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THE CARE SPAN

Default Options In Advance Directives Influence How Patients Set Goals For End-Of-Life Care

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ABSTRACT Although decisions regarding end-of-life care are personal and important, they may be influenced by the ways in which options are presented. To test this hypothesis, we randomly assigned 132 seriously ill patients to complete one of three types of advance directives. Two types had end-of-life care options already checked—a default choice—but one of these favored comfort-oriented care, and the other, life-extending care. The third type was a standard advance directive with no options checked. We found that most patients preferred comfort-oriented care, but the defaults influenced those choices. For example, 77 percent of patients in the comfort-oriented group retained that choice, while 43 percent of those in the life-extending group rejected the default choice and selected comfort-oriented care instead. Among the standard advance directive group, 61 percent of patients selected comfort-oriented care. Our findings suggest that patients may not hold deep-seated preferences regarding end-of-life care. The findings provide motivation for future research examining whether using default options in advance directives may improve important outcomes, including patients' receipt of wanted and unwanted services, resource use, survival, and quality of life.

Most seriously ill patients value comfort and dignity over life extension,¹ but routine care often leads to treatment oriented toward extending life.^{2,3} Deviating from this life-extending norm requires that someone actively request or suggest doing so.⁴⁻⁶

Specifying one's goals of care in the living will component of an advance directive provides patients with an opportunity to counter this tendency.⁷ However, the text and structure of commonly used advance directives carry some of the same implicit biases that tend to favor life

extension in the absence of advance directives.² For example, in the widely used "Five Wishes" document,⁸ the option "I want to have life support" is listed first in all three clinical scenarios, despite evidence that the ordering of choices influences the choices selected and that the one presented first often dominates.^{9,10}

Federal law encourages people to complete advance directives,¹¹ and their use appears to be increasing.¹² Given the importance of the choices embedded in advance directives, it is essential to understand how the structure of advance directives affects patients' stated preferences. In studies providing hypothetical

directives to college students¹³ and elderly outpatients,¹⁴ Laura Kressel and colleagues found that people were significantly more likely to indicate preferences to forgo life-sustaining interventions when completing advance directives in which forgoing these interventions was the default than when they had to actively choose to forgo the interventions.¹⁴

These findings using hypothetical scenarios raise the possibility that people might not have well-formulated, strongly held views on what forms of care at the end of life will best promote their values. Indeed, insights from behavioral economics suggest that preferences for end-of-life care are likely to be “constructed” at the moment people are asked to express them, rather than reflective of deeply ingrained preferences, because such choices are made infrequently and often without opportunity for feedback on whether the choices made promoted patients’ interests.^{2,15} We tested this hypothesis by examining whether default options influence the choices of seriously ill patients in real advance directives, even after patients were alerted to the default option and their responses to it.

Study Data And Methods

DESIGN OVERVIEW, SETTING, AND PARTICIPANTS

We randomly assigned real advance directives, which differed only in their embedded default options, to outpatients who were at least fifty years old, lacked prior advance directives, had incurable diseases of the chest, and were not being considered for lung transplantation (Exhibit 1 and online Appendix Exhibit A).¹⁶ Patients were recruited in the thoracic oncology and pulmonary outpatient clinics at the Hospital of the University of Pennsylvania from May 2010 through January 2012. The University of Pennsylvania Institutional Review Board approved this study.

Each week a research nurse screened electronic health records to identify eligible patients and obtained permission from these patients’ physicians to recruit them. The research nurse then met with potentially eligible patients in person, described the study, reviewed the potential benefits of completing advance directives, answered all questions, and provided patients with a written informed-consent document. The consent form and nurse’s spoken guidance

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EXHIBIT 1

Characteristics Of Patients In The Study To Assess The Affect Of Default Options In End-Of-Life Care Planning

Characteristic	Life-extension default (n=49)		Standard advance directive (n=43)		Comfort default (n=40)	
	Number	Percent	Number	Percent	Number	Percent
Age (mean years)	64.6	—	64.4	—	64.8	—
SEX						
Male	24	49.0	15	34.9	17	42.5
Female	25	51.0	28	65.1	23	57.5
RACE						
Black or African American	11	22.4	14	32.6	10	25.0
White or Caucasian	34	69.4	29	67.4	28	70.0
Other/unknown	4	8.2	0	0.0	2	5.0
RELIGION						
Catholic	12	24.5	10	23.3	12	30.0
Protestant	15	30.6	13	30.2	13	32.5
Other Christian	1	2.0	4	9.3	2	5.0
Jewish	2	4.1	3	7.0	1	2.5
Other faiths	13	26.5	10	23.3	6	15.0
Unaffiliated	6	12.2	3	7.0	6	15.0
DIAGNOSIS						
Non-small cell lung cancer/other thoracic malignancy ^a	18	36.7	16.9	37.2	13	32.5
Chronic obstructive pulmonary disease	14	28.6	15	34.9	14	35.0
Idiopathic pulmonary fibrosis	8	16.3	3	7.0	5	12.5
Other incurable fibrotic lung diseases	6	12.2	7	16.3	5	12.5
Other ^b	3	6.1	2	4.7	3	7.5

SOURCE Authors’ analysis. ^aOther thoracic malignancies include malignant pleural effusion (for example, from breast cancer) and mesothelioma. ^bChronic obstructive asthma, bronchiectasis, cystic fibrosis, chronic pulmonary heart disease, other pulmonary insufficiency not elsewhere classified, other respiratory abnormalities, radiation pneumonitis, beryllium disease, lung involvement in systemic sclerosis, SLE (systemic lupus erythematosus), RA (rheumatoid arthritis).

informed patients that different types of advance directives would be assigned by chance, that patients in all groups could select or decline the same interventions and treatment goals, and that patients could change their choices at any time.

INTERVENTIONS Consenting patients were randomly assigned to complete one of three advance directives. All three were modified slightly from the professionally endorsed directive published by the Allegheny County Medical Society.¹⁷ Each was deemed consistent with Pennsylvania law by the University of Pennsylvania Office of the General Counsel. Each included an identical section for the designation of a durable power of attorney for health care and a living will section that was altered among the three versions, as described below. Facsimiles of all of the advance directive forms used in this study can be found in the online Appendix.¹⁶

In all versions, patients were shown the exact same options. The versions differed in whether or not they contained a default—that is, whether a particular option was already marked with an X. When such a preselected default was used, that choice was placed first of the three options. Patients first were asked to choose an overall plan of care that prioritized extending life or one that prioritized minimization of pain and suffering.

The precise language used was adapted from that used by William Knaus in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), a landmark clinical trial.¹⁸ Patients could expand upon or clarify their choices by writing in the additional space provided.

Patients also were asked to choose whether or not they wished to receive five potentially life-sustaining interventions, such as feeding tube insertion, if they became unable to make decisions themselves. Again, patients could opt not to make these choices, and they could expand upon their choices in the additional space provided.

Allocation of individual patients was determined by electronic number generation, with assignment probabilities of 33.3 percent to each group. The research nurse recruiting patients used a numbered packet containing the assigned advance directive for each sequentially randomized patient.

One-third of patients were assigned to receive a “comfort default advance directive” that defaulted to the goal of relief of pain and suffering and nonreceipt of life-sustaining interventions. Patients were instructed to make other choices if they preferred by crossing out the default options and initialing lines next to their selections.

Another one-third of patients, in the “life-extension default advance directive” group, received a directive that defaulted to the goal of life extension and receipt of potentially life-sustaining interventions. Again, patients were shown how to make alternative selections.

Patients in a third group were assigned to receive a “standard advance directive” that required patients to actively choose their goals of care or preferences for specific interventions. As in usual practice, if patients did not make active choices, surrogates and clinicians would make decisions if patients lost capacity.

All patients were encouraged to involve their family members and physicians in completing their advance directives and to return them. If completed directives were not returned within ten days, the nurse telephoned patients up to three times to remind them and, if desired, to schedule a clinic visit specifically for help in completing the advance directive. For an advance directive to be considered complete, the signatures of two witnesses or a notary were required, as per Pennsylvania law.

DEBRIEFING After patients returned completed advance directives, one investigator called patients to debrief¹⁹ them about the precise differences between their assigned advance directive and the advance directives that other study participants received. The investigator used an Institutional Review Board–approved debriefing script.¹⁶ After explaining the goals of the study, including the concept of default options, the investigator read patients’ choices back to them and asked if they wished to make any changes.

OUTCOMES The primary outcome was the proportion of patients across the three intervention groups who selected a comfort-oriented goal of care. Given the propensity of the health care system to try to extend life in the absence of a directive otherwise,^{3,4,7} patients who selected a life-extending goal of care and those who did not select an overall goal of care were jointly considered to have not selected a comfort-oriented goal.

We also assessed patients’ satisfaction with their advance care planning two months after the debriefing. One of two authors blinded to patients’ group assignments contacted patients by phone and administered the Canadian Healthcare Evaluation Project (CANHELP) questionnaire. This thirteen-item questionnaire has been validated for assessing satisfaction with end-of-life care planning.^{20,21}

STATISTICAL ANALYSIS Our protocol specified a primary analysis in which we included only patients who returned completed advance directives. This analysis assessed the efficacy of

default options in advance directives among patients who completed them.

Because such analyses are susceptible to selection effects, intention-to-treat analyses were also conducted in which all patients who were randomly assigned an advance directive were included in the analyses. These intention-to-treat analyses were considered secondary because they are heavily biased toward the null. Specifically, they make the implausible assumption that all patients who did not complete advanced directives chose not to receive comfort-oriented plans of care and chose not to forgo any potentially life-sustaining interventions.

Chi-square tests, Cochran-Armitage tests of trend, and *t* tests were used as appropriate for two-group binary, three-group binary, and continuous outcomes data, respectively. In secondary analyses, logistic regression models were created to adjust for chance imbalance across arms in patient-level variables.

The clinic where patients were recruited for the study was modeled as a random effect to adjust for potentially correlated outcomes within clinics and to prevent confounding by clinic.²² Analyses were performed using the software Stata, version 11.0, except for the Cochran-Armitage tests, which were performed using SAS, version 9.3.

We targeted a sample size of ninety-three patients. If evenly distributed across the three ordered groups, this sample would yield 81 percent power to declare significance at $p = 0.05$ for a difference in the proportion of patients selecting comfort-oriented goals of care of 35 percent. This calculation assumed that the proportion in the standard advance directive group (the middle group) would be roughly equidistant between the proportions in the life-extension and comfort default groups.

LIMITATIONS This study was designed to enroll a relatively small number of patients from a single health system. Although it was a randomized trial, the sample size does not allow us to rule out the possibility that results were confounded by unmeasured variables, such as how well patients understood their illnesses or how often they spoke with their physicians about prognosis.

Second, we did not randomly assign the ordering of options within the standard advance directive but instead listed the comfort-oriented goal of care and the options to forgo specific interventions first for all patients in that arm. Because the first-listed option tends to be more commonly selected,^{9,10} the observed differences in selections between the comfort-default advance directive and standard advance directive may actually underestimate the magnitude of the default effect.

Third, we enrolled only patients with serious thoracic diseases—primarily lung cancer and obstructive and restrictive lung diseases. The findings from this group of patients might not be generalizable to all patients or to patients with other specified health conditions.

Study Results

One thousand and seventy-nine patients were screened and determined to be eligible for this study based upon reviews of their electronic health records. Of these, physicians requested that 43 not be contacted for study enrollment at the time of their visit, and 332 missed or rescheduled their visit or were not approached by the research nurse because of scheduling conflicts. Of the remaining 704 patients, 391 (55.5 percent) were deemed ineligible when in-person questioning revealed that they had existing advance directives.¹⁶ Thus, there were 313 fully eligible patients, 132 (42.2 percent) of whom consented to participate.

One patient was excluded because he completely rewrote the assigned advance directive, making choices that were not classifiable using our coding scheme. The other 131 consented patients were included in intention-to-treat analyses.

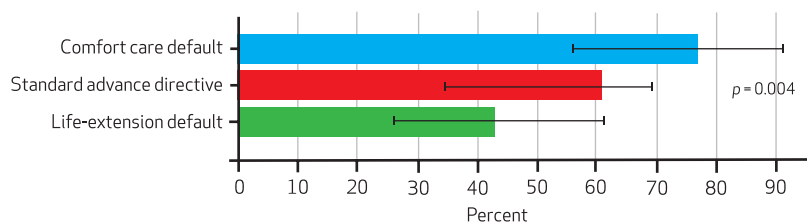
Completed advance directives were returned by ninety-five patients (72.0 percent), only two of whom (2.1 percent) elected to reconsider their choices during the debriefing. One of these patients returned a new advance directive in which the only change was his selection of a new durable power of attorney; the other patient did not return a completed advance directive by the end of the study. Thus, ninety-four patients were included in per protocol analyses. Principal diagnoses and demographic characteristics among the 132 patients who consented to participate are shown in Exhibit 1.

GOALS OF CARE The specific goals selected by patients in each group are shown in online Appendix Exhibit F.¹⁶ This exhibit shows that fifty-four (57.4 percent) of the ninety-four patients who returned a completed advance directive made a choice regarding their overall goals that differed from the default option.

Nonetheless, in per protocol analyses, advance directive default options significantly influenced the proportions of patients who chose comfort-oriented goals of care. Among the comfort default group, 77 percent retained comfort as their overall goal of care; 61 percent in the standard advance directive group chose comfort as their goal; and 43 percent of those in the life-extension default group rejected the default choice and indicated comfort as their primary

EXHIBIT 2

Percentage Of Patients Choosing A Comfort-Oriented Goal Of Care (Per Protocol Population)



SOURCE Authors' analysis. NOTES Standard error bars denote 95% confidence intervals.

goal ($p < 0.01$ for test of trend; Exhibit 2).

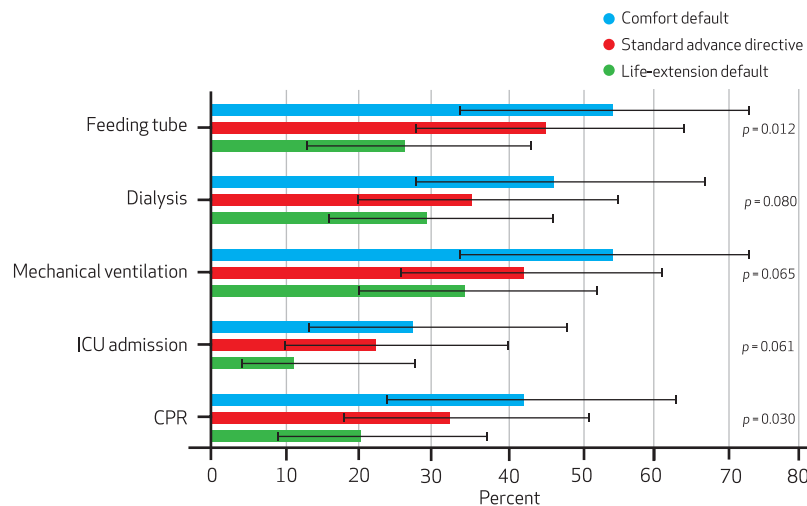
Intention-to-treat analyses produced a similar trend in proportions: 50 percent in the comfort default group, 47 percent in the standard advance directive group, and 31 percent in the life-extension default group ($p = 0.04$).¹⁶

In secondary analyses adjusting for race, sex, age, marital status, and the recruiting research nurse, group assignment remained significantly associated with selections of comfort-oriented goals of care in per-protocol analyses (odds ratio: 2.12; 95% confidence interval: 1.21–3.72; $p < 0.01$). Intention-to-treat analyses yielded similar but nonsignificant results (odds ratio: 1.51; 95% confidence interval: 0.96–2.37; $p = 0.07$). These results were robust to different modeling strategies.¹⁶

Among the thirty-six patients in whom education level was measured, patients who had never attended college (10/17, 59 percent) were as

EXHIBIT 3

Percentage Of Patients Choosing To Forgo Each Intervention, By Type Of Advance Directive (Per Protocol Population)



SOURCE Authors' analysis. NOTES Standard error bars denote 95% confidence intervals. CPR is cardiopulmonary resuscitation.

likely as patients who had attended college (10/19, 53 percent) to make selections other than the default option (odds ratio: 1.33; 95% confidence interval: 0.26–6.68).

CHOICES TO RECEIVE POTENTIALLY LIFE-SUSTAINING INTERVENTIONS Patients completing different advance directive versions also had different probabilities of choosing to forgo potentially life-sustaining interventions. For example, the proportions of patients choosing to forgo feeding-tube insertion were 54 percent in the comfort-default group, 45 percent in the standard advance directive group, and 26 percent in the life-extension default group ($p = 0.01$ for test of trend; Exhibit 3). For cardiopulmonary resuscitation, corresponding proportions were 42 percent, 32 percent, and 20 percent ($p = 0.03$).

Similar but nonsignificant trends were noted for intensive care unit admission ($p = 0.06$), mechanical ventilation ($p = 0.06$), and hemodialysis ($p = 0.08$). Similar trends were also noted in intention-to-treat analyses, although only the test for feeding-tube insertion was statistically significant.¹⁶

SATISFACTION WITH END-OF-LIFE CARE PLANNING Assessments of patients' satisfaction with end-of-life care planning were completed for seventy-eight of the ninety-four patients who completed advance directives (83.0 percent). Of the remaining sixteen patients, at least five died within two months; the remainder were lost to follow-up, and it was not known with certainty that they were still living. Global and average satisfaction scores were high across the three intervention groups (greater than 4.5 out of a possible 5) and no significant between- or among-group differences were identified.¹⁶

Discussion

Default options, or the events or conditions that will be set into place if no alternative is actively chosen,^{23,24} have been shown to influence decisions in domains as diverse as drivers' insurance,²⁵ retirement savings,^{26,27} influenza vaccination,²⁸ and organ donation.^{29,30} A hallmark of defaults is that they lead gently, without restricting any options.

Thus, when people have strong preferences, such as for low-deductible health care insurance, they commonly make choices that counter the default. This is precisely what happened, for example, with the roll-out of Medicare Part D drug coverage, when despite the default annual deductible of \$250, most Americans chose plans with no deductible at all.²⁴

The study on which we report here shows that default options have large influences on

seriously ill patients' actual choices for health care interventions at the end of life. Overall, most patients with terminal illnesses stated preferences for comfort-oriented care when offered the opportunity to state these preferences in real advance directives, but the proportions of patients choosing this option differed markedly as a function of how the default was set.

Importantly, these effects manifested even after patients were made aware of the defaults and shown how they had responded to them, and after it was made easy to choose counter to the default, which many patients did, particularly in the life-extension default and standard advance directive groups.¹⁶ Only 2.1 percent of patients in this study elected to reconsider their selections after being alerted to the manipulation of the default option, but ultimately these patients did not change their original selections. Furthermore, intentionally setting defaults was not associated with any changes in patients' satisfaction with their choices, which suggests that patients were content to be guided in such decisions.

Although one might expect patients to hold strong prior preferences about end-of-life treatments, the findings that people were heavily swayed by defaults, and content to be swayed, suggest that many seriously ill patients lack deep-seated preferences about their end-of-life care. Despite the importance of end-of-life health care decisions, it should come as no surprise that many patients lack well-established preferences in this domain. People commonly lack prior preferences for decisions that are made infrequently and provide few opportunities for learning after the fact whether the choices made did or did not promote their goals.¹⁵ These are precisely the characteristics of end-of-life care choices.

The power of defaults in determining stated end-of-life care preferences underlines the importance of selecting defaults carefully without limiting patients' options.^{24,31} At the same time, clinicians should recognize that it is often difficult to avoid defaults, and they should therefore consider carefully the predictable consequences of which defaults are used or allowed to remain.^{2,24,32}

Indeed, there is a default option embedded in the standard approach to advance care planning: If patients do not actively choose specific goals in advance directives, clinicians and surrogates must make decisions for patients who lose capacity. Because many patients do not complete advance directives or merely designate a durable power of attorney, this "default to surrogate decision making" not only is prevalent, but also carries important bereavement consequences for family members.³³⁻³⁵

Given that most patients place a high priority on not burdening their loved ones³⁵⁻³⁹ and that most patients in our study selected comfort-oriented goals even in the standard advance directive group, there is reason to believe that the current systemic default of life extension might not optimally promote patients' wishes and values.

These results can also be interpreted as evidence that advance directive forms, absent a well-structured conversation among patients, family members, and providers, will not meaningfully promote patients' values.⁴⁰ A preferable approach to advance care planning may be one that relies not on forms but on carefully structured conversations that explore patients' values in the presence of their potential surrogate decision makers.⁴¹

For particular patients and families cared for by particular clinicians—for example, patients with good access to physicians well trained in end-of-life communication and with family members experienced in advance care planning—such coordinated communication may indeed prove optimal. But it is uncertain whether this approach could be implemented across diverse populations with differential access to skilled clinicians and experienced family members.

By contrast, designing an advance directive that would help the majority of patients make decisions that promote their goals could provide a way to improve end-of-life care more broadly, for all Americans. Recent evidence provides substantial motivation to try, as observational studies in the United States show that patients who complete advance directives less commonly die in a hospital,^{12,42-44} more often receive care consistent with their preferences,¹² have surrogates who are less likely to report concerns with communication near the end of life,⁴³ and, in certain regions, receive less costly care.⁴⁴

This study shows that using default options in advance directives strongly influences the end-of-life care choices that people make without affecting their satisfaction with their advance care planning. Furthermore, because the effects of defaults were identical even after patients were directly told about the default, this study suggests that for many patients, "preferences" for end-of-life care are not deeply held.

This study also provides motivation for future research examining whether using default options in advance directives may improve important outcomes, including patients' receipt of wanted and unwanted services, survival, quality of life, resource use, and family members' bereavement. If such research shows that setting defaults in advance directives improves such

outcomes while adhering to ethical standards for default setting (including assurances that patients are aware of the decisions to be made and that countering the default can be done easily),^{3,24,45,46} then the clinical use of default options in advance directives may provide a novel way to improve end-of-life care for large populations of seriously ill patients. ■

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Scott D. Halpern is the director of the Fostering Improvement in End-of-Life Decision Science Program, University of Pennsylvania.

In this month's *Health Affairs*, Scott Halpern and coauthors report on their study testing whether end-of-life care decisions are influenced by the ways in which options are presented. They randomly assigned 132 seriously ill patients to complete one of three types of advance directives that had either different "default" choices already selected for comfort-oriented care or life-extending care, or no options checked at all. The results indicated that the defaults clearly influenced patients' choices and that patients might not hold deep-seated preferences regarding end-

of-life care, the authors write. The authors recommend further research to determine whether use of advance directives with these default options leads to outcomes important to patients, families, and society.

