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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.

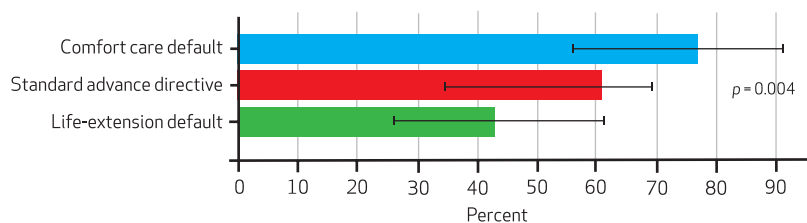
Completed advance directives were returned by ninety-five patients (72.0 percent), only two of whom (2.1 percent) elected to reconsider their choices during the debriefing. One of these patients returned a new advance directive in which the only change was his selection of a new durable power of attorney; 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

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).

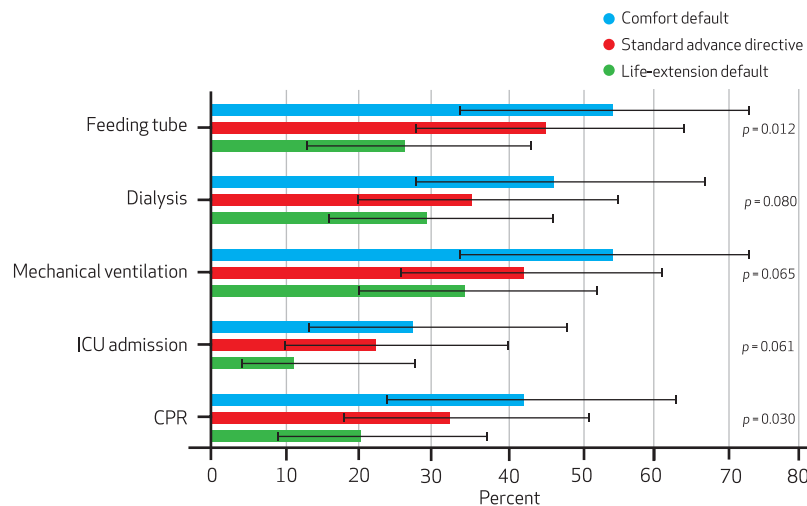
CHOICES TO RECEIVE POTENTIALLY LIFE-SUSTAINING INTERVENTIONS Patients completing different advance directive versions also had different probabilities of choosing to forgo potentially life-sustaining interventions. For example, the proportions of patients choosing to forgo feeding-tube insertion were 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

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.

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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NOTES

- 1 Fried TR, Bradley EH, Towle VR, Allore H. Understanding the treatment preferences of seriously ill patients. *N Engl J Med.* 2002;346(14):1061–6.
- 2 Halpern SD. Shaping end-of-life care: behavioral economics and advance directives. *Semin in Respir Crit Care Med.* 2012;33:393–400.
- 3 Blinderman CD, Krakauer EL, Solomon MZ. Time to revise the approach to determining cardiopulmonary resuscitation status. *JAMA.* 2012;307(9):917–8.
- 4 White DB, Arnold RM. The evolution of advance directives. *JAMA.* 2011;306(13):1485–6.
- 5 Schroeder SA. Personal reflections on the high cost of American medical care. *Arch Intern Med.* 2011;171:722–7.
- 6 Neuman MD. Surgeons' decisions and the financial and human costs of medical care. *N Engl J Med.* 2010;363(25):2382–3.
- 7 Halpern SD, Emanuel EJ. Advance directives and costs of care: greater clarity and perpetual confusion. *Arch Intern Med.* 2012;172:266–8.
- 8 Aging with Dignity. Five wishes [Internet]. Tallahassee (FL): Aging with Dignity; [cited 2012 Mar 13]. Available from: <http://www.agingwithdignity.org/forms/5wishes.pdf>
- 9 Krosnick JA, Alwin DF. An evaluation of a cognitive theory of response-order effects in survey measurement. *Public Opinion Quarterly.* 1987;51(2):201–19.
- 10 Bishop GF, Smith AE. Response-order effects in public opinion surveys: the plausibility of rival hypotheses [Internet]. Papers presented at: 52nd Annual Conference of the American Association for Public Opinion Research, Survey Research Methods Section, Norfolk, Virginia, 1997 May 15–18 [cited 2013 Jan 22]. Available from: http://www.amstat.org/sections/srms/Proceedings/papers/1997_179.pdf
- 11 Wolf SM, Boyle P, Callahan D, Fins JJ, Jennings B, Nelson JL, et al. Sources of concern about the Patient Self-Determination Act. *N Engl J Med.* 1991;325(23):1666–71.
- 12 Silveira MJ, Kim SYH, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med.* 2010;362(13):1211–8.
- 13 Kressel LM, Chapman GB. The default effect in end-of-life medical treatment preferences. *Med Decis Making.* 2007;27(3):299–310.
- 14 Kressel LM, Chapman GB, Leventhal E. The influence of default options on the expression of end-of-life treatment preferences in advance directives. *J Gen Intern Med.* 2007;22:1007–10.
- 15 Slovic P. The construction of preference. *Am Psychol.* 1995;50:364–71.
- 16 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 17 Allegheny County Medical Society. Advance health care directive: health care power of attorney and living will [Internet]. Pittsburgh (PA): The Society; 2009 [cited 2013 Jan 9]. Available from: <http://www.acba.org/Public/Legal-information/LivingWillPoweroAttyform.pdf>
- 18 Knaus WA, Connors AF, Dawson NV, Desbiens NA, Fulkerson WJ, Goldman L, et al. A controlled trial to improve care for seriously ill hospitalized-patients—the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA.* 1995;274(20):1591–8.
- 19 Miller FG, Gluck JP, Wendler D. Debriefing and accountability in deceptive research. *Kennedy Inst Ethics J.* 2008;18(3):235–51.
- 20 Heyland DK, Cook DJ, Rocker GM, Dodek PM, Kutsogiannis DJ, Skrobik Y, et al. The development and validation of a novel questionnaire to measure patient and family satisfaction with end of life care: the Canadian Health care Evaluation Project (CANHELP) Questionnaire. *Palliat Med.* 2010;24(7):682–95.
- 21 Heyland DK, Frank C, Tranmer J, Paul N, Pichora D, Jiang XR, et al. Satisfaction with end-of-life care: a longitudinal study of patients and their family caregivers in the last months of life. *J Palliat Care.* 2009;25(4):245–56.
- 22 Localio AR, Berlin J, Ten Have TR, Kimmel SE. Adjustments for center in multicenter studies: an overview. *Ann Intern Med.* 2001;135(2):112–23.
- 23 Carroll GD, Choi JJ, Laibson D, Madrian BC, Metrick A. Optimal defaults and active decisions. *Q J Econ.* 2009;124(4):1639–74.
- 24 Halpern SD, Ubel PA, Asch DA. Harnessing the power of default options to improve health care. *N Engl J Med.* 2007;357(13):1340–4.
- 25 Johnson EJ, Hershey JC, Meszaros J, Kunreuther H. Framing, probability distortions, and insurance decisions. *J Risk Uncertain.* 1993;7:35–51.
- 26 Choi JJ, Laibson D, Madrian BC, Metrick A. Defined contribution pensions: plan rules, participant decisions, and the path of least resistance. In: Poterba JM, editor. *Tax policy and the economy.* Vol. 16. Cambridge (MA): MIT Press; 2002. p. 67–113.
- 27 Madrian BC, Shea DF. The power of suggestion: inertia in 401(k) participation and savings behavior. *Q J Econ.* 2001;116(4):1149–87.
- 28 Chapman GB, Li M, Colby H, Yoon H. Opting in vs. opting out of influenza vaccination. *JAMA.* 2010;304(1):43–4.
- 29 Horvat LD, Cuerden MS, Kim SJ, Koval JJ, Young A, Garg AX. Informing the debate: rates of kidney transplantation in nations with presumed consent. *Ann Intern Med.* 2010;153(10):641–68.
- 30 Johnson EJ, Goldstein D. Do defaults save lives? *Science.* 2003;302(5649):1338–9.
- 31 Loewenstein G, Brennan T, Volpp KG. Asymmetric paternalism to improve health behaviors. *JAMA.* 2007;298(20):2415–7.
- 32 Camerer C, Issacharoff S, Loewenstein G, O'Donoghue T, Rabin M. Regulation for conservatives: behavioral economics and the case for asymmetric paternalism. *Univ PA Law Rev.* 2003;151(3):1211–54.
- 33 Azoulay E, Pochard F, Kentish-Barnes N, Chevret S, Aboab J, Adrie C, et al. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med.* 2005;171(9):987–94.
- 34 Wendler D, Rid A. Systematic review:

