hereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the part which can be given effect without the invalid provision or application, and to this end the provisions of this Part are severable.

§5-813. Uniformity of application and construction

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

§5-814. Short title

This Part may be cited as the Uniform Law Commissioners' Model Health Care Consent Act.

STATEMENT OF FACT

This bill adopts the Uniform Law Commissioners' Model Health Care Consent Act, adopted by the Uniform Law Commissioners in 1982. The comments of the Uniform Law Commissioners are reproduced here.

Commissioners' Prefatory Note

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." Scholendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E.92 at 93 (1914).

That often quoted statement of Judge Cardozo both states the premises underlying this Act and suggests by omission the subject matter of the Act. What if the human being is not of adult years and of sound mind or is otherwise unable to consent? Assuming consent is nonetheless required, who can give an effective consent? These questions plague hospital administrators, physicians and surgeons daily. They are also of grave importance to patients, their families and friends. Some certainty in this area of the law is needed for all the participants in the health care system, consumers as well as providers. Additional statements of fact identified as "Uniform Probate Code Comment*" are interspersed throughout the text to explain the meaning of individual sections.

Scope of the Act

This Act is procedural in nature and is purposefully narrow in scope. Its primary aim is to provide authorization to consent to health care. It does not address the substantive issues of consent; for instance, what constitutes informed consent, whether informed consent is required or under what circumstances one has a right to refuse treatment.

Many of the substantive aspects of consent involve conflicting social and ethical values. The law's response to many consent issues is halting and uncertain. It is reflective of the ambivalence in society. For instance, the right to refuse treatment raises questions about which there is no clear consensus in American law. The many ethical and moral dilemmas presented in those cases dealing with the right to refuse psychotrophic drugs or the right to refuse necessary medical care suggest that further experimentation is in order to propose a model solution for these questions would stifle creativity and is neither practicable nor desirable.

The "who" questions of consent (who is authorized to consent for himself or for another) do not, in the routine cases, present serious unresolved moral issues. Yet, at best, the law on these questions is far from clear and has been described as "haphazard."

This Act is drafted to provide assistance in the cases that occur daily and routinely in medical practice. It is not designed to provide answers for the extraordinary cases, such as terminal illness, organ donation, and the treatment of mental illness. These extraordinary cases present separate and discrete problems involving not only issues of competency but of the authority of a substitute decision maker as well. To force a single solution to these many problems would be at best a procrustean fit. To provide a statutory solution to the problem of the administration of antipsychotic medication to a noninstitutionalized incompetent person which is consistent with the due process clause would be completely unworkable if the problem to be solved is how to render treatment to a child with a broken arm while its parents are on an extended trip.

While this Act does not, indeed cannot, solve all the myriad and complex issues of consent, it can serve a very useful function. In an effort to replace the murkiness of custom with the clarity of legislation and to provide guidance for those involved daily with the problem of how medical decisions are to be made for an individual who cannot do so for himself, this Act embraces five general concepts.

First, the Act designates the individuals who may consent to health care for themselves. (Section 2 [5-802].) Section 2 [5-802] restates the common law that adults may consent for themselves unless incapable of consenting. At common law, minors were not permitted to make health-care related decisions and the state entrusted that decision-making power to parents. However, over the years there have developed several well-defined exceptions to a minor's disability. Section 2 [5-802] incorporates those more widely recognized exceptions. In addition to the general exceptions to the status of minority which permit minors to consent to all forms of health care, many states have carved out more limited exceptions that authorize minors to consent to particular forms of health care without parental consent, for instance, treatment for drug or alcohol abuse. Section 2 [5-802] preserves existing state law on these matters.

Second, the Act provides a triggering mechanism to determine when an individual is incapable of consenting. (Section 3 [5-803].) This decision is made by the health-care provider and the standard for determining that one is incapable of consenting is whether the individual is capable of making a decision

regarding the proposed health care. It is important to note that the effect of a determination of incapacity is not to bypass consent but to shift the health care decision making to a third party.