Halpern is the director of the Fostering Improvement in End-of-Life Decision Science Program and deputy director of the Center for Health Incentives and Behavioral Economics at the Leonard Davis Institute of Health Economics, Wharton School, University of Pennsylvania. He is also an assistant professor of medicine, specializing in pulmonary and critical care, epidemiology, and medical ethics and health policy at the university.

Halpern is a member of the Secretary of Health and Human Services Advisory Committee on Blood and Tissue Safety and Availability and of the Technical Advisory Committee to the

Scientific Registry of Transplant Recipients. He received a Robert Wood Johnson Foundation Young Leader Award in 2012. Halpern earned master's degrees in bioethics and clinical epidemiology, a doctorate in epidemiology, and a medical degree from the University of Pennsylvania.



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George Loewenstein is the Herbert A. Simon Professor of Economics and Psychology at Carnegie Mellon University and one of the founders of the fields of behavioral economics and



Despite Gains In Advance Directives, Study Finds More Intensive End-Of-Life Cancer Care

By **Michelle Andrews** | July 21, 2015

Conversations about end-of-life care are difficult. But even though most people now take some steps to communicate their wishes, many may still receive more intensive care than they would have wished, a [study this month found](#).

The study, published online in JAMA Oncology, examined survey data from the Health and Retirement Study, a national study of U.S. residents older than age 50. Researchers analyzed the responses from the next of kin, usually a spouse or child, of 1,985 participants with cancer who died between 2000 and 2012.

The patients' family members responded to questions about how frequently patients had signed durable power of attorney documents or living wills or participated in conversations about their end-of-life-preferences. Researchers then examined the association between those advance-care-planning activities and the medical care the cancer patients received at the end of life.



Over the study period, the use of durable power of attorney assignment, sometimes called a health care proxy, grew from 52 percent to 74 percent among participants. Small declines were reported in other planning activities — from 49 percent to 40 percent for living wills and 68 percent to 60 percent for end-of-life discussions — but they weren't statistically significant because the levels varied throughout the study period, says Dr. Amol Narang, a radiation oncologist at Johns Hopkins School of Medicine and the lead author of the study.

“Our hypothesis was that we’d see significant increases over the study period in advance directives,” Narang says. “What we saw was that important aspects of advance care planning haven’t increased.”

in this series



At the same time, the proportion of patients who were reported to have received “all care possible” at the end of their lives increased substantially over the study period, from 7 percent to 58 percent, even though such intensive treatment may have been counter to their stated wishes.

A durable power of attorney allows consumers to appoint someone to

make health care decisions for them if patients are unable to do so. Living wills describe the types of medical care people wish to receive (or don't wish to receive) if they're incapacitated. Neither requires a lawyer, and forms are often available online.

Simply signing a document isn't enough, experts say. There's no substitute for regular communication with friends and family about end-of-life preferences.

"Patients may have signed that power of attorney, but if they haven't discussed their preferences with that person the proxy may default to 'all care necessary,'" Narang says. In other words, lacking clear guidance, the health care proxy may choose to err on the safe side and approve more care rather than limit or withhold it.

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ails).

Living wills spell out which treatments someone would want — specifying that they would want to be put on a ventilator, for example, or fed through a tube. But some experts say treatment-focused specificity may not serve patients' best interests.

Spelling out treatment preferences is only useful in context, says Dr. Diane Meier, director of the Center to Advance Palliative Care.

"Of course you would want to be put on a ventilator if it was going to return you to health," Meier says.

The more important question is a qualitative one: What is the quality of life that is unacceptable to you? Would you want every measure taken to treat an illness or injury even if it meant enduring extreme pain with little likelihood of improvement? Or would you rather forgo such intensive treatment and be kept comfortable instead? Those are the conversations that need to happen, experts say.

The issue is front and center these days as policy makers debate the recent federal proposal to reimburse physicians for conversations with Medicare patients about advance care planning.

"It's a significant step in the right direction," says Jonathan Keyserling, senior vice president for health policy at the National Hospice and Palliative Care Organization.

"Now that health care professionals can soon be reimbursed for these intimate and thoughtful conversations, I think we'll see changes in practice patterns and in decisions by family members."

Some policy experts say that changing payment practices won't be enough to change clinical practice. For physicians, offering treatment, even if there's little chance it will help, is the only way they may know to show their loyalty and love for a patient, says Meier.

"We have to change the training or nothing will change," she says.

For that reason, she hopes that the Centers for Medicare and Medicaid Services will require doctors to get

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some training in how to introduce and take part in conversations about advance care planning rather than simply check a box on a form that says a conversation took place.

Please contact Kaiser Health News to send comments or ideas for future topics for the Insuring Your Health column.

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Original Investigation

Trends in Advance Care Planning in Patients With Cancer Results From a National Longitudinal Survey

Amol K. Narang, MD; Alexi A. Wright, MD, MPH; Lauren H. Nicholas, PhD, MPP

IMPORTANCE Advance care planning (ACP) may prevent end-of-life (EOL) care that is nonbeneficial and discordant with patient wishes. Despite long-standing recognition of the merits of ACP in oncology, it is unclear whether participation in ACP by patients with cancer has increased over time.

OBJECTIVES To characterize trends in durable power of attorney (DPOA) assignment, living will creation, and participation in discussions of EOL care preferences and to explore associations between ACP subtypes and EOL treatment intensity as reflected in EOL care decisions and terminal hospitalizations.

DESIGN, SETTING, AND PARTICIPANTS We analyzed prospectively collected survey data from 1985 next-of-kin surrogates of Health and Retirement Study (HRS) participants with cancer who died between 2000 and 2012, including data from in-depth "exit" interviews conducted with the surrogates after the participant's death. The HRS is a nationally representative, biennial, longitudinal panel study of US residents older than 50 years. Trends in ACP subtypes were tested, and multivariable logistic regression models examined for associations between ACP subtypes and measures of treatment intensity.

MAIN OUTCOMES AND MEASURES Trends in the surrogate-reported frequency of DPOA assignment, living will creation, and participation in discussions of EOL care preferences; associations between ACP subtypes and both surrogate-reported EOL care decisions and terminal hospitalizations.

RESULTS From 2000 to 2012, there was an increase in DPOA assignment (52% to 74%, $P = .03$), without significant change in use of living wills (49% to 40%, $P = .63$) or EOL discussions (68% to 60%, $P = .62$). Surrogate reports that patients received "all care possible" at EOL increased during the period (7% to 58%, $P = .004$), and rates of terminal hospitalizations were unchanged (29% to 27%, $P = .70$). Limiting or withholding treatment was associated with living wills (adjusted odds ratio [AOR], 2.51; 95% CI, 1.53-4.11; $P < .001$) and EOL discussions (AOR, 1.93; 95% CI, 1.53-3.14; $P = .002$) but not with DPOA assignment.

CONCLUSIONS AND RELEVANCE Use of DPOA increased significantly between 2000 and 2012 but was not associated with EOL care decisions. Importantly, there was no growth in key ACP domains such as discussions of care preferences. Efforts that bolster communication of EOL care preferences and also incorporate surrogate decision makers are critically needed to ensure receipt of goal-concordant care.

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In response to concerns about the quality of end-of-life (EOL) care provided to patients with chronic illnesses approaching death, the Institute of Medicine (IOM) recently released a report entitled *Dying in America*.¹ The IOM report describes EOL care in the United States as intensive and frequently inconsistent with patients' preferences. The report advocates a broader definition of advance care planning (ACP), characterized by ongoing clinician-patient discussions of EOL care preferences over time, to help ensure goal-concordant care at EOL.

Advance care planning is particularly relevant to oncology because cancer is the second leading cause of death in the United States, with more than half a million cancer-related deaths reported in 2013.² Moreover, to a greater extent than common noncancer causes of death, cancer has a distinct trajectory of functional decline and a predictable terminal period during which patients might benefit from ACP and palliative care.^{3,4} Professional oncologic organizations have long realized the value of early ACP as a key component of optimal palliative care, as reflected in National Comprehensive Care Network (NCCN) guidelines as early as 2001.⁵ Similarly, the American Society of Clinical Oncology (ASCO) has endorsed early ACP as far back as 1998,⁶ with continued emphasis in more recent statements.^{7,8}

Nevertheless, evidence suggests that cancer care continues to be both highly intensive and geographically variable, likely driven in large part by local practice patterns instead of patients' preferences.⁹⁻¹⁴ Indeed, research published over a decade ago that described an environment of increasingly aggressive cancer care¹⁵ is mirrored in more recent studies showing persistent use of hospital-based services near death, despite evidence that aggressive EOL interventions may not be associated with better medical or quality-of-life outcomes.¹⁶⁻²⁰

In light of the continued intensity of EOL cancer care, it is important to examine whether oncologists' long-standing recognition of the merits of ACP have translated into gains in patient participation in ACP and whether certain forms of ACP are more strongly linked to EOL treatment intensity. To address this question, we sought to characterize trends in ACP and EOL treatment intensity in a cohort of patients with cancer who participated in a nationally representative survey and who died between 2000 and 2012.

Methods

Study Population

We analyzed survey data from the Health and Retirement Study (HRS),^{21,22} a nationally representative, longitudinal panel survey that conducts biennial interviews with a sample of more than 26 000 US residents older than 50 years and their spouses. The HRS is designed to collect detailed health, demographic, and financial information about older adults. Following the death of study participants, the HRS study team conducts in-depth "exit interviews" with a proxy informant who is knowledgeable about the deceased respondent, often the next of kin. Exit informants are asked detailed questions about the study participant's EOL experience, including questions about the medical care received. Exit interview response rates are high,

At a Glance

- In a cohort of cancer decedents, trends in the prevalence of advance care planning (ACP) are characterized, as is the association between types of ACP and end-of-life treatment intensity.
- From 2000 to 2012, power-of-attorney assignment increased (52% to 74%, $P = .03$), with no significant change in use of living wills (49% to 40%, $P = .63$) or end-of-life discussions (68% to 60%, $P = .62$).
- During the same period, surrogate reports that patients received "all care possible" at end of life increased (7% to 58%, $P = .004$), and rates of terminal hospitalizations were unchanged (29% to 27%, $P = .70$).
- Limiting or withholding treatment was associated with living wills (adjusted odds ratio [AOR], 2.51; 95% CI, 1.53-4.11) and EOL discussions (AOR, 1.93; 95% CI, 1.53-3.14) but not with durable power of attorney assignment.
- Although associated with reduced end-of-life treatment intensity, key ACP domains are not being increasingly utilized, highlighting the need for new measures to bolster their adoption.

with reported rates over 85% since 2000.²³ Given our interest in understanding patterns of ACP among patients with cancer, we examined responses from proxy informants of decedents who died between 2000 and 2012 and had either (1) died from cancer or (2) received cancer treatment during the last 2 years of life, as noted by the proxy informant. Oral informed consent was obtained from study participants and proxies as part of the HRS process. In addition, our study was approved by the institutional review board of Johns Hopkins Hospital.

ACP and EOL Treatment Intensity

For our analysis, we broadened our definition of ACP beyond traditional advance directives to be consistent with the IOM's recommendation.¹ As such, ACP was defined as the presence of a living will, assignment of a durable power of attorney (DPOA), or participation in a discussion about EOL care preferences prior to death, as noted by the proxy informant. For living wills, informants were asked "Did [first name] provide written instructions about the treatment or care [she/he] wanted to receive during the final days of [her/his] life?" For DPOA, informants were asked "Did [first name] make any legal arrangements for a specific person or persons to make decisions about [his/her] care or medical treatment if [he/she] could not make those decisions [himself/herself]?" For EOL care discussions, informants were asked "Did [first name] ever discuss with you or anyone else the treatment or care [he/she] wanted to receive in the final days of [his/her] life?"

To assess the intensity of EOL care, proxy informants were asked whether "all care possible under any circumstances in order to prolong life" was delivered at EOL or whether certain treatments were limited or withheld. In addition, we examined the percentage of decedents who experienced proxy-reported terminal hospitalizations over time as another measure of EOL treatment intensity, since hospital deaths are associated with worse mental health outcomes in bereaved caregivers.²⁴ Of note, the proxy informant was the primary decision maker for the decedent's EOL care in 79% of cases that

required surrogate decision making. These proxy reports of ACP and EOL treatment intensity have been used previously in palliative care research.^{25,26}

Statistical Analysis

We used a multivariable logistic regression model to evaluate the association between year of death and ACP, with adjustment for multiple decedent characteristics, including age, sex, race, ethnicity, level of education, marital status, type of religion, importance of religion to the decedent, time from cancer diagnosis to death, medical comorbidities, veteran status, residence in a nursing home, geographic region, year of death, and relationship of the proxy to the decedent. We subsequently tested a null hypothesis of the absence of a linear trend in the use of ACP over time by performing a contrast test on the individual variable coefficients corresponding to each year of death from our multivariable model.¹⁹ Specifically, we tested if a linear combination of the year of death variable coefficients summed to zero, using 2000 as the baseline reference year and applying equally spaced, sum-to-zero weights. We also performed multivariable analysis to characterize the association between year of death and measures of treatment intensity and similarly applied the contrast test to assess for a linear trend in treatment intensity over time.

In addition, we used multivariable logistic regression to characterize associations between ACP subtypes and measures of treatment intensity, adjusting for the covariates described herein. A logistic regression model was fit to each outcome variable separately. Furthermore, when calculating an adjusted odds ratio (AOR) for a particular ACP subtype, we included variables that corresponded to the presence of other ACP subtypes as covariates to isolate the independent association between a particular ACP subtype and measures of treatment intensity.

Of note, HRS selects its participants using a complex, multistage, area probability sampling design in which geographic units that are representative of the nation are defined, and age-eligible members of households within these units are screened with an in-person interview.²⁷ Because HRS oversamples African Americans and Hispanics, respondent-level and household-level weights are created such that the weighted HRS sample is representative of all US households that contain at least 1 age-eligible member, with poststratification weights based on the Current Population Survey.²⁸ In all calculations, we accounted for the complex sampling design by applying respondent-level sampling weights that were taken from the last interview in which the decedent participated prior to death.

Throughout the analysis, 2-sided significance testing was used, and a $P = .05$ was considered statistically significant. All statistical analyses were performed with Stata/IC software, version 10.0 (StataCorp LP).

Results

A total of 8193 HRS participants died between 2000 and 2012 and had exit interviews completed by proxy informants. Of

these decedents, 2040 (25%) either died from cancer or received active cancer treatment in the last 2 years of life. Complete information regarding living will status, DPOA assignment, and participation in EOL discussions was unavailable for 55 decedents (3%), who were excluded from the analysis. The remaining 1985 decedents served as our study population. The relationship of proxy informants to the decedents was most commonly a spouse or partner (43%), son or daughter (38%), sibling (5%), or other (14%). Median time from death to exit interview was 12 months (range, 1-36 months).

Overall, 81% of decedents in our cohort had engaged in at least 1 form of ACP, including 48% who had completed a living will, 58% who had designated a power of attorney, and 62% who had engaged in discussions regarding their EOL care preferences, as noted by the proxy. **Table 1** lists the baseline sociodemographic and clinical characteristics of the decedent population by ACP participation. Decedents who did not participate in any form of ACP were more likely to be male, African American, Hispanic, married, and to consider religion to be an influential factor in their lives compared with those who did engage in ACP ($P < .05$ for all comparisons; Table 1). They were also less likely to be widowed or have completed high school or college ($P < .01$ for all comparisons; Table 1).

Figure 1 illustrates adjusted levels of ACP participation over time, as reported by the proxy. Over the study period, there was no significant increase in the percentage of decedents who engaged in any form of ACP ($P = .19$). Similarly, there were no significant changes in the use of living wills ($P = .63$) or participation in EOL discussions ($P = .62$). There was, however, a significant increase in the frequency of DPOA assignment ($P = .03$). As an example, the adjusted percentage of decedents who designated a DPOA increased from 52% in 2000 to 74% in 2012.

Figure 2 displays the adjusted yearly percentages of measures of EOL treatment intensity among decedents over time, as reported by the proxy. Over the study period, there were no significant changes in the percentage of decedents who experienced terminal hospitalizations ($P = .70$) or the percentage of decedents who had treatments limited or withheld at EOL ($P = .84$). However, there was a significant increase in the percentage of decedents who received all care possible at EOL ($P = .004$). As an example, the adjusted percentage of decedents who received all care possible at EOL rose from 7% for decedents in 2000 to 58% for decedents in 2012.

As listed in **Table 2**, creation of a living will was significantly associated with increased odds of having treatments limited or withheld at EOL (AOR, 2.51; 95% CI, 1.53-4.11). Similarly, participation in EOL discussions was also significantly associated with increased odds of having treatments limited or withheld at EOL (AOR, 1.93; 95% CI, 1.53-3.14). Conversely, DPOA assignment was not associated with having treatments limited or withheld at EOL but was associated with decreased odds of experiencing a terminal hospitalization (AOR, 0.70; 95% CI, 0.52-0.94). As an example of the influence of ACP subtype on care decisions, treatments were limited or withheld in 88% of decedents who had both a living will and EOL discussions, while treatments were limited or withheld in only 53% of decedents who had neither a living will nor an EOL discussion.

Table 1. Clinical and Demographic Characteristics of Study Decedents

Characteristic ^a	Advance Planning, % ^b		P Value
	Any (n = 1601)	None (n = 384)	
Age at death, median (IQR), y	74.7 (74.1-75.4)	73.5 (72.2-74.8)	.13
Female sex	47.4	40.6	.04
Race ^c			
White	89.7	72.0	<.001
African American	7.8	22.7	
Other	2.4	5.3	
Hispanic ethnicity ^c	3.2	11.7	<.001
Education			
Did not complete high school	26.4	43.8	<.001
Completed high school	53.2	41.0	
Completed some college	20.3	15.2	
Marital status			
Married	51.9	61.5	.008
Widowed	31.6	21.0	
Separated or divorced	12.5	12.1	
Single	3.8	5.3	
Other	0.2	0.2	
Religion			
Protestant	60.0	65.9	.07
Catholic	28.0	28.3	
Jewish	2.5	1.2	
No preference	8.2	4.0	
Other	1.3	0.6	
Importance of religion			
Very important	54.1	67.9	<.001
Somewhat important	30.0	25.7	
Not too important	15.9	6.3	
Veteran	33.9	30.1	.24
Nursing home resident	25.0	20.8	.16
Time from cancer diagnosis to death, median (IQR), y	1.0 (0.5-2.1)	1.0 (0.5-2.0)	.54
Comorbid medical conditions			
Heart disease	39.2	35.2	.22
Chronic lung disease	26.7	22.3	.15
Prior stroke	16.4	16.8	.88
Memory-related disease	8.5	5.8	.10
Region ^d			
New England	6.1	6.5	.002
Mid-Atlantic	12.6	11.3	
East North Central	18.6	13.6	
West North Central	8.1	8.0	
South Atlantic	22.3	28.9	
East South Central	5.3	6.8	
West South Central	9.7	15.9	
Mountain	4.5	3.7	
Pacific	12.9	5.5	

Abbreviation: IQR, interquartile range.

^a Data were missing from the following categories: race (0.4%); Hispanic ethnicity (0.3%); education (0.5%); marital status (0.6%); religion (0.7%); importance of religion (2.0%); veteran status (0.7%); nursing home resident status (0.1%); time from diagnosis to death (11.7%); heart disease (1.2%); lung disease (1.5%); stroke (0.9%); and memory-related disease (1.8%).

^b Percentages are weighted using the sampling weights from the Health and Retirement Study.^{21,22} Totals may not sum to 100% owing to rounding.

^c Race and ethnicity were both self-reported in the Health and Retirement Study.

^d Regions were defined as follows: New England included Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut; Mid-Atlantic, New York, New Jersey, and Pennsylvania; East North Central, Ohio, Illinois, Indiana, Michigan, and Wisconsin; West North Central, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas; South Atlantic, Delaware, Maryland, Washington DC, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida; East South Central, Kentucky, Tennessee, Alabama, and Mississippi; West South Central, Arkansas, Louisiana, Oklahoma, and Texas; Mountain, Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, and Nevada; Pacific, Washington, Oregon, California, Alaska, and Hawaii.

In both scenarios, the presence of a DPOA did not appreciably alter these care decisions (eTable in the Supplement).

Other factors associated with increased odds of receiving all care possible at EOL included African American race (AOR, 1.92; 95% CI, 1.03-3.42) vs white race and Hispanic ethnicity

(AOR, 3.69; 95% CI, 1.54-8.87) vs non-Hispanic ethnicity. Similarly, African American race was associated with higher odds of dying in the hospital (AOR, 1.63; 95% CI, 1.11-2.40), as was geographic region (New England AOR, 1.88; 95% CI, 1.09-3.25; mid-Atlantic AOR, 1.90; 95% CI, 1.25-2.87).