- the effect on surrogates of making treatment decisions for others. *Ann Intern Med.* 2011;154(5):336–46.
- 35 Wright AA, Zhang BH, Ray A, Mack JW, Trice E, Balboni T, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA.* 2008;300(14):1665–73.
- 36 Terry PB, Vettese M, Song J, Forman J, Haller KB, Miller DJ, et al. End-of-life decision making: when patients and surrogates disagree. *J Clin Ethics.* 1999;10(4):286–93.
- 37 Singer PA, Martin DK, Lavery JV, Thiel EC, Kelner M, Mendelssohn DC. Reconceptualizing advance care planning from the patient's perspective. *Arch Intern Med.* 1998; 158(8):879–84.
- 38 Mead GE, O'Keeffe ST, Jack CI, Maestri-Banks AM, Playfer JR, Lye M. What factors influence patient preferences regarding cardiopulmonary resuscitation? *J R Coll Physicians Lond.* 1995;29(4):295–8.
- 39 Steinhilber AE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA.* 2000;284(19):2476–82.
- 40 Sudore RL, Fried TR. Redefining the "planning" in advance care planning: preparing for end-of-life decision making. *Ann Intern Med.* 2010;153(4):256–61.
- 41 Kirchhoff KT, Hammes BJ, Kehl KA, Briggs IA, Brown RL. Effect of a disease-specific planning intervention on surrogate understanding of patient goals for future medical treatment. *J Am Geriatr Soc.* 2010; 58(7):1233–40.
- 42 Degenholtz HB, Rhee Y, Arnold RM. Brief communication: the relationship between having a living will and dying in place. *Ann Intern Med.* 2004 Jul;141(2):113–7.
- 43 Teno JM, Gruneir A, Schwartz Z, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J Am Geriatr Soc.* 2007;55(2):189–94.
- 44 Nicholas LH, Langa KM, Iwashyna TJ, Weir DR. Regional variation in the association between advance directives and end-of-life Medicare expenditures. *JAMA.* 2011;306(13): 1447–53.
- 45 Blumenthal-Barby JS, Burroughs H. Seeking better health care outcomes: the ethics of using the "nudge." *Am J Bioeth.* 2012;12(2):1–10.
- 46 Quill CM, Halpern SD. Deciphering the appropriateness of defaults: the need for domain-specific evidence. *J Med Ethics.* 2012;38(12):721–2.

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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

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

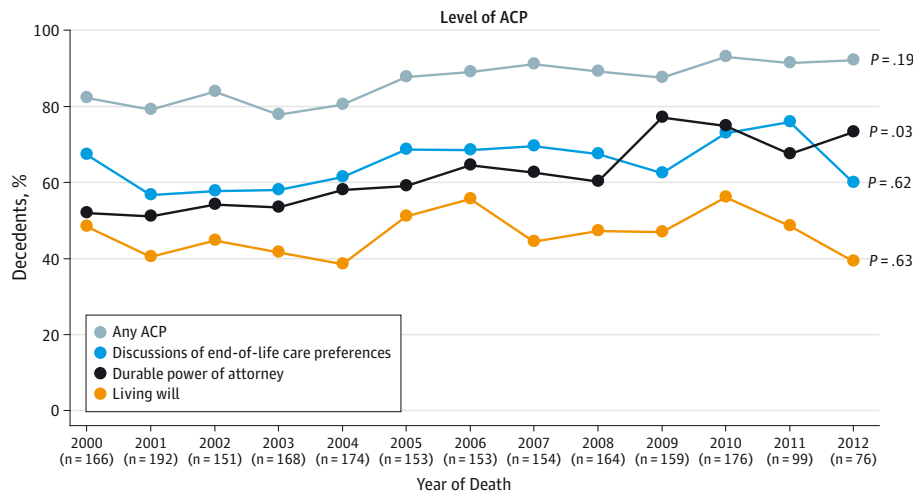


Figure 2. Adjusted Yearly Percentages of End-of-Life (EOL) Treatment Intensity Over Time