Third, the Act provides a scheme for determination of a proxy decision maker to act for one incapable of consenting. (Section 4 [5-804].) At common law, parents were entrusted with making health care decisions for their children. The state's power to care for an incompetent adult was traditionally exercised through guardianship. That much is clear in existing law. However, unless the person in need of health care is an infant or has been accorded protection through a formal adjudication of incompetency, the common law affords no clearly established authorization for one family member to act for another. Courts and treatise writers have indicated that authorization from a spouse or other close family member is permissible. While that accords with custom, actual adjudicated authority to that effect is sparse. Section 4 [5-804] provides both an authorization and system of priorities for proxy decision makers.

Fourth, the Act permits family members authorized to consent for another by Section 4 [5-804] to delegate their authority to make health-care decisions. (Section 5 [5-805].) The authorization is intended to permit relatives to delegate their decisional power while they are separated from other family members. For instance, while children are away at summer camp the power of a parent to delegate decisional authority to a camp director would be extremely useful.

Fifth, the Act authorizes an individual to appoint another to serve as a health-care representative and to make health-care decisions on his behalf. (Section 6 [5-806].) A concern for personal autonomy underlies this provision. Section 6 [5-806] is designed to provide an alternative to the system of third-party consent outlined in Section 4 [5-804]. Section 6 [5-806] permits an individual to make his own designation if he so chooses. While the provision is perhaps novel to the field of health care, the power to make such a designation exists in jurisdictions that have statutes similar to the Uniform Curable Power of Attorney Act.

One authorized to make health-care decisions for another is in every important sense of that word a fiduciary. A proxy decision maker must use good faith and act in the best interest of the individual for whom decisions are made. Those authorized to act under Section 4 [5-804] are empowered to act either because of a legally imposed relationship (in the case of a

guardian) or because of a family relationship. A health-care representative authorized under Section 6 [5-806] is empowered because a patient has designated him to make treatment decisions; autonomy is the basis for the appointment.

The best interest standard governs both a Section 4 [5-804] proxy and a Section 6 [5-806] health-care representative. In the case of a Section 4 [5-804] proxy, best interest incorporates an objective general standard, whereas the Section 6 [5-806] health-care representative must also act in accordance with the purposes of the individual as stated in the appointment. Best interest is an evolving standard governed by state law. In the case of Section 4 [5-804] proxy, best interest requires that the decision maker act reasonably. In most cases the Section 4 [5-804] decision maker will be a family member. His power does not arise from the patient having placed him in a position of trust but from his relationship to the patient. His power thus turns on the community's perception of what authority a relative ought to have. That is generally defined in terms of an objective best interest test. However, the Section 6 [5-806] health-care representative acts because he has been designated to serve by the patient. Autonomy is the basis for that appointment and the health-care representative's obligation can be determined from the creator of the power, i.e., from the specific instructions in the document appointing him. When the patient has expressed his desire, that is the strongest evidence of his best interest.

There are important limitations on the substitute decision maker's power contained in the Act. One of the most important limitations concerns the treatment of mental illness. The Act does not displace existing law on the consent related questions of mental-health treatment. One important issue that has been the subject of recent litigation concerns the right to refuse psychotropic drugs in the treatment of psychosis. Some litigated cases require prior judicial approval for the administration of these drugs to nonconsenting, noninstitutionalized, incompetent persons. See In the Matter of Guardianship of Roe III, __ Mass.____, 421 N.E.2d 40 (1981). Many difficult questions remain unanswered; for instance whether absent an emergency, a state can forcibly medicate an involuntarily institutionalized person without a prior judicial determination of incapacity. See Mills v. Rogers, ____U.S.____, 102 S.Ct. 2442 (1982). This is one of those areas in which there is no clear consensus and Section 11 [5-811] of the Act preserves that ongoing debate. Section 11 [5-811] does not authorize any individual to consent to mental-health treatment unless in compliance with state law.