Figure 1. Adjusted Yearly Percentages of Advance Care Planning (ACP) and Subtypes Over Time

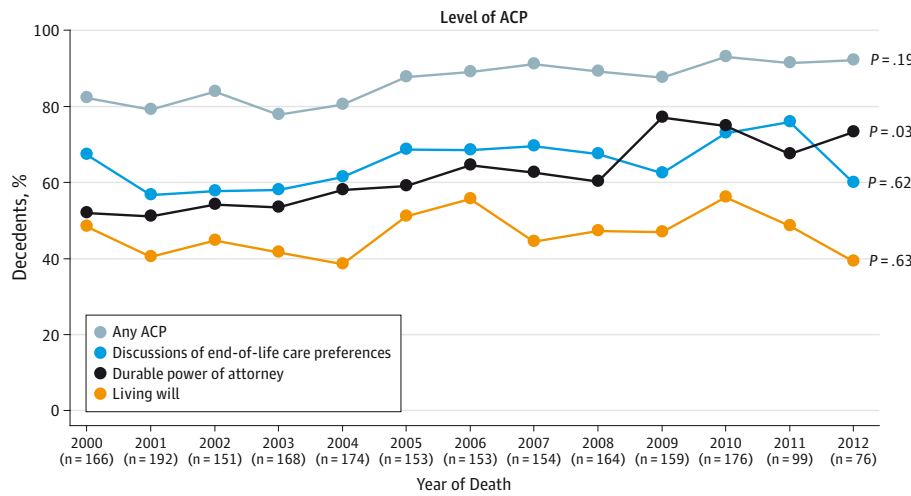


Figure 2. Adjusted Yearly Percentages of End-of-Life (EOL) Treatment Intensity Over Time

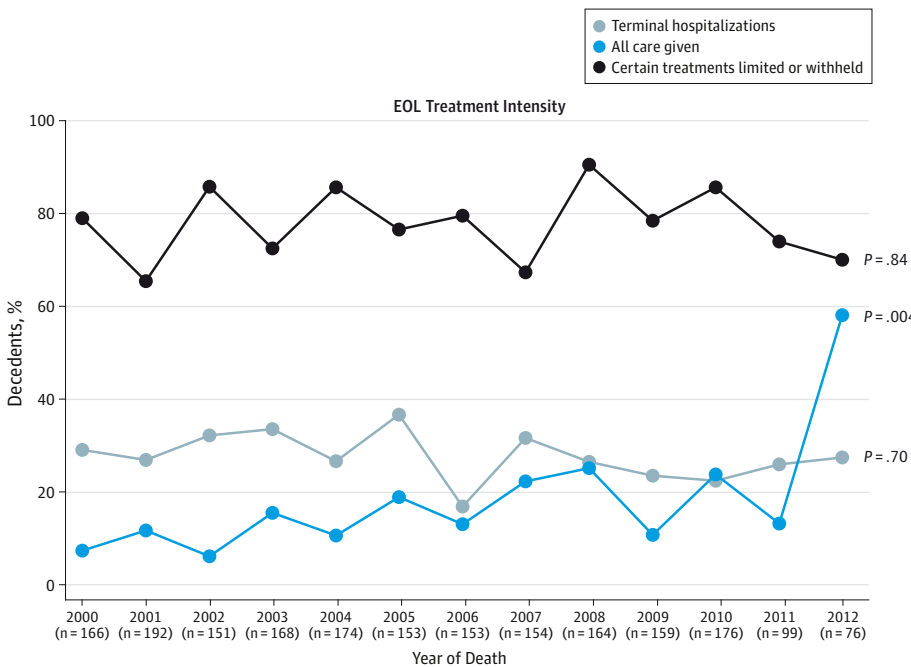


Table 2. Associations Between ACP and EOL Treatment Intensity^a

ACP Subtype	Certain Treatments Limited or Withheld (n = 1316)	All Care Possible Given (n = 204)	Terminal Hospitalizations (n = 597)
Discussion of EOL care preferences	1.93 (1.53-3.14) ^b	0.58 (0.36-0.92) ^c	0.83 (0.63-1.08)
Living will	2.51 (1.53-4.11) ^d	0.49 (0.29-0.84) ^b	0.93 (0.69-1.25)
Durable power of attorney	1.52 (0.78-2.66)	0.68 (0.41-1.10)	0.70 (0.52-0.94) ^c

Abbreviations: ACP, advance care planning; EOL, end of life.

^a Multivariable models adjusted for age, sex, race, ethnicity, education level, marital status, religion, importance of religion to decedent, veteran status, whether patient lived in nursing home, time from diagnosis to death, comorbidities, geographic region, year of death, relationship of the proxy to

the decedent, and other forms of ACP.

^b $P < .01$.

^c $P < .05$.

^d $P < .001$.

To address potential bias from variation in the relationship between proxy and decedent, a sensitivity analysis was performed in the 21% of proxy informants who did not report being primary decision makers for incapacitated decedents. In this subset, the multivariable model yielded similar results. End-of-life discussions continued to be associated with increased odds of having treatments limited or withheld at EOL (AOR, 2.05; 95% CI, 1.26-3.35), as did creation of a living will (AOR, 2.00; 95% CI, 1.17-3.42), while DPOA assignment was not associated with having treatments limited or withheld at EOL but was associated with decreased odds of experiencing a terminal hospitalization (AOR, 0.70; 95% CI, 0.49-0.98).

Discussion

Using nationally representative survey data from the HRS, we examined use of ACP among patients with cancer over time, as reported by proxy informants. We found that DPOA assignment was the only ACP domain that increased significantly between 2000 and 2012, despite increasing recognition of the merits of early ACP by patients, physicians, and health care payers over this period.^{29,30} Conversely, use of living wills and participation in EOL care discussions did not increase significantly; in 2012, 40% of study participants still had not discussed their EOL care preferences prior to death.

Importantly, DPOA assignment was the only form of ACP not associated with decisions to limit or provide all care possible at EOL, as reported by the proxy. Decedents who were most likely to receive aggressive EOL care were those who did not have a living will and had not discussed their EOL treatment preferences prior to death; among this group, the assignment of a DPOA did not further reduce the likelihood of receiving aggressive EOL care. Taken together, these findings suggest that if patients' EOL treatment preferences have not been explicitly communicated, either through writing or conversation, health care proxies may default to providing all care possible instead of limiting potentially intensive, life-prolonging care.

Multiple indicators of EOL treatment intensity suggest that cancer care in the United States continues to be intensive, with evidence of increasing rates of hospitalizations, intensive care unit stays, and emergency department visits in the last month of life, along with persistently high rates of terminal hospitalizations, late hospice referrals, and burdensome transitions near death.^{9-13,15,19} In this cohort, between 25% and 30% of terminally ill patients with cancer died in the hospital, consistent with what others have found.^{12,19} In addition, patients were more likely, not less, to receive all potentially life-prolonging care at EOL over time. Whether these findings are concordant with patient preferences is unclear, but considerable research suggests that terminally ill patients often receive care that is more intensive than their stated treatment preferences.³¹⁻³³

Given the stagnant growth in both living will creation and participation in EOL discussions, despite evidence of their association with reduced EOL treatment intensity, new avenues must be pursued for bolstering their adoption. Pioneering health system initiatives provide precedent for how this

may be accomplished.³⁴ In La Crosse, Wisconsin, reported rates of written advance directives among decedents have exceeded 80%.³⁵ The widespread uptake in ACP has been achieved through general awareness campaigns that promote ACP and an electronic record system that prompts all patients reaching age 55 years to discuss their EOL care preferences with their primary care provider, among other initiatives.

Other health care systems have described similar success with electronic prompts encouraging patient engagement in ACP and modifications of the electronic record to ensure clear communication of patients' wishes.³⁴ Further gains in ACP may also be seen on a policy level through payment reform. Although initial Medicare proposals to reimburse clinician engagement in ACP were derailed by sensationalized rhetoric likening such discussions to "death panels," more recent proposals that include financial incentives for both clinician and patient engagement in EOL care discussions have gained bipartisan support.^{36,37} Whether a 1-time reimbursement will have significant impact on outcomes is unclear given the importance of ongoing discussions, but the reemergence of dialogue on the subject is encouraging.

Importantly, our findings also highlight the limitations of the DPOA when EOL care preferences have not been communicated to surrogate decision makers. Interviews with surrogates consistently illustrate that a familiarity with patient preferences eases decision making, reduces decisional regret, and improves caregivers' bereavement outcomes.^{18,38-40} As such, it is critical that health care agents and caregivers are integrated into each step of the ACP process, including ongoing clinician-patient discussions of prognosis, goals of care, and treatment preferences with respect to foreseeable potential interventions.^{1,41,42} Indeed, significant gains in surrogate understanding of patient preferences have been demonstrated with the use of structured interviews on ACP that involve the patient, surrogate, and a trained facilitator who does not have to be a physician.⁴³⁻⁴⁵ Wider adoption of these tools will be a key component of better EOL care.⁴⁵

Interestingly, although DPOA assignment was not associated with EOL care decisions, it was associated with lower rates of terminal hospitalizations than other ACP subtypes, as reported by the proxy. Terminal hospitalizations have been previously linked to worse patient quality of life, increased psychiatric morbidity in caregivers, and significant EOL spending, but unfortunately still occur with substantial frequency.^{12,17-19,24} While a better understanding of the drivers of terminal hospitalizations is needed, recent studies have implicated uncontrolled symptoms as a common source of late hospitalizations in patients with advanced cancer, a scenario that might be preventable with better access to outpatient palliative services.^{46,47} In fact, early introduction of outpatient palliative services has been associated with a number of improved EOL care measures, including fewer emergency department visits, hospital admissions, and intensive care unit admissions, perhaps through better symptom management and/or ACP, highlighting the urgency of filling the current void of outpatient palliative clinics.^{48,49} Ultimately, the mechanism for how ACP subtypes influence patients' location of death is likely complex and should be further explored.^{26,50}

Finally, our findings confirm well-documented racial and ethnic disparities in ACP and EOL treatment intensity among patients with cancer, a complex multifactorial issue rooted in varying patient preferences, family values, religious views, and understanding of prognosis.⁵¹⁻⁵⁴ Rapid expected growth of the minority elderly population in the coming years underscores the critical nature of interventions that can help ensure goal-concordant care in minority populations.^{55,56}

Although our study has many strengths, it also has a few limitations. Foremost, information on ACP and EOL treatment decisions was obtained from proxy informants. While retrospective ascertainment of data from proxies is common in palliative care research, it is subject to recall and social desirability biases. Studies that have measured the level of discord between prospectively collected patient-reported data at EOL and retrospectively collected proxy-reported estimates of the same items have shown that discord is greatest for subjective domains such as pain and depression, whereas proxy responses for objective items such as place of death have shown high accuracy.⁵⁷⁻⁵⁹ Notably, in the setting of cancer, the discordance between decedents and their proxy respondents has been modest.⁶⁰

Our study contained 2 subjective end points, namely the provision of all care possible and limiting or withholding treatment, which may have been influenced by the proxy's own positive or negative experience during the decedents' EOL period. While questions regarding the presence of advance directives were more objective in nature, the accuracy of proxy responses for these items is also unclear. As such, we undertook a number of measures to minimize bias related to proxy reporting. Both the proxy's relationship to the decedent and the time from the decedent's death to the exit interview were included in the multivariable model; neither variable was independently associated with any of the end points. Furthermore, a sensitivity analysis indicated that

the study findings were not affected by whether the proxy was the primary decision maker. Moreover, if social desirability did influence proxy report of EOL treatment intensity, there is no reason to suspect that this bias followed the trends that we observed. If anything, one would expect social desirability to increasingly influence proxies to report reduced EOL treatment intensity with better recognition of the harms of intense EOL care. In addition, the proxy's recollection of the decedent's engagement in ACP provides intrinsic value because ACP that occurred without the proxy's knowledge was likely ineffective, given that the proxy was usually the primary decision-maker. Further limitations include an inability to generalize our results to populations of patients with cancer who were not well-represented in our cohort, for example younger patients, and the lack of complete documentation of decedents' EOL care preferences, a key component of assessing goal-concordant care and an important area of future research.

Conclusions

In conclusion, over the study period from 2000 to 2012, growth in ACP among patients with cancer was modest and predominantly focused on DPOA assignment without an accompanying increase in either EOL discussions or living wills. Without written or verbal direction, surrogate decision makers may struggle to make care decisions consistent with patient preferences. As such, policy and health system initiatives that support wider adoption of clinician-patient discussions of EOL care preferences are essential. In addition, these conversations must also include surrogate decision makers: efforts to educate surrogates on the goals, values, and care preferences of their loved ones have proven valuable across multiple chronic diseases^{43,44} and should be further explored in patients with advanced cancer.

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Study concept and design: Narang, Nicholas.
Acquisition, analysis, or interpretation of data: Narang, Wright, Nicholas.
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§ 90-21.13. Informed consent to health care treatment or procedure.

(a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or other person authorized to give consent for the patient where:

- (1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and
- (2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; or
- (3) A reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this subsection.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact. A consent that meets the foregoing standards, that is given by a patient, or other authorized person, who under all the surrounding circumstances has capacity to make and communicate health care decisions, is a valid consent.

(c) The following persons, in the order indicated, are authorized to consent to medical treatment on behalf of a patient who is comatose or otherwise lacks capacity to make or communicate health care decisions:

- (1) A guardian of the patient's person, or a general guardian with powers over the patient's person, appointed by a court of competent jurisdiction pursuant to Article 5 of Chapter 35A of the General Statutes; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority to the extent granted in the health care power of attorney and to the extent provided in G.S. 32A-19(a) unless the Clerk has suspended the authority of that health care agent in accordance with G.S. 35A-1208(a);
- (2) A health care agent appointed pursuant to a valid health care power of attorney, to the extent of the authority granted;
- (3) An attorney-in-fact, with powers to make health care decisions for the patient, appointed by the patient pursuant to Article 1 or Article 2 of Chapter 32A of the General Statutes, to the extent of the authority granted;
- (4) The patient's spouse;
- (5) A majority of the patient's reasonably available parents and children who are at least 18 years of age;
- (6) A majority of the patient's reasonably available siblings who are at least 18 years of age; or

- | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>(7) An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.</p> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(c1) If none of the persons listed under subsection (c) of this section is reasonably available, then the patient's attending physician, in the attending physician's discretion, may provide health care treatment without the consent of the patient or other person authorized to consent for the patient if there is confirmation by a physician other than the patient's attending physician of the patient's condition and the necessity for treatment; provided, however, that confirmation of the patient's condition and the necessity for treatment are not required if the delay in obtaining the confirmation would endanger the life or seriously worsen the condition of the patient.

(d) No action may be maintained against any health care provider upon any guarantee, warranty or assurance as to the result of any medical, surgical or diagnostic procedure or treatment unless the guarantee, warranty or assurance, or some note or memorandum thereof, shall be in writing and signed by the provider or by some other person authorized to act for or on behalf of such provider.

(e) In the event of any conflict between the provisions of this section and those of G.S. 35A-1245, 90-21.17, and 90-322, Articles 1A and 19 of Chapter 90, and Article 3 of Chapter 122C of the General Statutes, the provisions of those sections and Articles shall control and continue in full force and effect. (1975, 2nd Sess., c. 977, s. 4; 2003-13, s. 5; 2007-502, s. 13; 2008-187, s. 37(b).)

**Chapter 32A.
Powers of Attorney.**

Article 1.

Statutory Short Form Power of Attorney.

§ 32A-1. Statutory Short Form of General Power of Attorney.

The use of the following form in the creation of a power of attorney is lawful, and, when used, it shall be construed in accordance with the provisions of this Chapter.

"NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN CHAPTER 32A OF THE NORTH CAROLINA GENERAL STATUTES WHICH EXPRESSLY PERMITS THE USE OF ANY OTHER OR DIFFERENT FORM OF POWER OF ATTORNEY DESIRED BY THE PARTIES CONCERNED.

State of _____.

County of _____.

I _____, appoint _____ to be my attorney-in-fact, to act in my name in any way which I could act for myself, with respect to the following matters as each of them is defined in Chapter 32A of the North Carolina General Statutes. (DIRECTIONS: Initial the line opposite any one or more of the subdivisions as to which the principal desires to give the attorney-in-fact authority.)

- (1) Real property transactions..... _____
- (2) Personal property transactions _____
- (3) Bond, share, stock, securities and commodity transactions _____
- (4) Banking transactions _____
- (5) Safe deposits _____
- (6) Business operating transactions _____
- (7) Insurance transactions _____
- (8) Estate transactions..... _____
- (9) Personal relationships and affairs..... _____
- (10) Social security and unemployment _____
- (11) Benefits from military service..... _____
- (12) Tax matters..... _____
- (13) Employment of agents..... _____
- (14) Gifts to charities, and to individuals other than the attorney-in-fact..... _____
- (15) Gifts to the named attorney-in-fact _____
- (16) Renunciation of an interest in or power over property to benefit persons other than the attorney-in-fact..... _____
- (17) Renunciation of an interest in or power over property to benefit persons including the attorney-in-fact _____

(If power of substitution and revocation is to be given, add: 'I also give to such person full power to appoint another to act as my attorney-in-fact and full power to revoke such appointment.')

(If period of power of attorney is to be limited, add: "This power terminates ____, __")

(If power of attorney is to be a durable power of attorney under the provision of Article 2 of Chapter 32A and is to continue in effect after the incapacity or mental incompetence of the principal, add: 'This power of attorney shall not be affected by my subsequent incapacity or mental incompetence.')

(If power of attorney is to take effect only after the incapacity or mental incompetence of the principal, add: 'This power of attorney shall become effective after I become incapacitated or mentally incompetent.')

(If power of attorney is to be effective to terminate or direct the administration of a custodial trust created under the Uniform Custodial Trust Act, add: 'In the event of my subsequent incapacity or mental incompetence, the attorney-in-fact of this power of attorney shall have the power to terminate or to direct the administration of any custodial trust of which I am the beneficiary.')

(If power of attorney is to be effective to determine whether a beneficiary under the Uniform Custodial Trust Act is incapacitated or ceases to be incapacitated, add: 'The attorney-in-fact of this power of attorney shall have the power to determine whether I am incapacitated or whether my incapacity has ceased for the purposes of any custodial trust of which I am the beneficiary.')

Dated _____, _____ .

_____ (Seal)

Signature

STATE OF _____ COUNTY OF _____

On this _____ day of _____, _____, personally appeared before me, the said named _____ to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledged that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My Commission Expires _____.

(Signature of Notary Public)
Notary Public (Official Seal)"

(1983, c. 626, s. 1; 1985, c. 162, s. 1; c. 618, s. 1; 1995, c. 331, s. 1; c. 486, s. 2; 2009-48, s. 11.)

§ 32A-2. Powers conferred by the Statutory Short Form Power of Attorney set out in G.S. 32A-1.

The Statutory Short Form Power of Attorney set out in G.S. 32A-1 confers the following powers on the attorney-in-fact named therein:

- (1) Real Property Transactions. – To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as said attorney-in-fact shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that the principal owns at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as said attorney-in-fact shall deem proper.
- (2) Personal Property Transactions. – To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as said attorney-in-fact shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens and mortgages, and hypothecate, and in any way or manner deal with all or any part of any personal property whatsoever, tangible or intangible, or any interest therein, that the principal owns at the time of execution or may thereafter acquire, under such terms and

- conditions, and under such covenants, as said attorney-in-fact shall deem proper.
- (3) Bond, Share, Stock, Securities and Commodity Transactions. – To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument of similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, the principal at the time of execution or in which the principal may thereafter acquire interest, to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in the name of the principal for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for the principal, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.
 - (4) Banking Transaction. – To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for the principal.
 - (5) Safe Deposits. – To have free access at any time or times to any safe deposit box or vault to which the principal might have access as lessee or owner.
 - (6) Business Operating Transactions. – To conduct, engage in, and transact any and all lawful business of whatever nature or kind for the principal.
 - (7) Insurance Transactions. – To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance or any combination of such insurance procured by or on behalf of the principal prior to execution; and to procure new, different or additional contracts of insurance for the principal and to designate the beneficiary of any such contract of insurance, provided, however, that the agent himself cannot be such beneficiary unless the agent is spouse, child, grandchild, parent, brother or sister of the principal.
 - (8) Estate Transactions. – To request, ask, demand, sue for, recover, collect, receive, and hold and possess all devises, as are, owned by, or due, owing, payable, or belonging to, the principal at the time of execution or in which the principal may thereafter acquire interest, to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in the name of the principal for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for the principal, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.
 - (9) Personal Relationships and Affairs. – To do all acts necessary for maintaining the customary standard of living of the principal, the spouse and children, and other dependents of the principal; to provide medical, dental and surgical care, hospitalization and custodial care for the principal, the spouse, and children, and other dependents of the principal; to continue whatever provision has been made by the principal, for the principal, the spouse, and children, and other dependents of the principal, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by the principal, for the convenience of the principal, the spouse, and children, and other dependents of the principal, to

open such new accounts as the attorney-in-fact shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by the principal or the attorney-in-fact to make such charges; to continue the discharge of any services or duties assumed by the principal, to any parent, relative or friend of the principal; to continue payments incidental to the membership or affiliation of the principal in any church, club, society, order or other organization, or to continue contributions thereto.

In the event the attorney-in-fact named pursuant to G.S. 32A-1 makes a decision regarding the health care of the principal that is contradictory to a decision made by a health care agent appointed pursuant to Article 3 of this Chapter, the decision of the health care agent shall overrule the decision of the attorney-in-fact.

- (10) Social Security and Unemployment. – To prepare, execute and file all social security, unemployment insurance and information returns required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government.
- (11) Benefits from Military Service. – To execute vouchers in the name of the principal for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to the principal, arising from or based upon military service and to receive, to endorse and to collect the proceeds of any check payable to the order of the principal drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property of the principal from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private, to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute the claim of the principal to any benefit or assistance, financial or otherwise, to which the principal is, or claims to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.
- (12) Tax matters. – To prepare, execute, verify and file in the name of the principal and on behalf of the principal any and all types of tax returns, amended returns, declaration of estimated tax, report, protest, application for correction of assessed valuation of real or other property, appeal, brief, claim for refund, or petition, including petition to the Tax Court of the United States, in connection with any tax imposed or proposed to be imposed by any government, or claimed, levied or assessed by any government, and to pay any such tax and to obtain any extension of time for any of the foregoing; to execute waivers or consents agreeing to a later determination and assessment of taxes than is provided by any statute of limitations; to execute waivers of restriction on the assessment and collection of deficiency in any tax; to execute closing agreements and all other documents, instruments and papers relating to any tax liability of any sort; to institute and carry on through counsel any proceeding in connection with determining or contesting any such tax or to recover any tax paid or to resist any claim

- for additional tax on any proposed assessment or levy thereof; and to enter into any agreements or stipulations for compromise or other adjustments or disposition of any tax.
- (13) Employment of Agents. – To employ agents such as legal counsel, accountants or other professional representation as may be appropriate and to grant such agents such powers of attorney or other appropriate authorization as may be required in connection with such representation or by the Internal Revenue Service or other governmental authority.
- (14) Gifts to Charities, and to Individuals Other Than the Attorney-In-Fact. –
- a. Except as provided in G.S. 32A-2(14)b., to make gifts of any of the principal's property to any individual other than the attorney-in-fact or to any organization described in sections 170(c) and 2522(a) of the Internal Revenue Code or corresponding future provisions of federal tax law, or both, in accordance with the principal's personal history of making or joining in the making of lifetime gifts. As used in this subdivision "Internal Revenue Code" means the "Code" as defined in G.S. 105-228.90.
 - b. Except as provided in G.S. 32A-2(14)c., or unless gifts are expressly authorized by the power of attorney under G.S. 32A-2(15), a power described in G.S. 32A-2(14)a. may not be exercised by the attorney-in-fact in favor of the attorney-in-fact or the estate, creditors, or creditors of the estate of the attorney-in-fact.
 - c. If the power described in G.S. 32A-2(14)a. is conferred upon two or more attorneys-in-fact, it may be exercised by the attorney-in-fact or attorneys-in-fact who are not disqualified by G.S. 32A-2(14)b. from exercising the power of appointment as if they were the only attorney-in-fact or attorneys-in-fact.
 - d. An attorney-in-fact expressly authorized by this section to make gifts of the principal's property may elect to request the clerk of the superior court to issue an order to make a gift of the property of the principal.
- (15) Gifts to the Named Attorney-In-Fact. – To make gifts to the attorney-in-fact named in the power of attorney or the estate, creditors, or creditors of the estate of the attorney-in-fact, in accordance with the principal's personal history of making or joining in the making of lifetime gifts.
- (16) Renunciation of an interest in or power over property to benefit persons other than the attorney-in-fact. – To renounce, in accordance with Chapter 31B of the General Statutes, an interest in or power over property, including a power of appointment, to benefit persons other than the attorney-in-fact or the estate, creditors, or the creditors of the estate of the attorney-in-fact, or an individual to whom the attorney-in-fact owes a legal obligation of support.
- (17) Renunciation of an interest in or power over property to benefit persons including the attorney-in-fact. – To renounce, in accordance with Chapter 31B of the General Statutes, an interest in or power over property, including a power of appointment, to benefit persons including the attorney-in-fact, or the estate, creditors, or the creditors of the estate of the attorney-in-fact, or an individual to whom the attorney-in-fact owes a legal obligation of support. (1983, c. 626, s. 1; 1985, c. 618, s. 2; 1987, c. 77, s. 1; 1991, c. 639, s. 2; 1995, c. 331, ss. 2-4; 1999-385, ss. 1, 2; 2001-413, s. 5.1; 2009-48, s. 12; 2011-284, s. 36.)