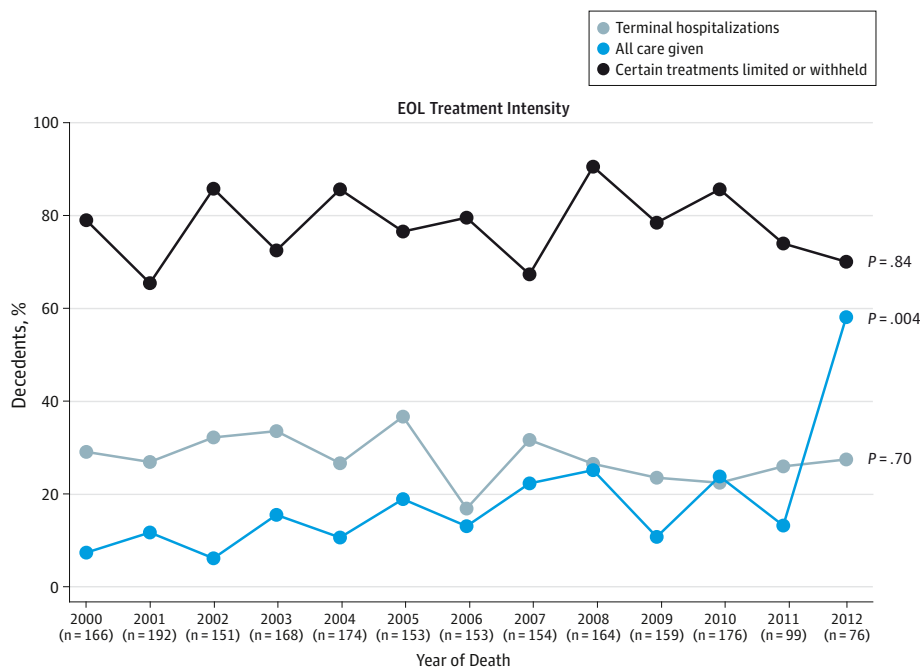


Table 2. Associations Between ACP and EOL Treatment Intensity^a

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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REFERENCES

1. Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: The National Academies Press; 2014.
2. Centers for Disease Control and Prevention. Leading causes of death. <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>. Accessed December 1, 2014.
3. Teno JM, Weitzen S, Fennell ML, Mor V. Dying trajectory in the last year of life: does cancer trajectory fit other diseases? *J Palliat Med*. 2001;4(4):457-464.
4. Lunney JR, Lynn J, Foley DJ, Lipson S, Guralnik JM. Patterns of functional decline at the end of life. *JAMA*. 2003;289(18):2387-2392.
5. Levy MH, Weinstein SM, Carducci MA; NCCN Palliative Care Practice Guidelines Panel. NCCN: Palliative care. *Cancer Control*. 2001;8(6)(suppl 2):66-71.
6. American Society of Clinical Oncology. Cancer care during the last phase of life. *J Clin Oncol*. 1998;16(5):1986-1996.
7. Peppercorn JM, Smith TJ, Helft PR, et al; American Society of Clinical Oncology. American society of clinical oncology statement: toward individualized care for patients with advanced cancer. *J Clin Oncol*. 2011;29(6):755-760.
8. Levy MH, Smith T, Alvarez-Perez A, et al. Palliative care, Version 1.2014: featured updates to the NCCN Guidelines. *J Natl Compr Canc Netw*. 2014;12(10):1379-1388.
9. Morden NE, Chang CH, Jacobson JO, et al. End-of-life care for Medicare beneficiaries with cancer is highly intensive overall and varies widely. *Health Aff (Millwood)*. 2012;31(4):786-796.
10. Teno JM, Gozalo PL, Bynum JP, et al. Change in end-of-life care for Medicare beneficiaries: site of death, place of care, and health care transitions in 2000, 2005, and 2009. *JAMA*. 2013;309(5):470-477.