§ 32A-3. Provisions not exclusive; reference to Chapter 32B; limitations on authority.

(a) The provisions of this Article are not exclusive and shall not bar the use of any other or different form of power of attorney desired by the parties concerned.

(b) A power of attorney under the provisions of this Article may refer to Chapter 32B as the same is set out in Chapter 626 of the 1983 Session Laws.

(c) Notwithstanding any other provision of this Chapter, no attorney-in-fact may exercise powers described in G.S. 36C-6-602.1(a) to alter the designation of beneficiaries to receive property on the settlor's death under the settlor's existing estate plan. This subsection shall not impair the authority of an attorney-in-fact to make gifts of the principal's property, as provided in Articles 2A and 2B of this Chapter. (1983, c. 626, s. 1; 1985, c. 609, s. 4; 2007-106, s. 1.1.)

§§ 32A-4 through 32A-7. Reserved for future codification purposes.

Article 2.

Durable Power of Attorney.

§ 32A-8. Definition.

A durable power of attorney is a power of attorney by which a principal designates another his attorney-in-fact in writing and the writing contains a statement that it is executed pursuant to the provisions of this Article or the words "This power of attorney shall not be affected by my subsequent incapacity or mental incompetence," or "This power of attorney shall become effective after I become incapacitated or mentally incompetent," or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent incapacity or mental incompetence. Unless the durable power of attorney provides otherwise, where the grant of power or authority conferred by a durable power of attorney is effective only upon the principal's subsequent incapacity or mental incompetence, any person to whom such writing is presented, in the absence of actual knowledge to the contrary, shall be entitled to rely on an affidavit, executed by the attorney-in-fact and setting forth that such condition exists, as conclusive proof of such incapacity or mental incompetence, subject to the provisions of G.S. 32A-13. (1983, c. 626, s. 1; 1991, c. 173, s. 1.)

§ 32A-9. Registered durable power of attorney not affected by incapacity or mental incompetence.

(a) All acts done by an attorney-in-fact pursuant to a durable power of attorney during any period of incapacity or mental incompetence of the principal have the same effect and inure to the benefit of and bind the principal and his successors in interest as if the principal were not incapacitated or mentally incompetent if the power of attorney has been registered under the provisions of subsection (b).

(b) No power of attorney executed pursuant to the provisions of this Article shall be valid subsequent to the principal's incapacity or mental incompetence unless it is registered in the office of the register of deeds of that county in this State designated in the power of attorney, or if no place of registration is designated, in the office of the register of deeds of the county in which the principal has his legal residence at the time of such registration or, if the principal has no legal residence in this State at the time of registration or the attorney-in-fact is uncertain as to the principal's residence in this State, in some county in the State in which the principal owns property or the county in which one or more of the attorneys-in-fact reside. A power of attorney executed pursuant to the provision of this Article shall be valid even though the time of such registration is subsequent to the incapacity or mental incompetence of the principal.

(c) Any person dealing in good faith with an attorney-in-fact acting under a power of attorney executed under this Article shall be protected to the full extent of the powers conferred upon such attorney-in-fact, and no person so dealing with such attorney-in-fact shall be responsible for the misapplication of any money or other property paid or transferred to such attorney-in-fact. (1983, c. 626, s. 1; 1987, c. 77, s. 2.)

§ 32A-10. Relation of attorney-in-fact to court-appointed fiduciary.

(a) If, following execution of a durable power of attorney, a court of the principal's domicile appoints a conservator, guardian of the principal's person or estate, or other fiduciary charged with the management of all of the principal's property or all of his property except specified exclusions, the attorney-in-fact is accountable to the fiduciary as well as to the principal. The fiduciary has the same power to revoke or amend the power of attorney that the principal would have had if he were not incapacitated or mentally incompetent.

(b) A principal may nominate, by a durable power of attorney, the conservator, guardian of his estate, or guardian of his person for consideration by the court if protective proceedings for the principal's person or estate are thereafter commenced. The court shall make its appointment in accordance with the principal's most recent nomination in a durable power of attorney except for good cause or disqualification. (1983, c. 626, s. 1.)

§ 32A-11. File with clerk, records, inventories, accounts, fees, and commissions.

(a) Within 30 days after registration of the power of attorney as provided in G.S. 32A-9(b), the attorney-in-fact shall file with the clerk of superior court in the county of such registration a copy of the power of attorney. Every attorney-in-fact acting under a power of attorney under this Article subsequent to the principal's incapacity or mental incompetence shall keep full and accurate records of all transactions in which he acts as agent of the principal and of all property of the principal in his hands and the disposition thereof.

(b) Any provision in the power of attorney waiving or requiring the rendering of inventories and accounts shall govern, and a power of attorney that waives the requirement to file inventories and accounts need not be filed with the clerk of superior court. Otherwise, subsequent to the principal's incapacity or mental incompetence, the attorney-in-fact shall file in the office of the clerk of the superior court of the county in which the power of attorney is filed, inventories of the property of the principal in his hands and annual and final accounts of the receipt and disposition of property of the principal and of other transactions in behalf of the principal. The power of the clerk to enforce the filing and his duties in respect to audit and recording of such accounts shall be the same as those in respect to the accounts of administrators, but the fees and charges of the clerk shall be computed or fixed only with relation to property of the principal required to be shown in the accounts and inventories. The fees and charges of the clerk shall be paid by the attorney-in-fact out of the principal's money or other property and allowed in his accounts. If the powers of an attorney-in-fact shall terminate for any reason whatever, he, or his executors or administrators, shall have the right to have a judicial settlement of a final account by any procedure available to executors, administrators or guardians.

(c) In the event that any power of attorney executed pursuant to the provisions of this Article does not contain the amount of compensation that the attorney-in-fact is entitled to receive or the way such compensation is to be determined, and the principal should thereafter become incapacitated or mentally incompetent, then, subsequent to the principal's incapacity or mental incompetence, the attorney-in-fact shall be entitled to receive reasonable compensation as determined by the clerk of superior court after considering the factors set forth in G.S. 32-54(b). (1983, c. 626, s. 1; 2004-139, s. 3.)

§ 32A-12. Appointment, resignation, removal, and substitutions.

(a) A power of attorney executed under this Article may contain any provisions, not unlawful, relating to the appointment, resignation, removal and substitution of an attorney-in-fact, and to the rights, powers, duties and responsibilities of the attorney-in-fact.

(b) If all attorneys-in-fact named in the instrument or substituted shall die, or cease to exist, or shall become incapable of acting, and all methods for substitution provided in the instrument have been exhausted, such power of attorney shall cease to be effective. Any substitution by a person authorized to make it shall be in writing signed and acknowledged by such person. Notice of every other substitution shall be in writing and acknowledged by the person substituted. No substitution or notice subsequent to the principal's subsequent incapacity or mental incompetence shall be effective until it has been recorded in the office of the register of deeds of the county in which the power of attorney has been recorded. (1983, c. 626, s. 1.)

§ 32A-13. Revocation.

(a) Every power of attorney executed pursuant to the provisions of this Article and registered in an office of the register of deeds in this State as provided in G.S. 32A-9(b) shall be revoked by:

- (1) The death of the principal; or
- (2) Registration in the office of the register of deeds where the power of attorney has been registered of an instrument of revocation executed and acknowledged by the principal while he is not incapacitated or mentally incompetent, or by the registration in such office of an instrument of revocation executed by any person or corporation who is given such power of revocation in the power of attorney, or by this Article, with proof of service thereof in either case on the attorney-in-fact in the manner prescribed for service of summons in civil actions.

(b) Every power of attorney executed pursuant to the provisions of this Article which has not been registered in an office of the register of deeds in this State shall be revoked by:

- (1) The death of the principal;
- (2) Any method provided in the power of attorney;
- (3) Being burnt, torn, canceled, obliterated, or destroyed, with the intent and for the purpose of revoking it, by the principal himself or by another person in his presence and by his direction, while the principal is not incapacitated or mentally incompetent; or
- (4) A subsequent written revocatory document executed and acknowledged in the manner provided herein for the execution of durable powers of attorney by the principal while not incapacitated or mentally incompetent and delivered to the attorney-in-fact in person or to his last known address by certified or registered mail, return receipt requested.

(c) As to acts undertaken in good faith reliance upon an affidavit executed by the attorney-in-fact stating that he did not have, at the time of exercise of the power, actual knowledge of the termination of the power by revocation pursuant to the provisions of G.S. 32A-13(b) or by the principal's death, such affidavit is conclusive proof of the nonrevocation or nontermination of the power at that time. This section does not affect any provision in a power of attorney for its termination by the expiration of time or occurrence of an event other than an express revocation. (1983, c. 626, s. 1; 1991, c. 173, s. 2.)

§ 32A-14. Powers of attorney executed under the provisions of G.S. 47-115.1; reference to Chapter 32B; limitations on authority.

(a) A power of attorney executed prior to October 1, 1988, pursuant to G.S. 47-115.1 as it existed prior to October 1, 1983, shall be deemed to be a durable power of attorney as defined in G.S. 32A-8.

(b) A power of attorney under the provisions of this Article may refer to Chapter 32B as the same is set out in Chapter 626 of the 1983 Session Laws.

(c) Notwithstanding any other provision of this Chapter, no attorney-in-fact may exercise powers described in G.S. 36C-6-602.1(a) to alter the designation of beneficiaries to receive property on the settlor's death under the settlor's existing estate plan. This subsection shall not impair the authority of an attorney-in-fact to make gifts of the principal's property, as provided in Articles 2A and 2B of this Chapter. (1983, c. 626, s. 1; 1985, c. 609, s. 5; 1989 (Reg. Sess., 1990), c. 992, s. 1; 2007-106, s. 1.2; 2007-484, s. 39.)

Article 2A.

Authority of Attorney-In-Fact to Make Gifts and to Renounce.

§ 32A-14.1. Gifts under power of attorney.

(a) Except as provided in subsection (b) of this section, if any power of attorney authorizes an attorney-in-fact to do, execute, or perform any act that the principal might or could do or evidences the principal's intent to give the attorney-in-fact full power to handle the principal's affairs or deal with the principal's property, the attorney-in-fact shall have the power and authority to make gifts in any amount of any of the principal's property to any individual or to any organization described in sections 170(c) and 2522(a) of the Internal Revenue Code or corresponding future provisions of federal tax law, or both, in accordance with the principal's personal history of making or joining in the making of lifetime gifts. As used in this subsection, "Internal Revenue Code" means the "Code" as defined in G.S. 105-228.90.

(b) Except as provided in subsection (c) of this section, or unless gifts are expressly authorized by the power of attorney, a power described in subsection (a) of this section may not be exercised by the attorney-in-fact in favor of the attorney-in-fact or the estate, creditors, or the creditors of the estate of the attorney-in-fact.

(c) If the power of attorney described in subsection (a) of this section is conferred upon two or more attorneys-in-fact, it may be exercised by the attorney-in-fact or attorneys-in-fact who are not disqualified by subsection (b) of this section from exercising the power of appointment as if they were the only attorney-in-fact or attorneys-in-fact. If the power of attorney described in subsection (a) of this section is conferred upon one attorney-in-fact, the power of attorney may be exercised by the attorney-in-fact in favor of the attorney-in-fact or the estate, creditors, or the creditors of the estate of the attorney-in-fact pursuant to an order issued by the clerk in accordance with the procedures and provisions of Article 2B of this Chapter.

(d) Subsection (a) of this section shall not in any way impair the right, power, or ability of any principal, by express terms in the power of attorney, to authorize or limit the authority of any attorney-in-fact to make gifts of the principal's property.

(e) An attorney-in-fact expressly authorized by this section to make gifts of the principal's property may elect to request that the clerk of the superior court issue an order approving a gift or gifts of the property of the principal.

(f) This section shall apply to all powers of attorney executed prior to, on, or after October 1, 1995. (1995, c. 331, s. 5; 1999-456, s. 2; 2001-413, s. 5.2.)

§ 32A-14.2. Renunciation under power of attorney.

(a) If any power of attorney authorizes an attorney-in-fact to do, execute, or perform any act that the principal might or could do or evidences the principal's intent to give the attorney-in-fact full power to handle the principal's affairs or deal with the principal's property, but does not expressly authorize the attorney-in-fact to renounce an interest in or power over

property, the attorney-in-fact shall not have the power or authority to renounce on behalf of the principal pursuant to Chapter 31B of the General Statutes.

(b) Notwithstanding an express grant of general authority to renounce, an attorney-in-fact that is not an ancestor, spouse, or descendant of the principal may not renounce under a power of attorney to create in the attorney-in-fact or the estate, creditors, or the creditors of the estate of the attorney-in-fact, or in an individual to whom the attorney-in-fact owes a legal obligation of support, an interest in or power over the principal's property by reason of a renunciation unless the power of attorney expressly authorizes a renunciation that benefits the attorney-in-fact or the estate, creditors, or the creditors of the estate of the attorney-in-fact, or an individual to whom the attorney-in-fact owes a legal obligation of support. (2009-48, s. 14.)

§ 32A-14.3. Reserved for future codification purposes.

§ 32A-14.4. Reserved for future codification purposes.

§ 32A-14.5. Reserved for future codification purposes.

§ 32A-14.6. Reserved for future codification purposes.

§ 32A-14.7. Reserved for future codification purposes.

§ 32A-14.8. Reserved for future codification purposes.

§ 32A-14.9. Reserved for future codification purposes.

Article 2B.

Gifts Authorized by Court Order.

§ 32A-14.10. Gifts authorized by court order.

An attorney-in-fact, acting under a power of attorney that does not contain the grant of power set out in G.S. 32A-14.1 and does not expressly authorize gifts of the principal's property, may initiate a special proceeding before the clerk of superior court in accordance with the procedures of Article 33 of Chapter 1 of the General Statutes for authority to make gifts of the principal's property to the extent not inconsistent with the express terms of the power of attorney. The principal and any guardian ad litem appointed for the principal are the defendants in a proceeding pursuant to this Article. The clerk may issue an order setting forth the amounts, frequency, recipients, and proportions of any gifts of the principal's property after considering all relevant factors, including, but not limited to: (i) the size of the principal's estate; (ii) the principal's foreseeable obligations; (iii) the principal's foreseeable maintenance needs; (iv) the principal's personal history of making or joining in the making of lifetime gifts; (v) the principal's estate plan; and (vi) the tax effects of the gifts. If there is no appeal from the decision and order of the clerk within the time prescribed by law, the clerk's order shall be submitted to the judge of the superior court and approved by the court before the order becomes effective. (1995, c. 331, s. 5.)

§ 32A-14.11. Appeal; stay effected by appeal.

Any party in interest may appeal from the decision of the clerk to the judge of the superior court. The procedure for appeal is governed by Article 27A of Chapter 1 of the General Statutes. An appeal taken from the decision of the clerk stays the decision and order of the clerk until the cause is heard and determined by the judge upon the appeal taken. (1995, c. 331, s. 5; 1999-216, s. 7.)

§ 32A-14.12. Costs and fees.

All costs and fees arising in connection with a proceeding under this Article shall be assessed the same as costs and fees are assessed in special proceedings governed by Article 33 of Chapter 1 of the General Statutes. (1995, c. 331, s. 5.)

Article 3.

Health Care Powers of Attorney.

§ 32A-15. General purpose of this Article.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of an individual to control the decisions relating to his or her medical care, and that this right may be exercised on behalf of the individual by an agent chosen by the individual.

(b) The purpose of this Article is to establish an additional, nonexclusive method for an individual to exercise his or her right to give, withhold, or withdraw consent to medical treatment, including mental health treatment, when the individual lacks sufficient understanding or capacity to make or communicate health care decisions.

(c) This Article is intended and shall be construed to be consistent with the provisions of Article 23 of Chapter 90 of the General Statutes provided that in the event of a conflict between the provisions of this Article and Article 23 of Chapter 90, the provisions of Article 23 of Chapter 90 control. No conflict between these Chapters exists when either a health care power of attorney or a declaration provides that the declaration is subject to decisions of a health care agent. If no declaration has been executed by the principal as provided in G.S. 90-321 that expressly covers the principal's present condition and if the health care agent has been given the specific authority in a health care power of attorney to authorize the withholding or discontinuing of life-prolonging measures when the principal is in such condition, the measures may be withheld or discontinued as provided in the health care power of attorney upon the direction and under the supervision of the attending physician, as G.S. 90-322 shall not apply in such case. Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(d) This Article is intended and shall be construed to be consistent with the provisions of Part 3A of Article 16 of Chapter 130A of the General Statutes. In the event of a conflict between the provisions of this Article and Part 3A of Article 16 of Chapter 130A, the provisions of Part 3A of Article 16 of Chapter 130A control. (1991, c. 639, s. 1; 1993, c. 523, s. 1; 1998-198, s. 1; 1998-217, s. 53; 2007-502, s. 1; 2008-153, s. 4.)

§ 32A-16. Definitions.

The following definitions apply in this Article:

- (1) Disposition of remains. – The decision to bury or cremate human remains, as human remains are defined in G.S. 90-210.121, and, subject to G.S. 32A-19(b), arrangements relating to burial or cremation.
- (1a) Health care. – Any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for the principal's physical or mental health or personal care and comfort including life-prolonging measures. "Health care" includes mental health treatment as defined in subdivision (8) of this section.
- (2) Health care agent. – The person appointed as a health care attorney-in-fact.
- (3) Health care power of attorney. – A written instrument that substantially meets the requirements of this Article, that is signed in the presence of two qualified witnesses, and acknowledged before a notary public, pursuant to which an attorney-in-fact or agent is appointed to act for the principal in matters relating to the health care of the principal. The notary who takes the acknowledgement may but is not required to be a paid employee of the

- attending physician or mental health treatment provider, a paid employee of a health facility in which the principal is a patient, or a paid employee of a nursing home or any adult care home in which the principal resides.
- (4) Life-prolonging measures. – Medical procedures or interventions which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function, including mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and similar forms of treatment. Life-prolonging measures do not include care necessary to provide comfort or to alleviate pain.
 - (5) Principal. – The person making the health care power of attorney.
 - (6) Qualified witness. – A witness in whose presence the principal has executed the health care power of attorney, who believes the principal to be of sound mind, and who states that he or she (i) is not related within the third degree to the principal nor to the principal's spouse, (ii) does not know nor have a reasonable expectation that he or she would be entitled to any portion of the estate of the principal upon the principal's death under any existing will or codicil of the principal or under the Intestate Succession Act as it then provides, (iii) is not the attending physician or mental health treatment provider of the principal, nor a licensed health care provider who is a paid employee of the attending physician or mental health treatment provider, nor a paid employee of a health facility in which the principal is a patient, nor a paid employee of a nursing home or any adult care home in which the principal resides, and (iv) does not have a claim against any portion of the estate of the principal at the time of the principal's execution of the health care power of attorney.
 - (7) Advance instruction for mental health treatment or advance instruction. – As defined in G.S. 122C-72(1).
 - (8) Mental health treatment. – The process of providing for the physical, emotional, psychological, and social needs of the principal for the principal's mental illness. "Mental health treatment" includes electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness. (1991, c. 639, s. 1; 1998-198, s. 1; 1998-217, s. 53; 2005-351, s. 1; 2006-226, s. 32; 2007-502, s. 2.)

§ 32A-17. Who may make a health care power of attorney.

Any person having understanding and capacity to make and communicate health care decisions, who is 18 years of age or older, may make a health care power of attorney. (1991, c. 639, s. 1.)

§ 32A-18. Who may act as a health care attorney-in-fact.

Any competent person who is not engaged in providing health care to the principal for remuneration, and who is 18 years of age or older, may act as a health care agent. (1991, c. 639, s. 1.)

§ 32A-19. Extent of authority; limitations of authority.

(a) A principal, pursuant to a health care power of attorney, may grant to the health care agent full power and authority to make health care decisions to the same extent that the principal could make those decisions for himself or herself if he or she had capacity to make and communicate health care decisions, including without limitation, the power to authorize

withholding or discontinuing life-prolonging measures and the power to authorize the giving or withholding of mental health treatment. A health care power of attorney may also contain or incorporate by reference any lawful guidelines or directions relating to the health care of the principal as the principal deems appropriate.

(a1) A health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment prepared pursuant to Part 2 of Article 3 of Chapter 122C of the General Statutes. A health care agent's decisions about mental health treatment shall be consistent with any statements the principal has expressed in an advance instruction for mental health treatment if one so exists, and if none exists, shall be consistent with what the agent believes in good faith to be the manner in which the principal would act if the principal did not lack capacity to make or communicate health care decisions. A health care agent is not subject to criminal prosecution, civil liability, or professional disciplinary action for any action taken in good faith pursuant to an advance instruction for mental health treatment.

(b) A health care power of attorney may authorize the health care agent to exercise any and all rights the principal may have with respect to anatomical gifts, the authorization of any autopsy, and the disposition of remains; provided this authority is limited to incurring reasonable costs related to exercising these powers, and a health care power of attorney does not give the health care agent general authority over a principal's property or financial affairs.

(c) A health care power of attorney may contain, and the authority of the health care agent shall be subject to, the specific limitations or restrictions as the principal deems appropriate.

(d) The powers and authority granted to the health care agent pursuant to a health care power of attorney shall be limited to the matters addressed in it, and, except as necessary to exercise such powers and authority relating to health care, shall not confer any power or authority with respect to the property or financial affairs of the principal.

(e) This Article shall not be construed to invalidate a power of attorney that authorizes an agent to make health care decisions for the principal, which was executed prior to October 1, 1991.

(f) A health care power of attorney does not limit any authority in Article 5 of Chapter 122C of the General Statutes either to take a person into custody or to admit, retain, or treat a person in a facility. (1991, c. 639, s. 1; 1998-198, s. 1; 1998-217, s. 53; 2007-502, s. 3.)

§ 32A-20. Effectiveness and duration; revocation.