11. Goodman DC, Fisher ES, Chang C, et al. Quality of end-of-life cancer care for Medicare beneficiaries: Regional and hospital-specific analyses: a report of the Dartmouth Atlas Project. <http://www.rwjf.org/en/library/research/2010/11/quality-of-end-of-life-cancer-care-for-medicare-beneficiaries.html>. Accessed May 26, 2015.
12. Goodman D, Morden N, Chang C, Fisher E, Wennberg J. Trends in cancer care near the end of life: a Dartmouth Atlas health care brief. <http://www.rwjf.org/en/library/research/2013/09/trends-in-cancer-care-near-the-end-of-life.html>. Accessed May 26, 2014.
13. Miesfeldt S, Murray K, Lucas L, Chang CH, Goodman D, Morden NE. Association of age, gender, and race with intensity of end-of-life care for Medicare beneficiaries with cancer. *J Palliat Med*. 2012;15(5):548-554.
14. Anthony DL, Herndon MB, Gallagher PM, et al. How much do patients' preferences contribute to resource use? *Health Aff (Millwood)*. 2009;28(3):864-873.
15. Earle CC, Neville BA, Landrum MB, Ayanian JZ, Block SD, Weeks JC. Trends in the aggressiveness of cancer care near the end of life. *J Clin Oncol*. 2004;22(2):315-321.
16. Barnato AE, Chang CC, Farrell MH, Lave JR, Roberts MS, Angus DC. Is survival better at hospitals with higher "end-of-life" treatment intensity? *Med Care*. 2010;48(2):125-132.
17. Brooks GA, Li L, Sharma DB, et al. Regional variation in spending and survival for older adults with advanced cancer. *J Natl Cancer Inst*. 2013;105(9):634-642.
18. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. 2008;300(14):1665-1673.
19. Wright AA, Hatfield LA, Earle CC, Keating NL. End-of-life care for older patients with ovarian cancer is intensive despite high rates of hospice use. *J Clin Oncol*. 2014;32(31):3534-3539.
20. Zhang B, Wright AA, Huskamp HA, et al. Health care costs in the last week of life: associations with end-of-life conversations. *Arch Intern Med*. 2009;169(5):480-488.
21. Juster FT, Suzman R. An overview of the Health and Retirement Study. *J Hum Resour*. 1995;30(suppl):S7-S56.
22. Sonnega A, Faul JD, Ofstedal MB, Langa KM, Phillips JW, Weir DR. Cohort profile: the Health and Retirement Study (HRS). *Int J Epidemiol*. 2014;43(2):576-585.
23. Health and Retirement Study: sample sizes and response rates. <http://hrsonline.isr.umich.edu/sitedocs/sampleresponse.pdf>. Accessed December 1, 2014.
24. Wright AA, Keating NL, Balboni TA, Matulonis UA, Block SD, Prigerson HG. Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. *J Clin Oncol*. 2010;28(29):4457-4464.
25. Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med*. 2010;362(13):1211-1218.
26. Nicholas LH, Langa KM, Iwashyna TJ, Weir DR. Regional variation in the association between advance directives and end-of-life Medicare expenditures. *JAMA*. 2011;306(13):1447-1453.
27. Heeringa S, Connor J. *Technical Description of the Health and Retirement Study Sample Design*. Ann Arbor, MI: University of Michigan, Survey Research Center at the Institute for Social Research; 2011.
28. US Census Bureau. Current Population Survey. <http://www.census.gov/cps>. Accessed December 1, 2014.
29. Kerr CW, Donohue KA, Tangeman JC, et al. Cost savings and enhanced hospice enrollment with a home-based palliative care program implemented as a hospice-private payer partnership. *J Palliat Med*. 2014;17(12):1328-1335.
30. Kelly RJ, Smith TJ. Delivering maximum clinical benefit at an affordable price: engaging stakeholders in cancer care. *Lancet Oncol*. 2014;15(3):e112-e118.
31. Ahluwalia SC, Chuang FL, Antonio AL, Malin JL, Lorenz KA, Walling AM. Documentation and discussion of preferences for care among patients with advanced cancer. *J Oncol Pract*. 2011;7(6):361-366.
32. Mack JW, Weeks JC, Wright AA, Block SD, Prigerson HG. End-of-life discussions, goal attainment, and distress at the end of life: predictors and outcomes of receipt of care consistent with preferences. *J Clin Oncol*. 2010;28(7):1203-1208.
33. Mack JW, Cronin A, Keating NL, et al. Associations between end-of-life discussion characteristics and care received near death: a prospective cohort study. *J Clin Oncol*. 2012;30(35):4387-4395.
34. Bisognano M, Goodman E. Engaging patients and their loved ones in the ultimate conversation. *Health Aff (Millwood)*. 2013;32(2):203-206.
35. Gundersen Health System. Respecting Choices advance care planning. <http://www.gundersenhealth.org/respecting-choices>. Accessed December 1, 2014.
36. Personalize Your Care Act of 2013. H.R.1173, 113th Congress, 1st Session (2013).
37. Medicare Choices Empowerment and Protection Act. S 2240, 113th Congress, 2nd Session (2014).
38. Vig EK, Taylor JS, Starks H, Hopley EK, Fryer-Edwards K. Beyond substituted judgment: How surrogates navigate end-of-life decision-making. *J Am Geriatr Soc*. 2006;54(11):1688-1693.
39. Vig EK, Starks H, Taylor JS, Hopley EK, Fryer-Edwards K. Surviving surrogate decision-making: what helps and hampers the experience of making medical decisions for others. *J Gen Intern Med*. 2007;22(9):1274-1279.
40. Fried TR, O'Leary JR. Using the experiences of bereaved caregivers to inform patient- and caregiver-centered advance care planning. *J Gen Intern Med*. 2008;23(10):1602-1607.
41. Schenker Y, White DB, Arnold RM. What should be the goal of advance care planning? *JAMA Intern Med*. 2014;174(7):1093-1094.
42. Schenker Y, Barnato A. Expanding support for "upstream" surrogate decision making in the hospital. *JAMA Intern Med*. 2014;174(3):377-379.
43. Song MK, Kirchhoff KT, Douglas J, Ward S, Hammes B. A randomized, controlled trial to improve advance care planning among patients undergoing cardiac surgery. *Med Care*. 2005;43(10):1049-1053.
44. Kirchhoff KT, Hammes BJ, Kehl KA, Briggs LA, Brown RL. Effect of a disease-specific planning intervention on surrogate understanding of patient goals for future medical treatment. *J Am Geriatr Soc*. 2010;58(7):1233-1240.
45. Gillick MR. The critical role of caregivers in achieving patient-centered care. *JAMA*. 2013;310(6):575-576.
46. Rocque GB, Barnett AE, Illig LC, et al. Inpatient hospitalization of oncology patients: are we missing an opportunity for end-of-life care? *J Oncol Pract*. 2013;9(1):51-54.
47. Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer. *JAMA*. 2014;312(18):1888-1896.
48. Hui D, Elsayem A, De la Cruz M, et al. Availability and integration of palliative care at US cancer centers. *JAMA*. 2010;303(11):1054-1061.
49. Hui D, Kim SH, Roquemore J, Dev R, Chisholm G, Bruera E. Impact of timing and setting of palliative care referral on quality of end-of-life care in cancer patients. *Cancer*. 2014;120(11):1743-1749.
50. Lopez-Acevedo M, Havrilesky LJ, Broadwater G, et al. Timing of end-of-life care discussion with performance on end-of-life quality indicators in ovarian cancer. *Gynecol Oncol*. 2013;130(1):156-161.
51. Smith AK, Earle CC, McCarthy EP. Racial and ethnic differences in end-of-life care in fee-for-service Medicare beneficiaries with advanced cancer. *J Am Geriatr Soc*. 2009;57(1):153-158.
52. Loggers ET, Maciejewski PK, Paulk E, et al. Racial differences in predictors of intensive end-of-life care in patients with advanced cancer. *J Clin Oncol*. 2009;27(33):5559-5564.
53. Phelps AC, Maciejewski PK, Nilsson M, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA*. 2009;301(11):1140-1147.
54. Fischer SM, Sautia A, Min SJ, Kutner J. Advance directive discussions: lost in translation or lost opportunities? *J Palliat Med*. 2012;15(1):86-92.
55. US Department of Health and Human Services. Administration on Aging: a profile of older Americans. http://www.aoa.acl.gov/Aging_Statistics/Profile/index.aspx. Accessed December 1, 2014.
56. Garrido MM, Harrington ST, Prigerson HG. End-of-life treatment preferences: a key to reducing ethnic/racial disparities in advance care planning? *Cancer*. 2014;120(24):3981-3986.
57. Teno JM. Measuring end-of-life care outcomes retrospectively. *J Palliat Med*. 2005;8(suppl 1):S42-S49.
58. McPherson CJ, Addington-Hall JM. Judging the quality of care at the end of life: can proxies provide reliable information? *Soc Sci Med*. 2003;56(1):95-109.
59. Bischoff KE, Sudore R, Miao Y, Boscardin WJ, Smith AK. Advance care planning and the quality of end-of-life care in older adults. *J Am Geriatr Soc*. 2013;61(2):209-214.
60. Tang ST, McCorkle R. Use of family proxies in quality of life research for cancer patients at the end of life: a literature review. *Cancer Invest*. 2002;20(7-8):1086-1104.

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.

DOCUMENTS PROTOCOLS

In the Health Justice Clinic we offer four documents to clients. Clients decide which documents they would like us to prepare for them. The four documents are:

- Will
- Power of Attorney
- Health Care Power of Attorney
- Living Will

We meet documents clients in two settings. Some clients are referred directly to our office and we meet with them at the clinic office or at a medical appointment in the Triangle area. Other clients come to us through “road trips,” where a group of clinic students visit a clinic or AIDS services organization outside the local area and see a number of clients in one day. The process for handling documents cases vary slightly in these two situations and we note below where they are different.

1. **Initial Client Contact:** The first step in handling a documents case is contacting the client to arrange the initial interview. Clients usually will have already been screened through our case intake system and entered into Clio, but in some cases, including with road trip clients, you may be asked to do an initial intake (gathering name, address, and other basic information).

Scheduling: After the client has been entered into Clio, you will schedule an initial in-person interview with the client to gather information for all the documents the client wants. We try to schedule interviews at the law school, but due to client illness or transportation limitations, we often schedule those interviews at medical appointments or sometimes at a community agency that is accessible to the client. In rare occasions, we will do an initial interview at a hospital in-patient setting or patient’s home. Consult with your supervising attorney about the appropriate meeting location. You will conduct the interview on your own, and the supervising attorney will only join the interview if there are particularly difficult questions, or if the interview is at the client’s home.

Occasionally, when the client lives far from Durham and does not have any medical appointments in the area in the near future, we will schedule the interview over the telephone to save the client a long trip to Durham. This is not an optimal way to do an interview, so we try to avoid a telephone interview if at all possible.

Before the Interview:

- Inform the supervising attorney of the date/time of the interview. Although you will do the interview on your own, if possible, we like to be available to meet the client briefly and answer any questions for which you need back-up.
- Send the client an *Appointment Confirmation Letter*, enclosing *Brief Explanations* of the documents.
- If you are meeting at the law school, send directions and a parking pass.
- The letter can be sent by snail mail or, if the client is a regular user of email, via email.
- If you are working with two related clients (partners or spouses), prepare and send the *Joint Representation Agreement*
- Schedule a meeting room.
- Call the client a day or two before the appointment to confirm that they will be coming.

2. **The Interview:** The documents interview usually takes between 1.5 and 2 hours. At the interview, explain each of the four documents we offer, determine which documents the client would like, and gather information for all documents. There are three intake/questionnaire forms for documents:

- Will interview questionnaire
- Power of Attorney Intake
- Healthcare Power of Attorney/Living Will Intake

Prior to the interview, print out a blank copy of each interview form, and review the forms carefully so you understand all the questions you will be asking. It is helpful to also have your binder available in the interview so you can refer to documents forms and other references.

As you will learn, during the interview you will gather information about the client, the important people in her or her life, the client's goals with regard to their estate plan and directives, and the specific details needed to prepare each of the desired documents. Be sure to have a conversation with the client about these issues instead of just filling out the intake forms. But do make sure you gather all the information requested on the intake forms.

At the end of the interview, let the client know that you will be discuss their documents with your supervising attorney, prepare draft documents and send them to the client, contact them to go over the documents, and schedule a second meeting at which the documents will be executed. Also, let the client know the time frame for completing the drafts and executing the documents. This will vary depending on your schedule and the client's, but generally you should plan to have drafts sent to the client for their review within a week or two after the interview.

3. **After the interview:** Follow these steps after the interview.

- **Scan the hand-filled interview intake forms** into ONE document and upload that document to the client's case in Clio. Name it, "Completed documents intakes."
- **Prepare a detailed opening memo**, using the *Opening Memo – Documents* template. This is the document to which your supervising attorney will refer when they are reviewing the drafts of your documents, so it should have every little piece of information that they will need to understand the client's situation and review the documents.
- **Discuss any questions about the case** with your supervising attorney.
- **Call the client with follow-up questions** if you or your supervising attorney have follow-up questions or need additional information.
- **Prepare draft documents**, using the templates on the Clinic webpage, and upload them to Clio for review by the supervising attorney.
- **Make any edits/corrections** based on supervisor review and send the copies to the client by their preferred method – either snail mail or email – along with a cover letter asking the client to review the documents carefully and stating that you will call them in about a week to discuss the drafts.
- **Call the client and go over the documents.** Check the spellings of all names! This is the most common error in documents.
- **Make any changes based on client's review.** If the changes are major, send the client the revised version (after supervisor review).

- **Schedule appointment for executing the documents.**
- **Make sure you have witnesses and a notary available.** The documents will require witnesses and a notary. You and another student can be the witnesses. One of the supervising attorneys or Sandra Pettiford can notarize. If you are doing a signing at a clinic or other off-campus location, you will need to arrange to bring another Health Justice Clinic student as a witness (the student can log these hours). You will also need to make arrangements for a notary at the signing location. In some cases, the only option will be to bring your supervising attorney to notarize. Let the client know that the notary will require picture ID, so make sure your client brings picture ID.

4. Executing the documents:

- **Make sure you are familiar with the signing requirements** for each of the documents.
- **Witnesses:** Witnesses sign the documents and generally are attesting 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 do not read the document (and we generally do not review the document in front of the witnesses or notary). The witnesses' signatures will also be notarized, so they should have identification available for the notary.
 - Healthcare Power of Attorney & Living Will: Two witnesses and a notary are required. Note the following limitations for healthcare documents:
 - At least 18 years old
 - not related to the client;
 - not entitled to any portion of the estate of the client under the will or under The Intestate Succession Act;
 - not the client's attending physician or an employee of the attending physician;
 - not employees of the health facility where the client is a patient;
 - not employees of a nursing home or group care home where the client resides;
 - do not have any claims against the client.
 - Power of Attorney: No witnesses required. The document needs to be notarized only.
 - Will: Two witnesses and a notary are required.
 - The witnesses CAN be employees of the healthcare facility.
 - Witnesses must be at least 18 years old.
 - Witnesses must not be named in the Will.
 - We prefer that the witnesses not be family members, even if they are not included in the Will.
- **Notary guidelines:** The notary public must be present and witness the client signing the documents. It's ok to have the client initial (on the HCPOA and LW) outside the presence of the notary. The notary should ask the client for picture ID prior to notarizing, unless they know the client personally.
- **Pens & Ink:** We sign documents with BLUE pens so that the originals can be distinguished from photocopies. Bring four Blue Pens to the signing, so you, the witness, client, and notary will each have their own pen.

- **Review the documents** with the client prior to bringing the witnesses and notary into the room. Go through each document and explain the contents to the degree of detail the client wants. Some clients will want a detailed explanation of every paragraph. Some will prefer just a quick review. Make sure, again, that everything is the way the client wants and that all names are spelled correctly. As you review the HCPOA and LW, you can have the client initial where appropriate.
- **Make sure the client understands and has mental capacity to sign the documents.** It is your job to make sure the client has the mental capacity to sign the documents. The client must be alert, able to understand what she/he is doing, and have the intention to sign the documents. From time to time, medications, treatment side-effects, or cognitive impairment may impair the client's capacity to execute the documents. This may be temporary or permanent. If you have any doubt about the client's capacity, please consult with your supervising attorney prior to signing.
- **Signing:**
 - Use Blue Ink
 - Make sure the client signs the document exactly as her/his name is printed on the document.
 - The client should sign first, then the witnesses, the finally the notary.
 - Specific requirements for particular documents:
 - *Power of Attorney* – the document may be recorded at the register of deeds in the future, so the document must meet their standards:
 - Client's signature must be EXACTLY the same as the printed name
 - The signature and notarization must be at least ¼ inch from the edge of the page
 - *Will* – to establish testamentary capacity and lack of undue influence, you should ask the client the following questions prior to signing, in the presence of the witnesses and notary public:
 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.