(a) A health care power of attorney shall become effective when and if the physician or physicians or, in the case of mental health treatment, physician or eligible psychologist as defined in G.S. 122C-3(13d), designated by the principal determine in writing that the principal lacks sufficient understanding or capacity to make or communicate decisions relating to the health care of the principal, and shall continue in effect during the incapacity of the principal. The determination shall be made by the principal's attending physician or eligible psychologist if the physician or physicians or eligible psychologist designated by the principal is unavailable or is otherwise unable or unwilling to make this determination or if the principal failed to designate a physician or physicians or eligible psychologist to make this determination. A health care power of attorney may include a provision that, if the principal does not designate a physician for reasons based on his religious or moral beliefs as specified in the health care power of attorney, a person designated by the principal in the health care power of attorney may certify in writing, acknowledged before a notary public, that the principal lacks sufficient understanding or capacity to make or communicate decisions relating to his health care. The person so designated must be a competent person 18 years of age or older, not engaged in providing health care to the principal for remuneration, and must be a person other than the health care agent. For purposes of exercising authority described in G.S. 32A-19(b), however, a health care power of attorney shall be effective following the death of the principal without

regard to the principal's understanding or capacity when the principal was living. Nothing in this section shall be construed to prevent a principal from revoking a health care power of attorney.

(b) Except for purposes of exercising authority granted by a health care power of attorney with respect to anatomical gifts, autopsy, or disposition of remains as provided in G.S. 32A-19(b), a health care power of attorney is revoked by the death of the principal. A health care power of attorney may be revoked by the principal at any time, so long as the principal is capable of making and communicating health care decisions. The principal may exercise this right of revocation by executing and acknowledging an instrument of revocation, by executing and acknowledging a subsequent health care power of attorney, or in any other manner by which the principal is able to communicate an intent to revoke. This revocation becomes effective only upon communication by the principal to each health care agent named in the revoked health care power of attorney and to the principal's attending physician or eligible psychologist.

(c) The authority of a health care agent who is the spouse of the principal shall be revoked upon the entry by a court of a decree of divorce or separation between the principal and the health care agent; provided that if the health care power of attorney designates a successor health care agent, the successor shall serve as the health care agent, and the health care power of attorney shall not be revoked. (1991, c. 639, s. 1; 1993, c. 523, s. 2; 1998-198, s. 1; 1998-217, s. 53; 2005-351, s. 2; 2006-226, s. 32; 2011-344, s. 10; 2012-18, s. 3.11.)

§ 32A-21. Appointment, resignation, removal, and substitution.

(a) A health care power of attorney may contain provisions relating to the appointment, resignation, removal and substitution of the health care agent.

(b) If all health care agents named in the instrument or substituted, die or for any reason fail or refuse to act, and all methods of substitution have been exhausted, the health care power of attorney shall cease to be effective. (1991, c. 639, s. 1.)

§ 32A-22. Relation of the health care agent to a court-appointed fiduciary and to a general attorney-in-fact.

(a) If, following the execution of a health care power of attorney, a court of competent jurisdiction appoints a guardian of the person of the principal, or a general guardian with powers over the person of the principal, the guardian may petition the court, after giving notice to the health care agent, to suspend the authority of the health care agent during the guardianship. The court may suspend the authority of the health care agent for good cause shown, provided that the court's order must direct whether the guardian shall act consistently with the health care power of attorney or whether and in what respect the guardian may deviate from it. Any order suspending the authority of the health care agent must set forth the court's findings of fact and conclusions of law. The guardian shall act consistently with G.S. 35A-1201(a)(5). A health care provider shall be fully protected from liability in relying on a health care power of attorney until given actual notice of the court's order suspending the authority of the health care agent.

(b) A principal may nominate, by a health care power of attorney, the guardian of the person of the principal if a guardianship proceeding is thereafter commenced. The court shall make its appointment in accordance with the principal's most recent nomination in an unrevoked health care power of attorney, except for good cause shown.

(c) The execution of a health care power of attorney shall not revoke, restrict or otherwise affect any nonhealth care powers granted by the principal to an attorney-in-fact pursuant to a general power of attorney; provided that the powers granted to the health care agent with respect to health care matters shall be superior to any similar powers granted by the principal to an attorney-in-fact under a general power of attorney.

(d) A health care power of attorney may be combined with or incorporated into a general power of attorney which is executed in accordance with the requirements of this Article. (1991, c. 639, s. 1; 1998-198, s. 1; 1998-217, s. 53; 2007-502, s. 4.)

§ 32A-23. Article 2, Chapter 32A, not applicable.

The provisions of Article 2 of this Chapter shall not be applicable to a health care power of attorney executed pursuant to this Article. (1991, c. 639, s. 1.)

§ 32A-24. Reliance on health care power of attorney; defense.

(a) Any physician or other health care provider involved in the medical care of the principal may rely upon the authority of the health care agent contained in a signed and acknowledged health care power of attorney in the absence of actual knowledge of revocation of the health care power of attorney. The physician or health care provider may rely upon a copy of the health care power of attorney obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes to the same extent that the individual may rely upon the original document.

(b) All health care decisions made by a health care agent pursuant to a health care power of attorney during any period following a determination that the principal lacks understanding or capacity to make or communicate health care decisions shall have the same effect as if the principal were not incapacitated and were present and acting on his or her own behalf. Any health care provider relying in good faith on the authority of a health care agent shall be protected to the full extent of the power conferred upon the health care agent, and no person so relying on the authority of the health care agent shall be liable, by reason of his reliance, for actions taken pursuant to a decision of the health care agent.

(c) The withholding or withdrawal of life-prolonging measures by or under the orders of a physician pursuant to the authorization of a health care agent shall not be considered suicide or the cause of death for any civil or criminal purpose nor shall it be considered unprofessional conduct or a lack of professional competence. Any person, institution or facility, including without limitation the health care agent and the attending physician, against whom criminal or civil liability is asserted because of conduct described in this section, may interpose this section as a defense.

(d) The protections of this section extend to any valid health care power of attorney, including a document valid under G.S. 32A-27; these protections are not limited to health care powers of attorney prepared in accordance with the statutory form provided in G.S. 32A-25.1, or to health care powers of attorney filed with the Advance Health Care Directive Registry maintained by the Secretary of State. A health care provider may rely in good faith on an oral or written statement by legal counsel that a document appears to meet applicable statutory requirements for a health care power of attorney. These protections also extend to a document executed in another jurisdiction that is valid as a health care power of attorney under G.S. 32A-27. A health care provider shall have no liability for acting in accordance with a revoked health care power of attorney unless that provider has actual notice of the revocation. (1991, c. 639, s. 1; 2001-455, s. 3; 2001-513, s. 30(b); 2007-502, ss. 5(a), (b).)

§ 32A-25: Repealed by Session Laws 2007-502, s. 6(a), effective October 1, 2007.

§ 32A-25.1. Statutory form health care power of attorney.

(a) The use of the following form in the creation of a health care power of attorney is lawful and, when used, it shall meet the requirements of and be construed in accordance with the provisions of this Article:

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

***EXPLANATION:** You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

*This document gives the person you designate as your health care agent **broad powers** to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

*If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahcdr/>*

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____
Home Address: _____

Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____

B. Name: _____
Home Address: _____

Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____

C. Name: _____	Home Telephone: _____
Home Address: _____	Work Telephone: _____
_____	Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ (Physician)
2. _____ (Physician)

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

- A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. Employing or discharging my health care providers.
- C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

- D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.
- E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."
- F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.
- G. Authorizing the withholding or withdrawal of life-prolonging measures.
- H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.
- I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.
- J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your

health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

- A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent:

(Initial)

shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

(Initial)

shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.

(Initial)

- B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

NOTE: DO NOT initial unless you insert a limitation.

(Initial)

- C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

NOTE: DO NOT initial unless you insert a limitation.

(Initial)

D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):

NOTE: DO NOT initial unless you insert a limitation.

(Initial)

E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):

NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

(Initial)

donate any needed organs or parts; or

(Initial)

donate only the following organs or parts:

NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

(Initial)

donate my body for anatomical study if needed.

(Initial)

In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)

NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

- A. **Revocation of Prior Powers of Attorney.** I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.
- B. **Jurisdiction, Severability, and Durability.** This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.
- C. **Health Care Agent Not Liable.** My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds

arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

- D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.
- E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20_____.

_____ (SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of signer)

(type/print name of witness)

(type/print name of witness)

Date: _____
(Official Seal)

Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____

(b) Use of the statutory form prescribed in this section is an optional and nonexclusive method for creating a health care power of attorney and does not affect the use of other forms of health care powers of attorney, including previous statutory forms. (1991, c. 639, s. 1; 1993, c. 523, s. 3; 1998-198, s. 1; 1998-217, s. 53; 2005-351, s. 3; 2006-226, s. 32; 2007-502, s. 6(b); 2008-187, s. 37(a).)

§ 32A-26. Health care power of attorney and declaration of desire for natural death.

A health care power of attorney meeting the requirements of this Article may be combined with or incorporated into a Declaration of A Desire For A Natural Death which meets the requirements of Article 23 of Chapter 90 of the General Statutes. (1991, c. 639, s. 1.)

§ 32A-27. Health care powers of attorney executed in other jurisdictions.

Notwithstanding G.S. 32A-16(3), a health care power of attorney or similar document executed in a jurisdiction other than North Carolina shall be valid as a health care power of attorney in this State if it appears to have been executed in accordance with the applicable requirements of that jurisdiction or of this State. (2007-502, s. 7.)

Article 4.

Consent to Health Care for Minor.

§ 32A-28. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

§ 32A-29. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

- (1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.
- (2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.
- (3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.

- (4) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.
- (5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.
- (6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

§ 32A-30. Who may make an authorization to consent to health care for minor.

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

§ 32A-31. Extent and limitations of authority.

(a) A custodial parent of a minor child, pursuant to an authorization to consent to health care for minor, may grant an agent full power and authority to consent to and authorize health care for the minor child to the same extent that a custodial parent could give such consent and authorization.

(b) An authorization to consent to health care for minor may contain, and the authority of the agent designated shall be subject to, any specific limitations or restrictions as the custodial parent deems appropriate.

(c) A custodial parent may not, pursuant to an authorization to consent to health care for minor, authorize an agent to consent to the withholding or withdrawal of life sustaining procedures. (1993, c. 150, s. 1.)

§ 32A-32. Duration of authorization; revocation.

(a) An authorization to consent to health care for minor shall be automatically revoked as follows:

- (1) If the authorization to consent to health care for minor specifies a date after which it shall not be effective, then the authorization shall be automatically revoked upon such date.
- (2) An authorization to consent to health care for minor shall be revoked upon the minor child's attainment of the age of 18 years or upon the minor child's emancipation.
- (3) An authorization to consent to health care for minor executed by a custodial parent shall be revoked upon the termination of such custodial parent's rights to custody of the minor child.

(b) An authorization to consent to health care for minor may be revoked at any time by the custodial parent making such authorization. The custodial parent may exercise such right of revocation by executing and acknowledging an instrument of revocation, by executing and acknowledging a subsequent authorization to consent to health care for the minor, or in any other manner in which the custodial parent is able to communicate the parent's intent to revoke. Such revocation shall become effective only upon communication by the custodial parent to the agent named in the revoked authorization.

(c) In the event of a disagreement regarding the health care for a minor child between two or more agents authorized pursuant to this Article to consent to and authorize health care for a minor, or between any such agent and a parent of the minor, whether or not the parent is a custodial parent, then any authorization to consent to health care for minor designating any

person as an agent shall be revoked during the period of such disagreement, and the provisions of health care for the minor during such period shall be governed by the common law, the provisions of Article 1A of Chapter 90, and other provisions of law, as if no authorization to consent to health care for minor had been executed.

(d) An authorization to consent to health care for minor shall not be affected by the subsequent incapacity or mental incompetence of the custodial parent making such authorization. (1993, c. 150, s. 1.)

§ 32A-33. Reliance on authorization to consent to health care for minor.

(a) Any physician, dentist, or other health care provider involved in the health care of a minor child may rely upon the authority of the agent named in a signed and acknowledged authorization to consent to health care for minor in the absence of actual knowledge that the authorization has been revoked or is otherwise invalid.

(b) Any consent to health care for a minor child given by an agent pursuant to an authorization to consent to health care for minor shall have the same effect as if the custodial parent making the authorization were present and acting on behalf of the parent's minor child. Any physician, dentist, or other health care provider relying in good faith on the authority of an agent shall be protected to the full extent of the power conferred upon the agent, and no person so relying on the authority of the agent shall be liable, by reason of reliance, for actions taken pursuant to a consent of the agent. (1993, c. 150, s. 1.)

§ 32A-34. Statutory form authorization to consent to health care for minor.

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

"AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR."

I, _____, of _____ County, _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____, ____ . I authorize _____, an adult in whose care the minor child has been entrusted, and who resides at _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including _____, ____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)
Custodial Parent

Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of _____, _____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

§ 32A-35. Reserved for future codification purposes.

§ 32A-36. Reserved for future codification purposes.

§ 32A-37. Reserved for future codification purposes.

§ 32A-38. Reserved for future codification purposes.

§ 32A-39. Reserved for future codification purposes.

Article 5.

Enforcement of Power of Attorney.

§ 32A-40. Reliance on power of attorney.

(a) Unless (i) a person has actual knowledge that a writing is not a valid power of attorney, or (ii) the action taken or to be taken by a person named as attorney-in-fact in a writing that purports to confer a power of attorney is beyond the apparent power or authority of that named attorney-in-fact as granted in that writing, a person who in good faith relies on a writing that on its face is duly signed, acknowledged, and otherwise appears regular, and that purports to confer a power of attorney, durable or otherwise, shall be protected to the full extent of the powers and authority that reasonably appear to be granted to the attorney-in-fact designated in that writing, and no person so dealing in good faith with that named attorney-in-fact shall be held responsible for any breach of fiduciary duty by that attorney-in-fact, including any breach of loyalty, any act of self-dealing, or any misapplication of money or other property paid or transferred as directed by that attorney-in-fact. This subsection applies without regard to whether or not the person dealing with the attorney-in-fact demands or receives an affidavit under subsection (b) of this section. A person who conducts activities through employees or other agents has actual knowledge of a fact involving a power of attorney only from the time the information was received by an employee or agent having the authority to approve the power of attorney presented.

(b) A person may, prior to acceptance of the authority of the attorney-in-fact or at any other time, request an affidavit executed by the attorney-in-fact to the effect that the attorney-in-fact did not have, at the time of the presentation to the person of the writing purporting to confer a power of attorney, actual knowledge of either (i) the revocation of the power of attorney, or (ii) facts that would cause the attorney-in-fact to question the authenticity or validity of the power of attorney. An affidavit meeting the requirements of this subsection shall be sufficient proof to the requesting person, as of the date of the affidavit, of (i) the

nonrevocation of the power of attorney, and (ii) the authenticity and validity of the power of attorney. If the exercise of the power of attorney requires execution and delivery of an instrument that is recordable, the affidavit shall be prepared so as to be recordable. An affidavit prepared under this subsection may also be used as an affidavit under G.S. 32A-13(c). An affidavit in the form described in subsection (d) of this section shall be deemed to meet the requirements of this subsection but shall not be the sole means of meeting those requirements.

(c) This section does not affect any provision in a power of attorney for its termination by expiration of time or occurrence of an event other than an express revocation or a change in the principal's capacity.

(d) Example of Affidavit of Attorney-in-Fact.

STATE OF _____

COUNTY OF _____

The undersigned does hereby state and affirm the following:

- (1) The undersigned is the person named as Attorney-in-Fact in the Power of Attorney executed by _____ ("Principal") on [date]_____, _____ (the "Power of Attorney").
- (2) The Power of Attorney is currently exercisable by the undersigned.
- (3) The undersigned has no actual knowledge of any of the following:
 - a. The Principal is deceased.
 - b. The Power of Attorney has been revoked or terminated, partially or otherwise.
 - c. The Principal lacked the understanding and capacity to make and communicate decisions regarding his estate and person at the time the Power of Attorney was executed.
 - d. The Power of Attorney was not properly executed and is not a legal, valid power of attorney.
- (4) The undersigned agrees not to exercise any powers granted under the Power of Attorney if the undersigned becomes aware that the Principal is deceased or has revoked such powers.

This is the _____ day of _____.

[Signature]

[Acknowledgement]

(2005-178, s. 1.)

§ 32A-41. Penalty for unreasonable refusal to recognize power.

(a) A person dealing with an attorney-in-fact who unreasonably refuses to accept a power of attorney shall be subject to all of the following:

- (1) Liability for reasonable attorneys' fees and costs incurred in any action or proceeding necessary to confirm the validity of a power of attorney or to implement a power of attorney.
- (2) An order of the court requiring acceptance of the valid power of attorney.
- (3) Any other remedy available under applicable law.

(b) Acceptance of a power of attorney shall mean (i) acknowledging the validity and authenticity of the document, and (ii) allowing the attorney-in-fact to conduct business in accordance with the powers that reasonably appear to be granted in the document. (2005-178, s. 1.)

§ 32A-42. Protection for third parties.

(a) A person is not required to honor the attorney-in-fact's authority or to conduct business with the attorney-in-fact if the person is not otherwise required to conduct business with the principal in the same circumstances.

(b) Without limiting the generality of subsection (a) of this section, nothing in this Article requires a person to do any of the following:

- (1) Engage in any transaction with an attorney-in-fact if the attorney-in-fact has previously breached any agreement with the person, whether in an individual or fiduciary capacity.
- (2) Open an account for a principal at the request of an attorney-in-fact if the principal is not currently a customer of the person.
- (3) Make a loan to the principal at the request of the attorney-in-fact.

(c) A person who is presented with a power of attorney shall not be deemed to have unreasonably refused to accept the power of attorney solely on the basis of failure to accept the power of attorney within seven business days.

(d) A person who has reasonable cause to question the authenticity or validity of a power of attorney may refuse to accept the authority granted by that document.

(e) A person who promptly requests, and does not within a reasonable time receive, an affidavit as described in G.S. 32A-40(b), is not deemed under G.S. 32A-41 to have unreasonably refused to accept a power of attorney.

(f) The principal, the attorney-in-fact, or a person presented with a power of attorney may initiate a special proceeding in accordance with the procedures of Article 33 of Chapter 1 of the General Statutes to request a determination of the validity of the power of attorney. If the decision in that special proceeding is that reasonable cause to refuse to accept the power of attorney existed, and that the attorney-in-fact willfully misrepresented the authenticity or validity of the power of attorney, the attorney-in-fact, and not the principal, is liable for reasonable attorneys' fees and costs incurred in that action.

(g) Nothing in this Article requires a person who accepts a power of attorney to permit an attorney-in-fact to conduct business not authorized by the terms of the power of attorney, or otherwise not permitted by applicable statute or regulation.

(h) Nothing in this Article amends or modifies the rights of banks and other depository institutions to terminate any deposit account in accordance with applicable law. (2005-178, s. 1; 2006-264, s. 39(a).)

§ 32A-43. Scope of Article.

This Article shall apply to all or any portion of a document executed under Article 1, Article 2, or Article 2A of this Chapter. (2005-178, s. 1.)

Article 23.

Right to Natural Death; Brain Death.

§ 90-320. General purpose of Article.

(a) The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or the patient's representative has the fundamental right to control the decisions relating to the rendering of the patient's own medical care, including the decision to have life-prolonging measures withheld or withdrawn in instances of a terminal condition. This Article is to establish an optional and nonexclusive procedure by which a patient or the patient's representative may exercise these rights. A military advanced medical directive executed in accordance with 10 U.S.C. § 1044 or other applicable law is valid in this State.

(b) Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. Nothing in this Article shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-prolonging measures in any lawful manner. In such respect the provisions of this Article are cumulative. (1977, c. 815; 1979, c. 715, s. 1; 1983, c. 313, s. 1; 2007-502, s. 10.)

§ 90-321. Right to a natural death.

(a) The following definitions apply in this Article:

- (1) Declarant. – A person who has signed a declaration in accordance with subsection (c) of this section.
- (1a) Declaration. – Any signed, witnessed, dated, and proved document meeting the requirements of subsection (c) of this section.
- (2) Repealed by Session Laws 2007-502, s. 11(a), effective October 1, 2007.
- (2a) Life-prolonging measures. – As defined in G.S. 32A-16(4).
- (3) Physician. – Any person licensed to practice medicine under Article 1 of Chapter 90 of the laws of the State of North Carolina.
- (4) Repealed by Session Laws 2007-502, s. 11(a), effective October 1, 2007.

(b) If a person has expressed through a declaration, in accordance with subsection (c) of this section, a desire that the person's life not be prolonged by life-prolonging measures, and the declaration has not been revoked in accordance with subsection (e) of this section; and

- (1) It is determined by the attending physician that the declarant's present condition is a condition described in subsection (c) of this section and specified in the declaration for applying the declarant's directives, and
- (2) There is confirmation of the declarant's present condition as set out in subdivision (b)(1) of this section by a physician other than the attending physician;

then the life-prolonging measures identified by the declarant shall or may, as specified by the declarant, be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) The attending physician shall follow, subject to subsections (b), (e), and (k) of this section, a declaration:

- (1) That expresses a desire of the declarant that life-prolonging measures not be used to prolong the declarant's life if, as specified in the declaration as to any or all of the following:
 - a. The declarant has an incurable or irreversible condition that will result in the declarant's death within a relatively short period of time; or
 - b. The declarant becomes unconscious and, to a high degree of medical certainty, will never regain consciousness; or

- c. The declarant suffers from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible.
 - (2) That states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the life-prolonging measures; and
 - (3) That has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, licensed health care providers who are paid employees of the attending physician, paid employees of a health facility in which the declarant is a patient, or paid employees of a nursing home or any adult care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and
 - (4) That has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d1) of this section. A notary who takes the acknowledgement may but is not required to be a paid employee of the attending physician, a paid employee of a health facility in which the declarant is a patient, or a paid employee of a nursing home or any adult care home in which the declarant resides.
- (d) Repealed by Session Laws 2007-502, s. 11(b), effective October 1, 2007.
- (d1) The following form is specifically determined to meet the requirements of subsection (c) of this section:

ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: *You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.*

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

*If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and a notary*

public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahcdr/>

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply **IF** my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY AND ALL OF THESE CHOICES.

_____ I have an incurable or irreversible condition that will result
(Initial) in my death within a relatively short period of time.

_____ I become unconscious and my health care providers
(Initial) determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ I suffer from advanced dementia or any other condition
(Initial) which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ may withhold or withdraw life-prolonging measures.
(Initial)

_____ shall withhold or withdraw life-prolonging measures.
(Initial)

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ I *DO* want to receive BOTH artificial hydration AND
(Initial) artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.

(Initial)

I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.