If there is any doubt whatsoever about the testamentary capacity of the testator, ask the following additional questions in front of the witnesses:

6. Name your nearest relatives (spouse, children, parents, siblings).
7. According to the will, who will inherit your property?

8. What property do you own that you are planning to leave to these heirs?

5. **After the signing**

- Make hard copies of the documents for our file and processing.
- Scan all documents into one file and upload to Clio
- Staple the original documents and give them to the client in a large envelope, along with additional information:
 - How to revoke (for each document)
 - Topics to discuss with healthcare agent
 - Important Information for Agent (regarding POA)
- **Processing**
 - **Healthcare Power of Attorney & Living Will:** With client's permission, distribute copies as follows. Use the stamp pad to stamp each copy, "COPY".
 - Healthcare provider(s). There is a template cover letter for sending the documents. Some providers may prefer to receive the documents electronically.
 - Duke Medical Center: HCPOA and LW should be faxed to Medical Records department, with the client's name and date of birth typed at the top of each page. This can be done on the scanned copy by inserting a header in Acrobat Professional.
 - Healthcare agent(s): If the client wishes, we can send copies of the HCPOA and LW to the client's healthcare agents or other. Use Cover Letter to Agent template. Whether we send copies or not, advise the client to discuss her/his healthcare preferences with the agent, including end of life care.
 - **Power of Attorney:**
 - Recording: Prior to the adoption of a new power of attorney law in NC, effective January 1, 2018, it was necessary to record a power of attorney with the register of deeds in order for it to be valid after the principal's incapacity. This is no longer required. Recording is only necessary if the POA is to be used in a real estate transaction.
 - Copies to agent(s): If the client wishes, send a copy of the POA to the client's agent, along with a 1) Cover Letter (see template), and 2) *Important Information for Agent* handout.
 - **Will:**
 - If client desires, send a copy of the Will to the Executor or other person the client requests. Since clients often want to keep their Will private while they are living, DO NOT send out copies of the Will unless requested by the client.

Gifts/Transfers to facilitate eligibility for government benefits (eg for nursing home) or tax planning

Yes No

This power permits the agent to make potentially large gifts in order to facilitate **eligibility for public benefits, primarily Medicaid**, or to avoid Medicaid estate recovery (where the state recoups Medicaid benefits from the patient's estate after death). *Note that we can't advise about specifics of Medicaid planning and client should consult with an expert attorney if they have questions.*

This power also allows gifts for **tax planning purposes** – Few of our clients will have sufficient assets for this power to be relevant.

Create or change **rights of survivorship** on bank, brokerage, other accounts?

Yes No

In favor of agent? Yes No

In favor of person agent owes support obligation? Yes No

Create or change **beneficiary designations** on retirement, insurance, annuity, other accounts?

Yes No

In favor of agent? Yes No

In favor of person agent owes support obligation? Yes No

Authorize another person to exercise the authority granted under the POA

Yes No

Limited to particular person? Who?

Waive principal's right to be beneficiary under joint and survivor annuity, including retirement plan

Yes No

Exercise fiduciary powers principal has authority to delegate

Yes No

Disclaim or refuse an interest in property, including a power of appointment

Yes No

Exercise authority over the content of electronic communications

Yes No

Miscellaneous Matters

Records & Accountings

-The agent must keep records of transactions and provide records to principal on request. (This can be waived, but not advisable).
-If the patient is incompetent, who should the agent provide records to?

Name of person(s) who can request records if principal is incapacitated:

Guardianship. If a guardian ever needs to be appointed, does client nominate agent?
If co-agent, which co-agent?

Yes No

Compensation. Does the patient want the agent to serve without compensation other than reimbursement for expenses?

Yes No

Prepared by Duke Health Justice Clinic, Box 90360, Durham, NC 27708

STATE OF NORTH CAROLINA

DURABLE POWER OF ATTORNEY

COUNTY OF [COUNTY EXECUTED]

**ARTICLE I
DESIGNATION OF AGENT**

A. Designation of Agent. I, [Name of principal] of [Principal's County] County, North Carolina, name [Name of Agent] as my Agent to do the things listed below.

B. Designation of Successor Agent. If [Name of Agent] is unable or unwilling to serve as my Agent, I name the following person(s) as my successor Agent(s), each to act alone and successively in the order named:

Successor Agent Name:

Second Successor Agent Name:

I give my acting Agent the full power to appoint another Agent to act as my Agent, and full power to revoke such appointment, if no Agent named by me is willing or able to act.

**ARTICLE II
GRANT OF GENERAL AUTHORITY**

I grant my Agent and any successor Agent general authority to act for me with respect to the following subjects as defined in North Carolina General Statutes Sections 32C-2-204 through 32C-2-216.

1. Real Property
2. Tangible Personal Property
3. Stocks and Bonds
4. Commodities and Options

5. Banks and Other Financial Institutions
6. Operation of Entity or Business
7. Insurance and Annuities
8. Estates, Trusts and Other Beneficial Interests
9. Claims and Litigation
10. Personal and Family Maintenance
11. Benefits from Governmental Programs or Civil or Military Service
12. Retirement Plans
13. Taxes

ARTICLE III GRANT OF SPECIFIC AUTHORITY

I expressly grant my Agent the authority to do the following specific acts:

A. Gifts.

1. Make gifts to or for the benefit of any one or more of the following:
 - a. My spouse;
 - b. My issue;
 - c. The spouses of my issue;
 - d. Any other family member;
 - e. Any charitable, religious or educational organization described in Sections 170(c) and 2522(a) of the Internal Revenue.
2. Except as otherwise specified in this power of attorney, my Agent may make gifts only in amounts consistent with my history of making gifts.
3. Make gifts in any amount for the purpose of aiding in tax planning or government benefits planning. I understand that giving away my property may result in tax consequences or a period of ineligibility for some benefits, so I require that any such gift be made upon written advice of an attorney with knowledge and experience regarding these matters.
4. Make gifts to my Agent or a person to whom my Agent owes a legal obligation of support.
5. I do not authorize my Agent to make gifts or transfers of my assets.