(Initial)

I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

(Initial)

Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

(Initial)

Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE: DO NOT INITIAL BOTH BLOCKS. IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health

Care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

Print Name _____

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of declarant)

(type/print name of witness)

(type/print name of witness)

Date _____
(Official Seal)

Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____

(e) A declaration may be revoked by the declarant, in writing or in any manner by which the declarant is able to communicate the declarant's intent to revoke in a clear and consistent manner, without regard to the declarant's mental or physical condition. A health care provider shall have no liability for acting in accordance with a revoked declaration unless the provider has actual notice of the revocation. A health care agent may not revoke a declaration unless the health care power of attorney explicitly authorizes that revocation; however, a health care agent may exercise any authority explicitly given to the health care agent in a declaration. A guardian of the person of the declarant or general guardian may not revoke a declaration.

(f) The execution and consummation of declarations made in accordance with subsection (c) shall not constitute suicide for any purpose.

(g) No person shall be required to sign a declaration in accordance with subsection (c) as a condition for becoming insured under any insurance contract or for receiving any medical treatment.

(h) The withholding or discontinuance of life prolonging measures in accordance with this section shall not be considered the cause of death for any civil or criminal purposes nor shall it be considered unprofessional conduct or a lack of professional competence. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense. The protections of this section extend to any valid declaration, including a document valid under subsection (l) of this section; these protections are not limited to declarations prepared in accordance with the statutory form provided in subsection (d1) of this section, or to declarations filed with the Advance Health Care Directive Registry maintained by the Secretary of State. A health care provider may rely in good faith on an oral or written statement by legal counsel that a document appears to meet the statutory requirements for a declaration.

(i) Use of the statutory form prescribed in subsection (d1) of this section is an optional and nonexclusive method for creating a declaration and does not affect the use of other forms of a declaration, including previous statutory forms.

(j) The form provided by this section may be combined with or incorporated into a health care power of attorney form meeting the requirements of Article 3 of Chapter 32A of the General Statutes; provided, however, that the resulting form shall be signed, witnessed, and proved in accordance with the provisions of this section.

(k) Notwithstanding subsection (c) of this section:

(1) An attending physician may decline to honor a declaration that expresses a desire of the declarant that life-prolonging measures not be used if doing so would violate that physician's conscience or the conscience-based policy of the facility at which the declarant is being treated; provided, an attending physician who declines to honor a declaration on these grounds must not interfere, and must cooperate reasonably, with efforts to substitute an attending physician whose conscience would not be violated by honoring the declaration, or transfer the declarant to a facility that does not have policies in force that prohibit honoring the declaration.

(2) An attending physician may decline to honor a declaration if after reasonable inquiry there are reasonable grounds to question the genuineness or validity of a declaration. The subsection imposes no duty on the attending physician to verify a declaration's genuineness or validity.

(l) Notwithstanding subsection (c) of this section, a declaration or similar document executed in a jurisdiction other than North Carolina shall be valid in this State if it appears to

have been executed in accordance with the applicable requirements of that jurisdiction or this State. (1977, c. 815; 1979, c. 112, ss. 1-6; 1981, c. 848, ss. 1-3; 1991, c. 639, s. 3; 1993, c. 553, s. 28; 2001-455, s. 4; 2001-513, s. 30(b); 2007-502, ss. 11(a)-(e).)

§ 90-322. Procedures for natural death in the absence of a declaration.

(a) If the attending physician determines, to a high degree of medical certainty, that a person lacks capacity to make or communicate health care decisions and the person will never regain that capacity, and:

- (1) Repealed by Session Laws 2007-502, s. 12, effective October 1, 2007.
- (1a) That the person:
 - a. Has an incurable or irreversible condition that will result in the person's death within a relatively short period of time; or
 - b. Is unconscious and, to a high degree of medical certainty, will never regain consciousness; and
- (2) There is confirmation of the person's present condition as set out above in this subsection, in writing by a physician other than the attending physician; and
- (3) A vital bodily function of the person could be restored or is being sustained by life-prolonging measures;
- (4) Repealed by Session Laws 2007-502, s. 12, effective October 1, 2007.

then, life-prolonging measures may be withheld or discontinued in accordance with subsection (b) of this section.

(b) If a person's condition has been determined to meet the conditions set forth in subsection (a) of this section and no instrument has been executed as provided in G.S. 90-321, then life-prolonging measures may be withheld or discontinued upon the direction and under the supervision of the attending physician with the concurrence of the following persons, in the order indicated:

- (1) A guardian of the patient's person, or a general guardian with powers over the patient's person, appointed by a court of competent jurisdiction pursuant to Article 5 of Chapter 35A of the General Statutes; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority to the extent granted in the health care power of attorney and to the extent provided in G.S. 32A-19(b) unless the Clerk has suspended the authority of that health care agent in accordance with G.S. 35A-1208(a);
- (2) A health care agent appointed pursuant to a valid health care power of attorney, to the extent of the authority granted;
- (3) An attorney-in-fact, with powers to make health care decisions for the patient, appointed by the patient pursuant to Article 1 or Article 2 of Chapter 32A of the General Statutes, to the extent of the authority granted;
- (4) The patient's spouse;
- (5) A majority of the patient's reasonably available parents and children who are at least 18 years of age;
- (6) A majority of the patient's reasonably available siblings who are at least 18 years of age; or
- (7) An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

If none of the above is reasonably available then at the discretion of the attending physician the life-prolonging measures may be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) Repealed by Session Laws 1979, c. 715, s. 2.

(d) The withholding or discontinuance of such life-prolonging measures shall not be considered the cause of death for any civil or criminal purpose nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense. (1977, c. 815; 1979, c. 715, s. 2; 1981, c. 848, s. 5; 1983, c. 313, ss. 2-4; c. 768, s. 5.1; 1991, c. 639, s. 4; 1993, c. 553, s. 29; 2007-502, s. 12.)

§ 90-323. Death; determination by physician.

The determination that a person is dead shall be made by a physician licensed to practice medicine applying ordinary and accepted standards of medical practice. Brain death, defined as irreversible cessation of total brain function, may be used as a sole basis for the determination that a person has died, particularly when brain death occurs in the presence of artificially maintained respiratory and circulatory functions. This specific recognition of brain death as a criterion of death of the person shall not preclude the use of other medically recognized criteria for determining whether and when a person has died. (1979, c. 715, s. 3.)

§§ 90-324 through 90-328. Reserved for future codification purposes.

A BRIEF DESCRIPTION OF . . .

THE POWER OF ATTORNEY

When you give someone your “power of attorney,” you give him or her the power to handle your affairs. For example, they can get money from your bank account, they can pay your rent, they can make a dentist’s appointment for you, and they can pay your taxes. The way this works in practice is that you sign a piece of paper—which is itself called a “power of attorney”—in front of a notary. The paper says that the person you’ve chosen has your power of attorney. If that person needs to withdraw money from your bank account, they show the teller the paper.

Obviously, the person to whom you give this power should be a person that you trust completely. You can give your power of attorney to more than one person.

Just because you give someone your power of attorney doesn’t mean you can’t get money from your bank account, pay your rent, and so on. You don’t lose any power over your own affairs by giving someone your power of attorney—you just share it with that other person.

If you become “incapacitated” (incapable of handling your own affairs), the person you gave your power of attorney to can still handle your affairs for you, as long as you gave them a “durable” power of attorney, and they filed it properly. Your law student can explain these requirements more fully.

Some people want to handle their own affairs while they can, but want to give someone else their power of attorney for use only after they become incapacitated. While this is a good idea in some cases, it is often more trouble than it is worth. For example, if you gave someone a power of attorney like this, and you became incapacitated, they might have trouble convincing the bank that you really were incapacitated—and so they might not be able to pay your bills. Ask your law student if you have any questions about this kind of power of attorney.

If you give someone your power of attorney, and later decide that you don’t want them to have it, you can always revoke it (take it back). Your law student will tell you how to do this. If you need someone to be able to handle some of your affairs, but you do not want to give them all the powers that you usually give as part of the power of attorney, ask your law student about limiting the power of attorney, or about using another legal technique altogether.

Durable/Conditional Power of Attorney Protocols

NOTE: To interview a client about a power of attorney, have with you a Power of Attorney Intake Form, and a copy of N.C.G.S. 32A-2.

1. Initial meeting with client.

Find out if the client already has a POA, and, if so, determine if the previous POA needs to be revoked. Get a copy of the previous POA (in our case file if we did it, from client, from online access at Register of Deeds).

Explain general power of attorney to client. Explain the differences between a durable and a conditional power of attorney. Discourage client from executing a conditional power of attorney (i.e. a power of attorney which takes effect only after incompetence). The reasons for discouraging the use of this form of POA are: 1) Banks are quite skeptical about honoring such a power of attorney and some may even require a judicial finding of incompetence (even though the statute allows them to rely on an affidavit from the attorney-in-fact); and 2) There may be difficulty and therefore delay in obtaining the necessary physician certificates verifying the incompetence.

Recommend that the client execute a durable power of attorney, give it to the attorney-in-fact and instruct the attorney-in-fact not to use the document unless the person becomes incompetent or instructs the attorney-in-fact to use the document. If trust is an issue, perhaps the client should be choosing a different attorney-in-fact.

If the client insists on a conditional POA, there are many options for determining incompetence. One option is described in our conditional power of attorney form. The document should be discussed in some detail with your supervising attorney.

We generally recommend the short form durable power of attorney. Go over all the items on the blank form with the client. Usually we would leave in all the items if the client wants to give broad authority to his/her attorney-in-fact. We do have a longer form on disk for clients who want the authority spelled out, rather than simply incorporated by reference in the document. The statute defining each of the powers is included in the Advance Directives Exhibits in your Clinic Notebook. You should be familiar with what is involved in each power so you can answer client questions.

Giftng: This should be discussed separately. Clients who own their own home or who have some assets (more than \$2000) should be advised about the option of gifting to facilitate eligibility for government benefits. Clients without assets do not need this counseling. Explain that gifting power is limited to historical pattern of gifting.

Fill in the Power of Attorney Intake form (*document/power of attorney/power of attorney intake*).

2. Drafting. Draft the power of attorney. In most cases, we will use the short form power of attorney. In some instances, particularly if the client owns his/her home or has assets, we might recommend the long form.

When you prepare the form in Word, please use track changes so the supervising attorney can easily catch any changes you have made in the template form. If the document is to be recorded, the Register of Deeds office requires a 3" top margin on the first page and a clean 1" margin on all sides on all pages. **Please do not reformat our power of attorney form to eliminate these margins.**

At the top of the power of attorney form there is a blank space after the words "Return to." This is a direction to the Register of Deeds, who will return the original to that person after the power has been recorded. There are three options for that. The client may want the original to be returned to him/her; the client may want the original returned to the attorney-in-fact; the client may want to leave the space blank and decide when he/she takes the power to have it recorded

Delete any provisions in the form that the client is not including. When you are finished drafting, delete document comments that contain instructions.

After drafting, have the POA approved by your supervising attorney and send a draft to the client, with a cover letter. Call the client in about a week to see if there are any questions or any changes need to be made. If so, make the changes and have it re-approved by your supervisor. If not, arrange for a signing.

3. Signing: The durable and conditional powers of attorney are signed by the client in front of a notary. No witnesses are required. **Please make sure that no part of any signature or the notary seal encroaches on the 1" margins. Even a small encroachment may result in the document being rejected by the Register of Deeds.** After the client has signed the original and it has been notarized, make one photocopy. Keep the original if we are to record the document and give a copy to the client. (If the client is to record the document, give the original to the client.) Put one copy in the client's file, and, with the client's permission, mail a copy to the attorney-in-fact, with the cover letter identified as *document\power of attorney\agent cover letter*.

4. Recording the document: The power of attorney must be recorded in the Register of Deeds office of the client's county of residence in the following circumstances: 1) The document will be used in real estate transactions (then the document must also be recorded in the county where the real estate is located) and 2) if the document is used after the client becomes mentally incompetent. We recommend that the power be recorded right away. Then, if the client becomes incompetent suddenly, it can be used immediately. It will cost \$26 to record a power of attorney. If the client opts not to record the power of attorney at this time, he or she must be instructed to tell the attorney-in-fact that the document must be recorded after the client becomes incompetent if it is to be used at that point or if it is to be used for any real estate transaction.

Our default procedure is to record the power of attorney for the client (with the client's permission, of course) and to pay the recording fee. Ask the client where the original should be returned after it is recorded (usually either the client or the attorney-in-fact). Make sure that person's name is at the top of the power where it says: "Return to."

Ask your supervising attorney for a check for \$26, made out to the Register of Deeds of the county in which the client lives (and a second check for \$26 if the client owns real estate in a

separate county.) Send the check and the power of attorney, with a cover letter and stamped envelope addressed to the person to whom the original POA should be sent, to the Register of Deeds requesting that the power be recorded. The form cover letter can be found on our website, as well as in Clio as a template document. The names and addresses of the Register of Deeds are in the blue Lawyer's Handbook in the clinic office.

5. Revoking: Explain to the client how to revoke the power of attorney and give the client the sheet, *How to Revoke a Power of Attorney (document/power of attorney/revocation power of attorney.)*

If we are working with a client to revoke a previously signed and recorded Power of Attorney, you need to take the following steps:

- Draft the Revocation and have the client sign the Revocation in front of a notary.
- After the client has signed the original and it has been notarized, make one photocopy. Keep the original and give a copy to the client.
- Ask the client for the address of the previously named (and now revoked) attorney-in-fact and inform the client that the law requires that we notify that person of the Revocation.
- Serve a copy of the Revocation on the previously named (and now revoked) attorney-in-fact. Consult with your supervising attorney to figure out the service method: certified mail, sheriff, or publication in newspaper. Once the Revocation has been served, prepare proof of service:
 - *Sheriff*: You should receive Sheriff's Return of Service;
 - *Certified mail*: Affidavit of Service with return receipts attached;
 - *Publication*: obtain Affidavit of Publication from newspaper.
 -
- Send the original Revocation, along with proof of service and the recording fee of \$26, along with a cover letter and stamped return envelope to the Register of Deeds requesting that the Revocation be recorded.

POWER OF ATTORNEY INTAKE FORM

CLIENT:	
Full Name:	
County of residence	
Has the client previously done a Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what county? When?	County: _____ Year: _____
If yes, does the client have a copy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name/address of previous agent	_____
Does the prior POA need to be revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Power of Attorney wanted:	<input type="checkbox"/> In effect immediately & after incapacity (Durable) <input type="checkbox"/> Conditional (Springing)
AGENT/ATTORNEY IN FACT:	
Name	
County of Residence (city and state if not NC)	
ALTERNATE AGENT/ATTORNEY IN FACT:	
Name:	
County of Residence (city and state if not NC)	
POWERS GRANTED	
<input type="checkbox"/> All <input type="checkbox"/> Real property transactions <input type="checkbox"/> Personal Property Transactions <input type="checkbox"/> Bond, share and commodity transactions <input type="checkbox"/> Banking transactions <input type="checkbox"/> Safety Deposits <input type="checkbox"/> Business operating transactions	<input type="checkbox"/> Insurance transactions <input type="checkbox"/> Estate transactions <input type="checkbox"/> Personal relationships and affairs <input type="checkbox"/> Social Security and unemployment <input type="checkbox"/> Benefits from military service <input type="checkbox"/> Tax matters <input type="checkbox"/> Employment of agents
GIFT PROVISIONS	
Gifts: Give client a brief overview of gifting first. Does client want agent to have power to make gifts to charities (according to historical patterns)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does client want agent to be able to make other gifts, consistent with her/his history of making gifts (e.g. birthday, holidays, graduations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
To whom can agent make such gifts?	Names:
Can agent make gifts to him/herself?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Gifts/Transfers to facilitate eligibility for government benefits (eg for nursing home)</p> <p>Does the client own his/her own home?</p> <p>Does the client have assets of more than \$2000 (other than household goods & one car)?</p> <p><i>If client answered "yes" to either of these explain gifting for eligibility for public benefits ("if you have to go into a nursing home, would you want to use up your assets – eg sell your house and spend your money, or would you rather to save those assets for your heirs and apply for government assistance?)</i></p> <p>If client answered both questions "no," skip this</p> <p>If client authorizes gifts for benefit eligibility, to whom can gifts be made?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, total assets: _____</p> <p><input type="checkbox"/> Client wants to spend own money/house – no gifting for government benefit eligibility</p> <p><input type="checkbox"/> Client wants to save property for heirs – include gifting for government benefits eligibility</p> <p>Names of people who can receive gifts for benefits eligibility:</p>
<p>Guardianship</p> <p>If for some reason the POA fails, or there is a need to appoint a guardian for some other reason, does client want to nominate her/his agent and/or alternate in that role? (Note that choice must be consistent with Health Care Power of Attorney, which nominates health care agent)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, state who client would want as guardian if one was needed:</p> <p><input type="checkbox"/> omit guardianship nomination</p>
Accountability	
<p>Bond:</p> <p>Does the client want the agent to pay a bond to secure performance of the duties?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Accountings:</p> <p>Does the client want the agent to give him/her annual reports of all transactions?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Accountings:</p> <p>If the client is incompetent, does the client want the agent to make accountings to the clerk of court?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Does the client want the agent to make accountings to someone else (eg another family member):</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of person: _____</p>
Processing Power of Attorney	
<p>Return of POA after recording:</p> <p>When the POA is recorded at the Register of Deeds, to whom should it be returned?</p>	<p><input type="checkbox"/> Client <input type="checkbox"/> Agent</p> <p><input type="checkbox"/> Undecided at this time</p>
<p>To whom does client want us to send copies of POA?</p>	<p><input type="checkbox"/> Agent</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Do not send copies</p>

Prepared by: Duke Health Justice Clinic, Box 90360, Durham, NC 27708, Telephone: (919) 613-7169

Return to: Name and address of person to whom POA will be returned by Register of Deeds

STATE OF NORTH CAROLINA

DURABLE POWER OF ATTORNEY

COUNTY OF CLIENT'S COUNTY

I, the undersigned, Full Name of Client, of client's county County, North Carolina, hereby appoint Name of Agent, of County of residence of Agent County, North Carolina, as agent for me and give such person full power to act in my name, place and stead in any way which I myself could do if I were personally present with respect to the following matters as each of them is defined in Chapter 32A of the North Carolina General Statutes to the extent that I am permitted by law to act through an agent.

If Name of Agent is unable or unwilling to serve as agent, then I appoint Alternate Agent, of Alternate's county County, North Carolina, to serve as my agent.

- (1) Real property transactions;
- (2) Personal property transactions;
- (3) Bond, share and commodity transaction;
- (4) Banking transactions;
- (5) Safe deposits;
- (6) Business operating transactions;
- (7) Insurance transactions;
- (8) Estate transactions;
- (9) Personal relationships and affairs;

- (10) Social security and unemployment;
- (11) Benefits from military service;
- (12) Tax matters;
- (13) Employment of agents.

Additional Provisions, Powers and Limitations

A. With regard to gifts or transfers of my property without compensation, I specify the following powers and limitations:

Commented [AJR1]: Edit this section to choose the option desired by the client.

1. I authorize my agent to give away and transfer my property, real or personal, tangible or intangible, for the purpose of qualifying me for governmental benefits or assistance, or to reduce the effect of Medicaid estate recovery.
 - a. These gifts may be made to the following individuals, in such shares as my agent deems appropriate Enter the names of people to whom the agent may give gifts for purposes of benefits eligibility
 - b. I authorize my agent to give such gifts to him or herself.
 - c. I understand that giving away my property may result in a period of ineligibility for some benefits, so I require that any such gift shall be made upon the written advice of an attorney with knowledge and experience regarding these matters. These gifts shall not be limited in amount by my history of making such gifts.
2. I authorize my agent to give away and transfer my property to those charities to which I have a history of making gifts, in the amounts that I have given in the past.
3. I authorize my agent to give away and transfer my property to enter the names of people to whom the agent may make gifts in amounts consistent with my history of making such gifts, for events such as birthdays, holidays and graduations. I authorize my agent to give such gifts to him or herself.
4. I do not authorize my agent to make gifts or transfers of my assets.
5. I neither authorize nor deny my agent the authority to make gifts or transfers of my property. My agent may ask a court for permission to transfer or give away my assets, as provided under North Carolina law and after providing notice to my family members.

Commented [AJR2]: If the client does not authorize gifts, include this paragraph and delete the other gifting paragraphs

- B. My agent may sign an Internal Revenue Service Form 2848 or Form 8821 or comparable authorization, appointing agent or some other qualified individual to represent me in any tax matters before the Internal Revenue Service or any state, local or foreign taxing authority with respect to all types of taxes for the years 2010 to 2060.
- C. I give my agent full power to appoint another to act as my agent and full power to revoke such appointment.
- D. This power of attorney shall not be affected by my subsequent incapacity or mental incompetence. It is my intent that this Durable Power of Attorney shall remain in effect following and be superior to any appointment of a guardian of my estate. If it becomes necessary for a court to appoint a guardian of my estate, I nominate the persons designated as my agent in this Durable Power of Attorney, in the order named.
- E. My agent shall serve without bond.
- F. I hereby waive any requirement that my agent file any inventories or accounts with any court or clerk of court, to the extent I have the authority to waive such accounting.
- G. My agent shall keep full and accurate records of all transaction in which he or she acts as my agent.
- H. My agent shall annually give to me, if competent, inventories and accounts of all transactions. If I shall be incompetent, my agent shall give the same to name of person to receive accountings.

Commented [AJR3]: Make sure the client permits this for both agent and alternate. If not, change this

Commented [AJR4]: Make sure this is consistent with the Health Care Power of Attorney, which nominates the health care agent as guardian. If a client names different people for health care agent and attorney in fact, it will be necessary to adjust the guardianship nomination in one or both of the documents.

Commented [AJR5]: Change this if needed to reflect client wishes.

Dated, the ____ day of _____, 20 ____.