B. Create or Change Rights of Survivorship. The power to create, change or terminate any ownership arrangement, including bank and brokerage accounts, in which I am a joint tenant owning an interest with one or more other persons with rights of survivorship. My Agent may exercise this power in favor my Agent or an individual to whom my Agent owes a legal obligation of support.

C. **Create or Change a Beneficiary Designation.** The power to create a new beneficiary designation or change an existing beneficiary designation of any retirement plan or insurance or annuity contract or other account at any financial institution in which I have an interest. My Agent may exercise this power in favor my Agent or an individual to whom my Agent owes a legal obligation of support.

D. **Delegate Authority Granted Under the Power of Attorney.** The power to delegate to another person any of the authority granted to my Agent or engage another person, such as an attorney, accountant or other professional on my behalf. If an appointment of another Agent is necessary, my Agent may appoint such person and revoke the appointment.

E. **Exercise Fiduciary Powers that I Have Authority to Delegate.** The power to exercise any fiduciary powers that I have authority to delegate.

F. **Disclaim or Refuse Property and Power of Appointment.** The power to renounce in accordance with Chapter 31B of the General Statutes any property or interest in property to which I may have succeeded as a person listed in subdivision (1) through (9e) of General Statutes Section 31B-1(a).

G. **Exercise Authority Over the Content of Electronic Communications.** The power to exercise authority and take control over and request an authorized disclosure of the contents of any of my electronic communications sent or received by me, any catalogue of electronic communications sent or received by me and any other digital asset of mine.

ARTICLE IV LIMITATIONS ON EXERCISE OF POWERS BY AGENT

The following limitations shall apply to the exercise of the powers by my Agent, in addition to any other limitations stated elsewhere in this power of attorney:

A. **Exercise of Specific Authority:** Notwithstanding a grant of authority to do an act described in Article III of this power of attorney, my Agent may exercise such authority only as my Agent determines is consistent with my objectives if actually known by my Agent and, if unknown, as my Agent determines is consistent with my best interest based on all relevant factors which may include those set out in General Statutes Section 32C-2-201(b)(1) through (6).

B. **Exercise of Specific Authority in Favor of Agent:** Unless otherwise specifically provided in this power of attorney, my Agent may not exercise authority under this power of attorney to create in my Agent, or in an individual to whom my Agent owes a legal obligation of support, an interest in my property whether by gift, right of survivorship, beneficiary designation, disclaimer or otherwise.

C. **Use of Assets for Agent's Personal Bills:** My Agent shall not have the power to use my assets to pay for my Agent's legal obligations. My Agent shall be prohibited (except as specifically authorized in this instrument) from using my assets to discharge or secure any of

my Agent's obligations, including any obligation of support which my Agent may owe to others (excluding those whom I am equally with my Agent legally obligated to support).

**ARTICLE V
MISCELLANEOUS MATTERS RELATED TO MY AGENT**

A. **Records and Accountings:** My Agent shall keep a record of all receipts, disbursements, and transactions made on my behalf and shall provide such records to me upon request. If I am incapacitated, my Agent shall provide such records upon request to [person(s) who can request records after incapacity]

B. **Guardianship:** If it becomes necessary for a court to appoint a guardian of my estate or a general guardian, I nominate my Agent acting under this document to be the guardian to serve without bond or other security. If I have co-agents, I nominate [which co-agent is preferred as guardian?]

C. **Resignation of Agent:** My Agent shall have the right to resign by giving written notice of resignation to me if I am not incapacitated or if I am incapacitated to my guardian if one has been appointed and any coagent or, if none, the successor Agent next designated.

D. **Compensation of Agent:** My Agent shall serve without compensation, but shall be reimbursed for expenses properly incurred on my behalf.

**ARTICLE VI
RELIANCE ON THIS POWER OF ATTORNEY**

Any person, including my Agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

**ARTICLE VII
REVOCAION AND TERMINATION**

This power of attorney shall terminate upon (i) my death, (ii) my revocation of this power of attorney, (iii) my revocation of my Agent's authority, or upon my Agent's death, incapacity or resignation, if this power of attorney does not provide for another Agent to act, or (iv) upon termination by my general guardian or the guardian of my estate.

**ARTICLE VIII
MEANING AND EFFECT**

The meaning and effect of this power of attorney shall for all purposes be determined by the law of the State of North Carolina

ARTICLE IX
EFFECTIVE DATE AND DURABILITY

This power of attorney is effective on the date it is signed by me and shall not be affected by my subsequent incapacity.

Signed this _____ day of _____, 20_____.

[Principal's Name]

STATE OF NORTH CAROLINA
COUNTY OF _____

I certify that the following person personally appeared before me this day, acknowledging to me that he or she signed the foregoing document: [Principal's name]

Date: _____

Signature of Notary Public

Printed or Typed Name of Notary Public

My Commission Expires:

Prepared by Duke Health Justice Clinic, Box 90360, Durham, NC 27708

STATE OF NORTH CAROLINA

**DURABLE POWER OF ATTORNEY
(SPRINGING POWERS)**

COUNTY OF [COUNTY EXECUTED]

**ARTICLE I
DESIGNATION OF AGENT**

A. Designation of Agent. I, [Name of principal] of [Principal's County] County, North Carolina, name [Name of Agent] as my Agent to do the things listed below.

B. Designation of Successor Agent. If [Name of Agent] is unable or unwilling to serve as my Agent, I name the following person(s) as my successor Agent(s), each to act alone and successively in the order named:

Successor Agent Name:

Second Successor Agent Name:

I give my acting Agent the full power to appoint another Agent to act as my Agent, and full power to revoke such appointment, if no Agent named by me is willing or able to act.

**ARTICLE II
GRANT OF GENERAL AUTHORITY**

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2. Tangible Personal Property
3. Stocks and Bonds

4. Commodities and Options
5. Banks and Other Financial Institutions
6. Operation of Entity or Business
7. Insurance and Annuities
8. Estates, Trusts and Other Beneficial Interests
9. Claims and Litigation
10. Personal and Family Maintenance
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 - a. My spouse;
 - b. My issue;
 - c. The spouses of my issue;
 - d. Any other family member;
 - e. Any charitable, religious or educational organization described in Sections 170(c) and 2522(a) of the Internal Revenue.
2. Except as otherwise specified in this power of attorney, my Agent may make gifts only in amounts consistent with my history of making gifts.
3. Make gifts in any amount for the purpose of aiding in tax planning or government benefits planning. I understand that giving away my property may result in tax consequences or a period of ineligibility for some benefits, so I require that any such gift be made upon written advice of an attorney with knowledge and experience regarding these matters.
4. Make gifts to my Agent or a person to whom my Agent owes a legal obligation of support.
5. I do not authorize my Agent to make gifts or transfers of my assets.