Full name of client

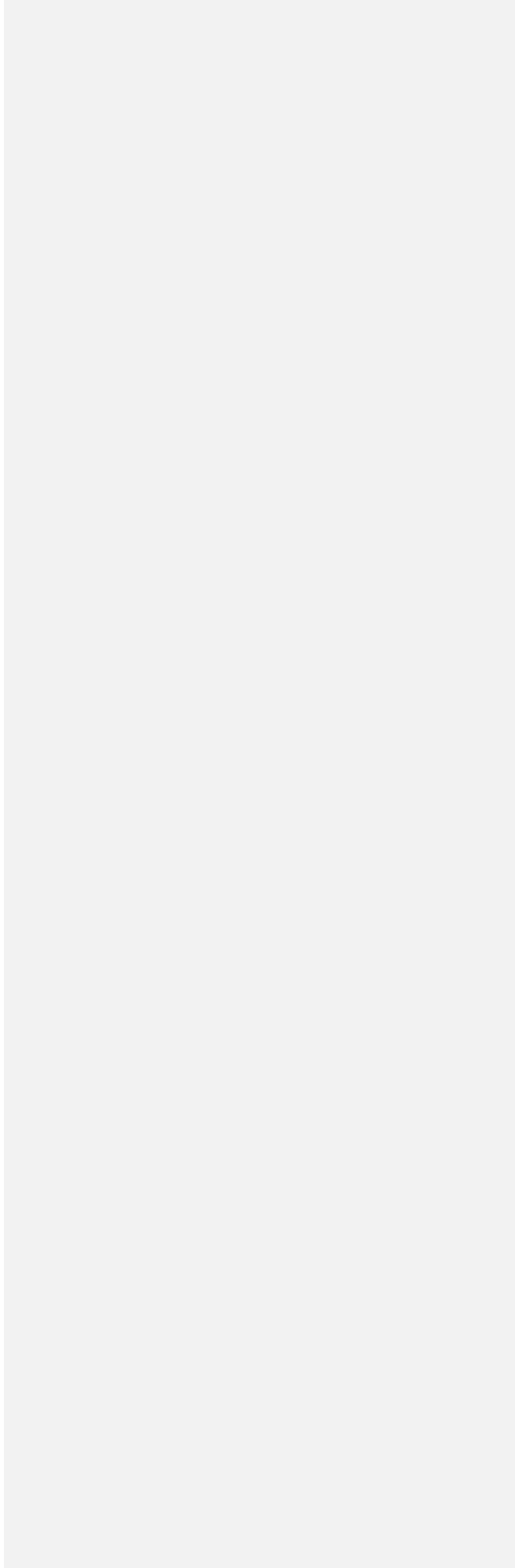
STATE OF NORTH CAROLINA
COUNTY OF _____

On this _____ day of _____, 20____, personally appeared before me, the said named Full Name of Client, to me known and known to me to be the person described in and who executed the foregoing instrument and he acknowledged that he executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My commission expires: _____

Notary Public
(Official seal or stamp)

Printed Name of Notary



Prepared by: Duke Health Justice Clinic, Box 90360, Durham, NC 27708, Telephone: (919) 613-7169

Return to: Jennifer A. Alvarez, 2002 Johnston St., Smithfield, NC 27865

STATE OF NORTH CAROLINA

DURABLE POWER OF ATTORNEY

COUNTY OF JOHNSTON

I, the undersigned, Jennifer A. Alvarez, of Johnston County, North Carolina, hereby appoint Rasheed Raymond, of Johnston County, North Carolina, as agent for me and give such person full power to act in my name, place and stead in any way which I myself could do if I were personally present with respect to the following matters as each of them is defined in Chapter 32A of the North Carolina General Statutes to the extent that I am permitted by law to act through an agent.

If Rasheed Raymond is unable or unwilling to serve as agent, then I appoint Bonnie Alvarez, of Wake County, North Carolina, to serve as my agent.

- (1) Real property transactions;
- (2) Personal property transactions;
- (3) Bond, share and commodity transaction;
- (4) Banking transactions;
- (5) Safe deposits;
- (6) Business operating transactions;
- (7) Insurance transactions;
- (8) Estate transactions;
- (9) Personal relationships and affairs;

(10) Social security and unemployment;

(11) Benefits from military service;

(12) Tax matters;

(13) Employment of agents.

Additional Provisions, Powers and Limitations

A. With regard to gifts or transfers of my property without compensation, I specify the following powers and limitations:

1. I authorize my agent to give away and transfer my property, real or personal, tangible or intangible, for the purpose of qualifying me for governmental benefits or assistance, or to reduce the effect of Medicaid estate recovery.
 - a. These gifts may be made to the following individuals, in such shares as my agent deems appropriate Angela Alvarez, Rasheed Raymond, and Bonnie Alvarez.
 - b. I authorize my agent to give such gifts to him or herself.
 - c. I understand that giving away my property may result in a period of ineligibility for some benefits, so I require that any such gift shall be made upon the written advice of an attorney with knowledge and experience regarding these matters. These gifts shall not be limited in amount by my history of making such gifts.
2. I authorize my agent to give away and transfer my property to those charities to which I have a history of making gifts, in the amounts that I have given in the past.
3. I authorize my agent to give away and transfer my property to Angela Alvarez, Rasheed Raymond, and Bonnie Alvarez in amounts consistent with my history of making such gifts, for events such as birthdays, holidays and graduations. I authorize my agent to give such gifts to him or herself.

B. My agent may sign an Internal Revenue Service Form 2848 or Form 8821 or comparable authorization, appointing agent or some other qualified individual to represent me in any tax matters before the Internal Revenue Service or any state, local or foreign taxing authority with respect to all types of taxes for the years 2010 to 2060.

C. I give my agent full power to appoint another to act as my agent and full power to revoke

such appointment.

- D. This power of attorney shall not be affected by my subsequent incapacity or mental incompetence. It is my intent that this Durable Power of Attorney shall remain in effect following and be superior to any appointment of a guardian of my estate. If it becomes necessary for a court to appoint a guardian of my estate, I nominate the persons designated as my agent in this Durable Power of Attorney, in the order named.
- E. My agent shall serve without bond.
- F. I hereby waive any requirement that my agent file any inventories or accounts with any court or clerk of court, to the extent I have the authority to waive such accounting.
- G. My agent shall keep full and accurate records of all transaction in which he or she acts as my agent.
- H. My agent shall annually give to me, if competent, inventories and accounts of all transactions.

Dated, the ____ day of _____, 20____.

Jennifer A. Alvarez

STATE OF NORTH CAROLINA
COUNTY OF _____

On this _____ day of _____, 20____, personally appeared before me, the said named Jennifer A. Alvarez, to me known and known to me to be the person described in and who executed the foregoing instrument and he acknowledged that he executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My commission expires:_____

Notary Public
(Official seal or stamp)

Printed Name of Notary

Prepared by: Duke Health Justice Clinic, Box 90360, Durham, NC 27708, Telephone: (919) 613-7169

Return to: Name and address of person to whom POA will be returned by Register of Deeds

**STATE OF NORTH CAROLINA
COUNTY OF CLIENT'S COUNTY**

CONDITIONAL POWER OF ATTORNEY

I, the undersigned, Full Name of Client, of client's county County, North Carolina, hereby appoint Name of Agent, of County of residence of Agent County, North Carolina, as agent for me and give such person full power to act in my name, place and stead in any way which I myself could do if I were personally present with respect to the following matters as each of them is defined in Chapter 32A of the North Carolina General Statutes to the extent that I am permitted by law to act through an agent.

If Name of Agent is unable or unwilling to serve as agent, then I appoint Alternate Agent, of Alternate's county County, North Carolina, to serve as my agent.

- (1) Real property transactions;
- (2) Personal property transactions;
- (3) Bond, share and commodity transaction;
- (4) Banking transactions;
- (5) Safe deposits;
- (6) Business operating transactions;
- (7) Insurance transactions;
- (8) Estate transactions;

- (9) Personal relationships and affairs;
- (10) Social security and unemployment;
- (11) Benefits from military service;
- (12) Tax matters;
- (13) Employment of agents.

Additional Provisions, Powers and Limitations

A. **Springing Powers:** This power of attorney shall be effective upon execution; however, my agent shall not be empowered to act on my behalf until I become incapacitated or mentally incompetent. My agent shall not (except at my written request) exercise any authority granted by this instrument unless and until my agent receives a written certificate by two licensed medical doctors stating that physically or mentally I am incapable of handling my own business affairs. My agent shall have no duty to inquire regarding my physical or mental condition, and shall have no duty (except by my written request) to exercise the powers under this instrument until her or she has received certification from two medical doctors as described above.

B. **Gifts:** With regard to gifts or transfers of my property without compensation, I specify the following powers and limitations:

Commented [AJR1]: Edit this section to choose the option desired by the client.

1. I authorize my agent to give away and transfer my property, real or personal, tangible or intangible, for the purpose of qualifying me for governmental benefits or assistance, or to reduce the effect of Medicaid estate recovery.
 - a. These gifts may be made to the following individuals, in such shares as my agent deems appropriate Enter the names of people to whom the agent may give gifts for purposes of benefits eligibility
 - b. I authorize my agent to give such gifts to him or herself.
 - c. I understand that giving away my property may result in a period of ineligibility for some benefits, so I require that any such gift shall be made upon the written advice of an attorney with knowledge and experience regarding these matters. These gifts shall not be limited in amount by my history of making such gifts.
2. I authorize my agent to give away and transfer my property to those charities to which I have a history of making gifts, in the amounts that I have given in the past.
3. I authorize my agent to give away and transfer my property to enter the names of

people to whom the agent may make gifts in amounts consistent with my history of making such gifts, for events such as birthdays, holidays and graduations. I authorize my agent to give such gifts to him or herself.

4. I do not authorize my agent to make gifts or transfers of my assets.

Commented [AJR2]: If the client does not authorize gifts, include this paragraph and delete the other gifting paragraphs

5. I neither authorize nor deny my agent the authority to make gifts or transfers of my property. My agent may ask a court for permission to transfer or give away my assets, as provided under North Carolina law and after providing notice to my family members.

C. My agent may sign an Internal Revenue Service Form 2848 or Form 8821 or comparable authorization, appointing agent or some other qualified individual to represent me in any tax matters before the Internal Revenue Service or any state, local or foreign taxing authority with respect to all types of taxes for the years 2010 to 2060.

D. I give my agent full power to appoint another to act as my agent and full power to revoke such appointment.

Commented [AJR3]: Make sure the client permits this for both agent and alternate. If not, change this

E. This power of attorney shall not be affected by my subsequent incapacity or mental incompetence. It is my intent that this Durable Power of Attorney shall remain in effect following and be superior to any appointment of a guardian of my estate. If it becomes necessary for a court to appoint a guardian of my estate, I nominate the persons designated as my agent in this Durable Power of Attorney, in the order named.

Commented [AJR4]: Make sure this is consistent with the Health Care Power of Attorney, which nominates the health care agent as guardian. If a client names different people for health care agent and attorney in fact, it will be necessary to adjust the guardianship nomination in one or both of the documents.

F. My agent shall serve without bond.

G. I hereby waive any requirement that my agent file any inventories or accounts with any court or clerk of court, to the extent I have the authority to waive such accounting.

H. My agent shall keep full and accurate records of all transaction in which he or she acts as my agent.

I. My agent shall annually give to me, if competent, inventories and accounts of all transactions. If I shall be incompetent, my agent shall give the same to name of person to receive accountings.

Commented [AJR5]: Change this if needed to reflect client wishes.

Dated, the ____ day of _____, 20____.

Full name of client

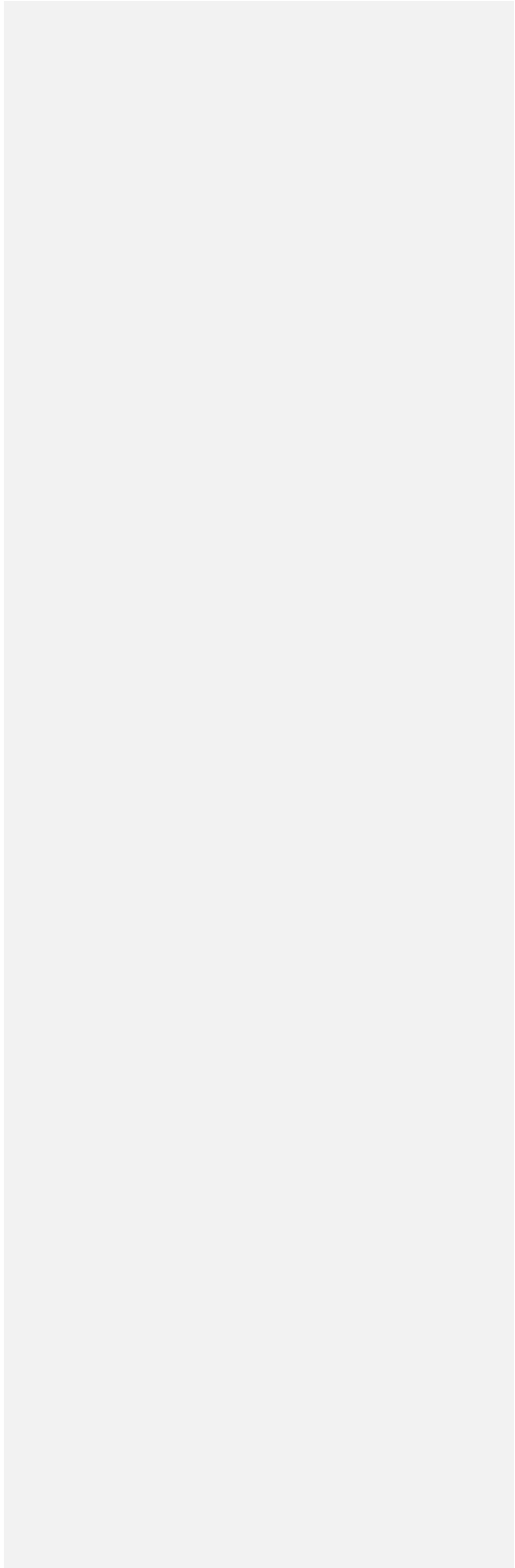
STATE OF NORTH CAROLINA
COUNTY OF _____

On this _____ day of _____, 20____, personally appeared before me, the said named Full Name of Client, to me known and known to me to be the person described in and who executed the foregoing instrument and he acknowledged that he executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My commission expires: _____

Notary Public
(Official seal or stamp)

Printed Name of Notary



HOW TO REVOKE A POWER OF ATTORNEY

All Powers of Attorney automatically end at your death. However, there may come a time before then when you decide that you would like to revoke or cancel your Power of Attorney (this can be your Health Care Power of Attorney or your Durable Power of Attorney).

Unregistered Power of Attorney:

If your Power of Attorney has not been registered with the Register of Deeds (most are not), it may be revoked in the following ways:

1. **By burning, tearing, canceling, or destroying the Power of Attorney** with the intent to revoke the document. This can be done by you or by another person acting under your direction and in your presence. You must be mentally competent and not incapacitated at the time of the destruction of your Power of Attorney.; or
2. **By delivering a written revocation to the attorney-in-fact by certified or registered mail, return receipt requested;** or
3. By any method you may have provided for in your Power of Attorney.

*In every case, you must notify your “attorney-in-fact” of your choice to revoke the Power of Attorney. (Your attorney-in-fact is the person to whom you gave your power of attorney. Another name for this person is your “agent,” as in your Health Care Agent)

Registered Power of Attorney:

If your Power of Attorney has been filed with the register of deeds, it may be revoked in the following way:

You may **register a revocation** at the same office in which the Power of Attorney was originally registered. The revocation must be executed by you while you are mentally competent and not incapacitated.

The attorney-in-fact must be given notice of your choice to revoke the Power of Attorney. The person who registers the revocation must show that notice has been given to the attorney-in fact in the same manner prescribed for a civil summons. One way to do it is to have the sheriff serve a copy of the revocation on the attorney-in-fact. Before attempting to file a revocation, please contact an attorney of your choosing. There are specific rules governing what must be contained in a revocation.

If you have any questions about revoking a Power of Attorney, please call the Duke Health Justice Clinic at (919) 613-7169.

Date

[name & address of Register of Deeds]

[Dear]:

Enclosed is an original notarized durable power of attorney for Client as well as a check in the amount of [_____]. Please record this power of attorney and return the recorded original to [person to whom POA is to be returned]. I have enclosed a stamped envelope addressed to [person to whom POA is to be returned] for your use.

Thank you for your time and attention.

Sincerely,

[student]
Certified Law Student
Under the Supervision of
[supervising attorney]
Supervising Attorney

[date]

[attorney in fact]

address

address

Dear [attorney in fact]:

Our office has recently prepared a power-of-attorney for [client]. In this paper, you have been named [client name]'s "attorney-in-fact." This means you have been given legal authority to do certain things on behalf of [client name]. A copy of the power-of-attorney is enclosed. [client name] has the original.

Let me explain your responsibilities as "attorney-in-fact." As an attorney-in-fact, you have what is called a "fiduciary duty" to [client name]. This means that anything you do in [client name]'s name must be for her benefit. For example, under this power-of-attorney, you can cash checks made out to [client name]. You must use the money for [client name] and not for yourself or anyone else. It is illegal for you to use this power except to benefit [client name] and you must always act in her best interest. Please review the list of powers that you have and let me know if you have any questions about what they mean.

Although the power-of-attorney is in effect right away, [client name] does not want you to use it unless she is unable to act for [herself/himself]. When you do need to use the power-of-attorney, you will need to have the original. You and [client name] should talk about how you will get the original if you need to use it.

I have sent the original of the power-of-attorney to the [county] County Register of Deeds, where it will be recorded and then mailed to [client name]. This will make it possible to use the power-of-attorney should [client name] become mentally incompetent or if you need to sign any deeds for real estate for [client name].

Please let me know if you have any questions at all about this important legal document.

Sincerely yours,

[student]

Certified Law Student

Under the Supervision of

[supervising attorney

Supervising Attorney

STATE OF NORTH CAROLINA)
)
COUNTY OF)
REVOCATION OF
DURABLE POWER OF ATTORNEY

I, the undersigned, CLIENT NAME, of CURRENT CLIENT COUNTY OF RESIDENCE County, North Carolina, under the provisions of North Carolina, General Statutes Section 32A-13, do hereby revoke, nullify, and void the Power of Attorney executed by me on DATE, naming ATTY IN FACT as my attorney-in-fact, and recorded in the office of the Register of Deeds of WHERE RECORDED County, North Carolina.

Dated, this the _____ day of _____, 200_____ .

CLIENT NAME (SEAL)

STATE OF NORTH CAROLINA)
)
COUNTY OF)
ACKNOWLEDGMENT

I, _____, a Notary Public for said county and state, do hereby certify that (CLIENT NAME) personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and notarial seal this the _____ day of _____, 200_____.

Notary Public

My Commission Expires:_____. (SEAL)

A BRIEF DESCRIPTION OF . . .

THE HEALTH CARE POWER OF ATTORNEY

When you sign a Health Care Power of Attorney, you give someone else the power to make decisions about your medical care when you are not mentally able to do so (when you are "incompetent"). The person you appoint to make decisions on your behalf is called your "Health Care Agent." You can also appoint an alternate Health Care Agent to make decisions if the Health Care Agent is unavailable, or is unwilling to make decisions.

It is important to remember that you can (and in fact, must) make your own health care choices while you are able. Your Health Care Agent can only act on your behalf when you have become "incompetent." Whether you are competent or incompetent is a decision made by the doctor (or doctors) of your choice, or if that doctor is not available, by your attending physician. You name this doctor (or these doctors) in the Health Care Power of Attorney document itself. If you are incompetent for a while, but recover and become competent again, you can (and in fact, must) make your own health care decisions again.

You can let your Health Care Agent make whatever decisions they see fit, or you can require them to do certain things in certain situations. At a minimum, you should discuss your health and your feelings about different types of treatment with your Health Care Agent.

The standard Health Care Power of Attorney form grants your Health Care Agent the power to authorize the withholding or withdrawal of life-supporting measures. You can leave the choice of whether and when to withhold life support to your Health Care Agent. Or, you can require your Health Care Agent to withhold life support in certain situations, or you can forbid your Health Care Agent from withholding life support. It is up to you.

If you name someone as your Health Care Agent but later decide that you do not want them to be your Health Care Agent, you can revoke (take back) the power you gave them. Your law student will explain how to do this.

If you have *any* questions about the Health Care Power of Attorney, ask your law student. He or she will be happy to explain the document to you, or to tailor it to your specific needs.

Health Care Power of Attorney Protocol

1. At the initial meeting, if the client is uncertain who to name as his or her health care agent, explain that the person should be someone he/she trusts and someone who would feel comfortable following the client's wishes regarding health care decisions. Give the client a copy of **Suggested Topics to Discuss with your Health Care Agent** and suggest that he/she use the questions listed as a guide for a discussion with the health care agent.
2. Get the information on the **Health Care Power of Attorney/Living Will Intake Form**. Go over the health care power of attorney form with the client so that he/she is familiar with the document. Any portion of the form can be changed to suit the client; you should point out the option of putting special requests, directions or limitations in the power.
3. Draft the document and have your supervising attorney review it. After it has been approved, send a copy of the draft to your client. Call the client in about a week to make sure everything is the way he/she wants it. If everything is OK, schedule a signing.
4. Health Care Power of Attorney signing:

A. Witnesses: The document must be signed before two witnesses who:

- (1) are not related to the client;
- (2) cannot be entitled to any portion of the estate of the client under the will or under The Intestate Succession Act;
- (3) are not the client's attending physician or an employee of the attending physician;
- (4) are not an employee of the health facility where the client is a patient;
- (5) are not an employee of a nursing home or group care home where the client resides;
- (6) do not have any claim against the client.

(NOTE: This means that you cannot use employees of the clinic or hospital where the client is a patient as witnesses).

B. Notarization: The witnesses' and the client's signatures must be notarized. Be sure that each person signs in front of the notary. Many notaries will also require identification before notarizing a document, so be sure to take your driver's license or some ID with you.

C. How many copies--instructions to client

Have the client sign the original. Make 3 photocopies of the signed original. Give the client the original. Keep one photocopy for our file. With the client's permission, send one copy to the primary health care agent and the other to the primary health care provider as discussed below. Instruct the client to keep the original document with his or her valuable papers--not in a safe deposit box. Tell the client that you will be contacting

the health care agent and that you will be sending a copy of the document to his or her primary medical providers. Instruct the client further that he or she should make sure that any new medical providers have a copy of the document. Explain to the client how to revoke the document and leave written instructions re: revocation of health care powers of attorney with the client. Finally, instruct the client to consult with an attorney about the health care power of attorney is s/he moves out of NC, as each state has different requirements.

D. Copy to Health Care Agent: With the client's permission, send a photocopy of the health care power of attorney to the health care agent using our form letter.

E. Copies to Medical Providers: Once the health care power of attorney has been signed, and with the client's permission, send a copy of the document to the client's primary treating physician and to any hospital where the client has been admitted in the past two years using our form letters. (Note: If the primary health care provider is at one of the major hospitals (i.e., Duke, UNC, VA), you do not need to send the document to both the doctor and the hospital. One copy to the doctor is sufficient.

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HEALTH CARE POWER OF ATTORNEY/LIVING WILL INTAKE

Client		
Name:		
Health Care Agent		
Name		Address
Home Phone	Work Phone	Cell Phone:
Alternate Health Care Agent		
Name		Address
Home Phone	Work Phone	Cell Phone
Second Alternate Health Care Agent		
Name		Address
Home Phone	Work Phone	Cell Phone
Physicians		
Treating Physician Name(s)		Address(s)
Determination of incapacity: The client can choose a doctor to determine if s/he is incapacitated and the health care agent needs to begin making decisions. Duke Medical Center recommends that for ease and efficiency, the client leave this decision to "the attending physician" – that is, whoever is caring for the patient in the hospital or other facility.		
Who does the client want to make the determination? Name physician or "attending physician?"		
Name of physician		Place of Employment
Confirm that "doctor" is an MD, not Nurse Practitioner or Physician's Assistant <input type="checkbox"/> Yes, doctor is MD <input type="checkbox"/> No, "doctor" is not MD (Client can name "attending physician for...") <input type="checkbox"/> Not sure (ask case manager or call clinic)		
Limitations on Health Care Agent's Authority		
General Limitations (apart from End of Life care): Does the client wish to place any limitations on health care agent's authority (e.g. a client might have religious objections to certain kinds of medical treatment and would then limit the health care agents' authority with regard to those treatments)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:		
Mental Health Decisions: Does the client wish to place any limitations on health care agent's authority to make mental health treatment decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the client have an Advance Instruction for Mental Health Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Remains: Does the client wish to restrict health care agent's authority to authorize an autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No Organ Donation permitted? <input type="checkbox"/> Yes <input type="checkbox"/> No Use of body for research permitted? <input type="checkbox"/> Yes <input type="checkbox"/> No Does client wish to be <input type="checkbox"/> buried or <input type="checkbox"/> cremated		

END OF LIFE CARE --- Withholding or Withdrawal of Life-Prolonging Measures

To Students: At this point you may wish to explain “Life Prolonging Measures” in plain English: **Here’s the technical definition:** Medical procedures/interventions which would only postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function, including mechanical ventilation, dialysis, antibiotics, artificial nutrition/hydration, etc. Life-prolonging measures do not include care to provide comfort or pain relief.

Withholding of Life Support: Does the client wish to give the health care agent the power to authorize the withholding or withdrawing of life-prolonging measure? Yes No

If client is authorizing withdrawal/withholding of life support, complete this section:

When to Withhold: Under what circumstances does client want to authorize the health care agent’s authority to withhold or withdraw life-prolonging measures:

- Client has an incurable or irreversible condition that will result in death within a relatively short period of time;
- Client becomes unconscious and client’s health care providers determine that, to a high degree of medical certainty, client will never regain consciousness;
- Client suffers from advanced dementia or any other condition which results in the substantial loss of cognitive ability and client’s health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

Nutrition and Hydration: EVEN IF client does not want his/her life prolonged in the above situation(s), does the client want to receive artificial hydration and nutrition?

Nutrition Yes No Limitations? _____

Hydration Yes No Limitations? _____

If the client desires artificial nutrition or hydration, does s/he want to endorse this exception:

unless my attending physician determines that artificial [hydration or nutrition] would decrease my comfort, increase pain and distress, or increase risk of harm to me (e.g. aspiration, fluid overload or other complications) while failing to prolong my life.

May/Should: Does the client want to **mandate** withdrawal or provision of life support? Yes No

Which trumps? Does client want the health care agent to be able to override client’s instructions about life prolonging measures Yes No

All clients: Does the client have any other wishes about end-of-life care? (Please describe below)

Documents

What documents does client want? Health Care Power of Attorney Living Will

To whom does client want us to send copies of the Health Care POA and Living Will?

- Doctor(s) _____ Health Care Agent Alternate Agent
- Other: _____ Do not send copies

SUGGESTED TOPICS TO DISCUSS WITH YOUR HEALTH CARE AGENT

Before having your health care agent sign any forms, you should discuss your beliefs and wishes with him or her. When instructing your health care agent about your wishes in the event you become incapacitated and they need to make health care decisions, we suggest you consider the following questions. We suggest no particular answers. Each person should answer these questions based on their own beliefs and convey those beliefs and wishes to their health care agent. Any other wishes or desires that you feel your health care agent should know should also be given to them so that they can carry out their responsibilities as you would wish.

1. Do you think it is a good idea to sign a legal document that says what medical treatments you would want when you are dying? (This is called a "living will.")
2. Do you think you would want to have any of the following medical treatments performed on you?
 - Kidney dialysis (if your kidneys stop working).
 - Cardiopulmonary resuscitation, also called CPR (used if your heart stops beating).
 - Respirator (used if you are unable to breath on your own).
 - Artificial nutrition (used if you are unable to eat food).
 - Artificial hydration (used if you are unable to drink fluids).
3. Do you want to donate parts of your body to someone else at the time of your death? (This is called organ donation.)
4. How would you describe your current health status? If you currently have any medical problems, how would you describe them?
5. If you have any health problems, in what ways do they affect your ability to function?
6. How do you feel about your current health status?
7. If you have a doctor, do you like him or her? Why?
8. Do you think your doctor should make the final decision about any medical treatments you may need?
9. How important is independence and self-sufficiency in your life?

10. If your physical and mental abilities were decreased, how would that affect your attitude toward independence and self-sufficiency?
11. Do you expect that your friends, family and others will support your decisions regarding medical treatment you may need now or in the future?
12. What will be important to you when you are dying (physical comfort, no pain, family members present)?
13. Where would you prefer to die?
14. What is your attitude toward death?
15. How do you feel about the use of life-sustaining measures in the face of terminal illness?
16. How do you feel about life-sustaining measures in the face of a permanent coma?
17. How do you feel about the use of life-sustaining measures in the face of an irreversible chronic illness, like Alzheimer's disease?
18. What is your religious background?
19. How do your religious beliefs affect your attitude toward serious or terminal illness?
20. Does your attitude toward death find support in your religion?
21. How does your faith community, church or synagogue view the role of prayer or religious sacraments in an illness?
22. What else do you feel is important for your agent to know?

If over time your beliefs or attitudes in any area change, you should let your Health Care Agent know. You should also let your health care agent know of any changes in your health. In the event you are informed of a terminal illness, you should discuss this with your agent. How well your agent performs depends on how well you have prepared him or her.

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

***EXPLANATION:** This document gives the person you designate as your health care agent **broad powers** to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not require your health care agent to use the powers you give, but when a power is used, your health care agent must use due care to act in your best interests and according to your wishes expressed in this document.

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

Name: _____

Home Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Cell Telephone Number: _____

Name: _____
 Home Address: _____
 Home Telephone Number: _____
 Work Telephone Number: _____
 Cell Telephone Number: _____

Name: _____
 Home Address: _____
 Home Telephone Number: _____
 Work Telephone Number: _____
 Cell Telephone Number: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ (Physician)
 _____ (Hospital/Clinic- Town- State)

2. _____ (Physician)
 _____ (Hospital/Clinic- Town- State)

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 6 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

- A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. Employing or discharging my health care providers.
- C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.
- D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.
- E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."
- F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures. If:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES:

_____ I have an incurable or irreversible condition that will result in
(Initial) my death within a relatively short period of time.

_____ I become unconscious and my health care providers
(Initial) determine that, to a high degree of medical certainty, I
will never regain my consciousness.

_____ I suffer from advanced dementia or any other condition
(Initial) which results in the substantial loss of my cognitive
ability and my health care providers determine that, to a high
degree of medical certainty, this loss is not reversible.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

_____ A. Limitations Concerning Health Care Decisions.
 (*Initial*) In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions:

NOTE: DO NOT initial unless you insert a limitation.

_____ B. Limitations About Artificial Nutrition and Hydration.
 (*Initial*) In exercising authority to make health care decisions on my behalf, my health care agent:

Shall not have the authority to withhold either artificial hydration or artificial nutrition (for example, through tubes) **unless** my attending physician determines that artificial hydration or nutrition would decrease my comfort, increase pain and distress, or increase risk of harm to me (e.g. aspiration, fluid overload or other complications) while failing to prolong my life.

NOTE: DO NOT initial unless you insert a limitation.

_____ C. Limitations Concerning Mental Health Decisions. In
 (*Initial*) exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

NOTE: DO NOT initial unless you insert a limitation.

-
- (Initial)*
- D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):

NOTE: DO NOT initial unless you insert a limitation.

-
- (Initial)*
- E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):

NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ donate any needed organs or parts; OR
(Initial)

_____ donate only the following organs or parts:
(Initial)

NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

_____ donate my body for anatomical study if needed.
(Initial)

_____ In exercising the authority to make donations, my health care
(Initial) agent is subject to the following special provisions and
limitations: (Here you may include any specific limitations
you deem appropriate such as: limiting the grant of authority
and the scope of authority, or instructions regarding gifts of
the body or body parts.)

NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors,

assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

- A. **Revocation of Prior Powers of Attorney.** I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.
- B. **Jurisdiction, Severability, and Durability.** This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.
- C. **Health Care Agent Not Liable.** My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.
- D. **No Civil or Criminal Liability.** No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20_____.

Principal –

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

STATE OF NORTH CAROLINA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me
this day by

(type/print name of signer)

(type/print name of witness)

(type/print name of witness)

_____, Notary Public
Commission expires _____

OFFICIAL SEAL

Directive for Maximum Treatment: I do not authorize my health care agent to withdraw, withhold or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery or the cost of the procedures.

NORTH CAROLINA
COUNTY OF

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, North Carolina, am the custodial parent having custody of _____, a minor child, born _____. I authorize _____, of _____ County, North Carolina, to do any acts which may be necessary or proper to provide for the health care of my minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand fully the import of this grant of powers to the agents named herein.

This _____ day of _____, 200____.

[client's name]

NORTH CAROLINA
_____ COUNTY

Sworn to and subscribed before me this _____ day of _____ 20____.

NOTARY PUBLIC
My commission expires:_____

SEAL

[Date]

[Mr./Ms.]

Dear [Mr./Ms.]:

We have assisted [_____] in drawing up a health care power of attorney. This document, a copy of which is enclosed, appoints you as the primary "health care agent." This document gives you the legal authority to make medical care decisions for [_____] if s/he is ever mentally or physically unable to do so for himself/herself. Please read over the health care power of attorney carefully.

We recommend that you discuss this document with _____, so that you understand (his/her) wishes regarding health care decisions you might be called upon to make.

Thank you for your attention to these documents.

Sincerely,

Certified Law Student
Under the Supervision of

Supervising Attorney

Enclosure

date

Dr.
[address]

Re: [client name]
DOB: [DOB]

Dear Dr. []

We have been assisting your patient named above in preparing advance directives. We have enclosed copies of these documents to be placed in this patient's chart.

We encourage you to discuss these documents with your patient at her next appointment. If you have any questions after reviewing the documents, please do not hesitate to call. Thank you for your attention to this matter.

Sincerely,

Certified Law Student
Under the supervision of

Supervising Attorney

Encl.

Date

[address]

Re: [client name]
DOB: [DOB]

To whom it may concern:

We have been assisting this patient of your facility in preparing a health care power of attorney. We have enclosed copies of these documents to be placed in this patient's chart.

Sincerely,

Certified Law Student
Under the supervision of

Supervising Attorney

Encl.

HOW TO REVOKE A HEALTH CARE POWER OF ATTORNEY

Provided by: Duke Health Justice Clinic

There may come a time when you decide that you would like to revoke (cancel) your Health Care Power of Attorney.

A Health Care Power of Attorney may be revoked in the following ways:

1. By executing a revocation (a document saying you are revoking the Health Care Power of Attorney);
2. By executing a new Health Care Power of Attorney;
3. By any other manner so as to communicate your intent to revoke the document.
4. It is automatically terminated upon your death, except for provisions that allow your agent to make decisions about your remains.

Note: The revocation of your Health Care Power of Attorney becomes effective only upon your communication to each agent named in the document and to your attending physician.

If you have any questions about how to revoke a document we have prepared for you, please give us a call at (919) 613-7169.

A BRIEF DESCRIPTION OF . . .

THE LIVING WILL

A Living Will expresses your desire to be allowed to die when your condition is medically hopeless and you can only be kept alive by artificial nutrition and hydration (“tube feeding”) or by extraordinary means (any medical care that artificially prolongs death—a breathing machine is one example). Your doctor will turn to your Living Will for guidance only if you are mentally unable to make your own health care decisions.

A Living Will does not allow a doctor to “pull the plug” on you if there is *any realistic chance* that you might recover to the point where you no longer need tube feeding or life support.

You have several choices about how your Living Will should work: (1) You can require your doctor to follow your Living Will; (2) You can allow but not require your doctor to follow your Living Will; or (3) You can appoint someone besides your doctor to make the decision about withholding life support if you are mentally incompetent. Ask your law student about a Health Care Power of Attorney.

If you have a Living Will, it will be kept with your medical records, but you should also tell your doctor(s) that you have one and discuss the document with him or her.

If you have any questions about Living Wills, ask your law student. He or she can explain the document to you, or can tailor it to your specific needs.

LIVING WILL PROTOCOL

1. Explain living will at initial meeting. Go over the living will form with the client so that he or she is familiar with the document. Get the information on the **Health Care Power of Attorney/Living Will Intake Form**.

2. Draft the document and have your supervising attorney review it. When it has been approved, send the draft to the client along with any other documents you have drafted. Call your client to make sure everything is as he/she wants it and schedule a time for the signing.

3. Living Will signing:

A. Witnesses: The document must be signed before two witnesses who:

- (1) are not related to the client;
- (2) are not entitled to any portion of the estate of the client under the will or under The Intestate Succession Act;
- (3) are not the client's attending physician or an employee of the attending physician;
- (4) are not employees of the health facility where the client is a patient;
- (5) are not employees of a nursing home or group care home where the client resides;
- (6) do not have any claims against the client.

(NOTE: This means that you cannot use employees of the clinic or hospital where the client is a patient as witnesses; nor can you use employees of Blevins House as witnesses. You may use unpaid volunteers or other clinic students as witnesses).

B. Notarization: The witnesses' and the client's signatures must be notarized. Be sure that each person signs in front of the notary. Many notaries will also require identification before notarizing a document, so be sure to take your driver's license or some ID with you.

C. How many copies--instructions to client

After the client signs the original, make one copy. Give the client the original. Instruct the client to keep the original document with his or her valuable papers--not in a safe deposit box. Instruct the client further that he or she should make sure that any new medical providers have a copy of the document. Explain to the client how to revoke the document: A living will can be revoked in any manner by which the declarant is able to communicate his intent to revoke, without regard to his mental or physical condition. The revocation is only effective upon communication to the attending physician by the declarant or by an individual acting on behalf of the declarant. See N.C. G. S. 90-321(e). Finally, instruct the client to consult with an attorney about the living will if he or she moves out of NC, as each state has different requirements.

D. Copies to Medical Providers and Health Care Agents: Keep one copy for our files. With the client's permission, make additional copies and send one copy to the primary health care agent (if there is one) along with the health care power or attorney (see instructions for health care power of attorney). Send the another copy to his or her primary medical provider along with the health care power of attorney. If the doctor is not at one of the major hospitals (i.e., Duke, UNC, or VA), and the client has been hospitalized in a local hospital in the past two years, also send a copy to that hospital.

ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

***GENERAL INSTRUCTIONS:** This Advance Directive ("Living Will") gives instructions for the future to your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices.*

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply **IF** my attending physician (designated in my Health Care Power of Attorney) determines that I lack capacity to make or communicate health care decisions **AND**:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

- _____ I have an incurable or irreversible condition that will
(Initial) result in my death within a relatively short period of time.

- _____ I become unconscious and my health care providers
(Initial) determine that, to a high degree of medical certainty, I will never regain my consciousness.

- _____ I suffer from advanced dementia or any other
(Initial) condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ **may** withhold or withdraw life-prolonging measures.
(Initial)

OR

_____ **shall** withhold or withdraw life-prolonging measures.
(Initial)

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ I *DO* want to receive BOTH artificial hydration AND artificial
(Initial) nutrition (for example, through tubes) in those situations **unless**
my attending physician determines that artificial hydration or
nutrition would decrease my comfort, increase pain and distress, or
increase risk of harm to me (e.g. aspiration, fluid overload or other
complications) while failing to prolong my life.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

(Initial) Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

OR

(Initial) Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE: DO NOT INITIAL BOTH BLOCKS. IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

Signature of
Declarant _____

Type/Print Name _____

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____

Witness: _____

Date: _____

Witness: _____

STATE OF NORTH CAROLINA

_____ COUNTY

Sworn to (or affirmed) and subscribed before me this day by

(type/print name of declarant)

(type/print name of witness)

(type/print name of witness)

Date _____

Signature of Notary Public

Printed or typed name of Notary Public

(Official Seal)

My commission expires: _____

Document Signing Instructions

Please call the Duke Health Justice Clinic at 919-613-7169 with any questions

Thank you for agreeing to assist our client with the signing of his/her legal documents. Please follow these instructions to insure that the documents can take effect.

It is recommended that any person who is named in the documents (for example as executor of the will, beneficiary in the will, agent in the power of attorney) be excluded from the room while the documents are being signed.

Will:

A will must be signed in the presence of two witnesses (age 18 or older) and a notary public. The witnesses should not be relatives and should not be anyone who will receive property under the will. By signing, the witnesses are attesting to the fact that the person signing the will is who he says he is, is mentally competent and is signing the will freely and voluntarily. The witnesses need not read the will or be aware of the contents of the will. The witnesses' signatures will also be notarized, so they should have identification available for the notary.

Procedure: The client should have the original document ready to be signed. Before the witnesses and notary are gathered, check with the client to make sure the client is satisfied with the contents of the will. If the client has any questions or concerns about the contents, please give us a call and do not proceed with the signing. When the client is ready to sign, gather the witnesses and notary together and, in their presence, ask the client the following questions:

1. What is the document you are about to sign?
2. Have you reviewed it carefully?
3. Does it reflect your desires about how your property will pass after your death?
4. Is anyone pressuring you to sign this will?
5. Do you want these people to witness your signing of this will?

Note: if the client does not identify the document as his/her will, indicates that he/she has not read it, states that it does not reflect his/her desires, or that someone is forcing him/her to sign, do not proceed with the signing. Please call the Duke Health Justice Clinic.

After the questions are answered, the client should sign the will in the space provided, then the witnesses should sign. Then the notary public should notarize everyone's signatures. Make sure the will is dated (above the client's signature) and that the notary fills in the county above his/her notarization.

Copies: Review the will to make sure all the blanks have been filled in. Then make two photocopies of the will. Give the original and one copy to the client and mail one copy to the Duke Health Justice Clinic, Box 90360, Durham NC 27708-0360. Remind the client to keep the

will in a safe place –but not in a safe deposit box – and let his or her executor know where the original will be kept. The client may wish to give the copy to his or her executor.

Health Care Power of Attorney:

A health care power of attorney must be signed in the presence of two witnesses (age 18 or older) and a notary public. The witnesses may not be:

- a relative of the client,
- anyone who expects to receive anything under the client’s will,
- the client’s doctor or any employee of the client’s doctor,
- an employee of a health facility in which the client is or was a patient,
- an employee of a nursing home or any group-care home in which the client resides, or
- anyone with any kind of financial claim against the client.

Procedure: The client should have the original document ready to be signed. Before the witnesses and notary are gathered, check with the client to make sure the client is satisfied with the contents of the health care power of attorney. If the client has any questions or concerns about the contents, please give us a call and do not proceed with the signing. When the client is ready to sign, gather the witnesses and notary together and, in their presence, ask the client the following questions:

1. What is the document you are about to sign?
2. Have you reviewed it carefully?
3. Does it reflect your desires about who should make medical decisions for you should you be unable to make them for yourself?

Note: If the client does not understand what the document is or that he/she is appointing someone to make medical decisions for him/her during any period of incompetency, do not proceed with the signing. Call the Health Justice Clinic

Have the client sign in the space provided, and then have the witnesses sign in the spaces provided. Then have the notary notarize all the signatures. Be sure the document is dated above the client’s signature.

The form has a place for the health care agent to sign on the last page. This signature is not required in order for the document to take legal effect. Obtain the signature if you can, but proceed with the other signatures even if the agent is unavailable.

Copies: Review the health care power of attorney to make sure all the blanks have been filled in. Then make two photocopies. Give the original and one copy to the client and mail one copy to the Duke Health Justice Clinic, Box 90360, Durham NC 27708-0360. The client should give his/her copy to the chosen agent. We will mail a copy to the client’s doctor to be placed in the client’s medical chart.

Living Will:

A living will must be signed in the presence of two witnesses (age 18 or older) and a notary public. The witnesses may not be:

- a relative of the client,
- anyone who expects to receive anything under the client's will,
- the client's doctor or any employee of the client's doctor,
- an employee of a health facility in which the client is or was a patient,
- an employee of a nursing home or any group-care home in which the client resides, or
- anyone with any kind of financial claim against the client.

Procedure: The client should have the original document ready to be signed. Before the witnesses and notary are gathered, check with the client to make sure the client is satisfied with the contents of the living will. If the client has any questions or concerns about the contents, please give us a call and do not proceed with the signing. When the client is ready to sign, gather the witnesses and notary together and, in their presence, ask the client the following questions:

1. What is the document you are about to sign?
2. Have you reviewed it carefully?
3. Does it reflect your desire not to be kept alive by extraordinary means if you are in a persistent vegetative state or in a condition that is terminal and incurable?

Note: If the client does not understand what the document is or what it means, do not proceed with the signing. Call the Health Justice Clinic.

Have the client sign in the space provided, and then have the witnesses sign in the spaces provided. Then have the notary notarize all the signatures. Be sure the document is dated above the client's signature.

Copies: Review the living will to make sure all the blanks have been filled in. Then make two photocopies. Give the original and one copy to the client and mail one copy to the Duke Health Justice Clinic, Box 90360, Durham NC 27708-0360. The client should give his/her copy to his/her health care agent if he/she has one; if not to his/her closest family member. We will mail a copy to the client's doctor to be placed in the client's medical chart.

Power of Attorney:

The power of attorney must be signed in the presence of a notary public. The power of attorney does not require witnesses.

Procedure: The client should have the original document ready to be signed. Before the notary is present, check with the client to make sure the client is satisfied with the contents of the power of attorney. If the client has any questions or concerns about the contents, please give us a call and do not proceed with the signing. When the client is ready to sign, ask the client the following questions:

1. What is the document you are about to sign?
2. Have you reviewed it carefully?
3. Does it reflect your desires about who has the power to handle your financial affairs?

Note: If the client does not understand what the document is or that he/she is appointing someone to handle his or her financial affairs, do not proceed with the signing. Call the Health Justice Clinic.

The client should sign and date the power of attorney and the notary should notarize it.

Copies: Review the power of attorney to make sure all the blanks are filled in. Then make two photocopies of the power of attorney. Give the original and one copy to the client and mail one to the Duke Health Justice Clinic, Box 90360, Durham, NC 27708-0360. We will be in contact with the client about recording the power of attorney with the Register of Deeds.