B. Create or Change Rights of Survivorship. The power to create, change or terminate any ownership arrangement, including bank and brokerage accounts, in which I am a joint tenant owning an interest with one or more other persons with rights of survivorship. My Agent may exercise this power in favor my Agent or an individual to whom my Agent owes a legal obligation of support.

C. **Create or Change a Beneficiary Designation.** The power to create a new beneficiary designation or change an existing beneficiary designation of any retirement plan or insurance or annuity contract or other account at any financial institution in which I have an interest. My Agent may exercise this power in favor my Agent or an individual to whom my Agent owes a legal obligation of support.

D. **Delegate Authority Granted Under the Power of Attorney.** The power to delegate to another person any of the authority granted to my Agent or engage another person, such as an attorney, accountant or other professional on my behalf. If an appointment of another Agent is necessary, my Agent may appoint such person and revoke the appointment.

E. **Exercise Fiduciary Powers that I Have Authority to Delegate.** The power to exercise any fiduciary powers that I have authority to delegate.

F. **Disclaim or Refuse Property and Power of Appointment.** The power to renounce in accordance with Chapter 31B of the General Statutes any property or interest in property to which I may have succeeded as a person listed in subdivision (1) through (9e) of General Statutes Section 31B-1(a).

G. **Exercise Authority Over the Content of Electronic Communications.** The power to exercise authority and take control over and request an authorized disclosure of the contents of any of my electronic communications sent or received by me, any catalogue of electronic communications sent or received by me and any other digital asset of mine.

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The following limitations shall apply to the exercise of the powers by my Agent, in addition to any other limitations stated elsewhere in this power of attorney:

A. **Exercise of Specific Authority:** Notwithstanding a grant of authority to do an act described in Article III of this power of attorney, my Agent may exercise such authority only as my Agent determines is consistent with my objectives if actually known by my Agent and, if unknown, as my Agent determines is consistent with my best interest based on all relevant factors which may include those set out in General Statutes Section 32C-2-201(b)(1) through (6).

B. **Exercise of Specific Authority in Favor of Agent:** Unless otherwise specifically provided in this power of attorney, my Agent may not exercise authority under this power of attorney to create in my Agent, or in an individual to whom my Agent owes a legal obligation of support, an interest in my property whether by gift, right of survivorship, beneficiary designation, disclaimer or otherwise.

C. **Use of Assets for Agent's Personal Bills:** My Agent shall not have the power to use my assets to pay for my Agent's legal obligations. My Agent shall be prohibited (except as

specifically authorized in this instrument) from using my assets to discharge or secure any of my Agent's obligations, including any obligation of support which my Agent may owe to others (excluding those whom I am equally with my Agent legally obligated to support).

**ARTICLE V
MISCELLANEOUS MATTERS RELATED TO MY AGENT**

A. **Records and Accountings:** My Agent shall keep a record of all receipts, disbursements, and transactions made on my behalf and shall provide such records to me upon request. If I am incapacitated, my Agent shall provide such records upon request to [person(s) who can request records after incapacity]

B. **Guardianship:** If it becomes necessary for a court to appoint a guardian of my estate or a general guardian, I nominate my Agent acting under this document to be the guardian to serve without bond or other security. If I have co-agents, I nominate [which co-agent is preferred as guardian?]

C. **Resignation of Agent:** My Agent shall have the right to resign by giving written notice of resignation to me if I am not incapacitated or if I am incapacitated to my guardian if one has been appointed and any coagent or, if none, the successor Agent next designated.

D. **Compensation of Agent:** My Agent shall serve without compensation, but shall be reimbursed for expenses properly incurred on my behalf.

**ARTICLE VI
RELIANCE ON THIS POWER OF ATTORNEY**

Any person, including my Agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

**ARTICLE VII
REVOCATION AND TERMINATION**

This power of attorney shall terminate upon (i) my death, (ii) my revocation of this power of attorney, (iii) my revocation of my Agent's authority, or upon my Agent's death, incapacity or resignation, if this power of attorney does not provide for another Agent to act, or (iv) upon termination by my general guardian or the guardian of my estate.

**ARTICLE VIII
MEANING AND EFFECT**

The meaning and effect of this power of attorney shall for all purposes be determined by the law of the State of North Carolina

**ARTICLE IX
SPRINGING POWERS**

This power of attorney shall become effective on upon one of more of the following dates:

Upon the date that I instruct my agent in writing to exercise the authority granted in this power of attorney, or

Upon the date that [name of person to determine incapacity] determines in writing that I am incapacitated, or

Upon the date that, after personal examination of me, two physicians determine that I am incapacitated.

For purposes of this power of attorney, "incapacity" means my inability to manage property or business affairs because I have i) an impairment in the ability to receive and evaluated information or make or communicate decisions even with the use of technological assistance, OR ii) I am missing, detained, including incarceration in a penal system, or outside of the United States and unable to return.

Signed this _____ day of _____, 20_____.

[Principal's Name]

STATE OF NORTH CAROLINA
COUNTY OF _____

I certify that the following person personally appeared before me this day, acknowledging to me that he or she signed the foregoing document: [Principal's name]

Date: _____

Signature of Notary Public

Printed or Typed Name of Notary Public

My Commission Expires:

HOW TO REVOKE A POWER OF ATTORNEY

All Powers of Attorney automatically end at your death. They can only be used while you are living. However, there may come a time before then when you decide that you would like to revoke or cancel your Durable Power of Attorney

Unregistered Durable Power of Attorney:

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

1. By signing a written document revoking the power of attorney, called a “revocation.” The revocation must be notarized.
2. **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
3. By any method you may have provided for in your Power of Attorney.

You must notify your “agent” that you have revoked the Power of Attorney. You can do this by hand deliver, mail or certified mail. It’s best to document the revocation by certified mail, return receipt requested.

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:

1. Sign a written revocation in front of a notary.
2. Register the revocation in 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 that you have revoked the power of attorney. That may be done by mail.

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 your Power of Attorney, please call the Duke Health Justice Clinic at (919) 613-7169.

[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.

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

IMPORTANT INFORMATION FOR AGENT
Agent's Duties

A power of attorney is a document in which one person, called the "principal," gives another person, called the "agent," the power to act on his or her behalf. You have been named as the "agent."

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or your authority is terminated or the power of attorney is terminated or revoked. You must:

- (1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
- (2) Act in good faith;
- (3) Do nothing beyond the authority granted in this power of attorney; and
- (4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: (Principal's Name) by (Your Signature) as Agent.

Unless the Additional Provisions and Exclusions in this power of attorney state otherwise, you must also:

- (1) Act loyally for the principal's benefit;
- (2) Avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) Act with care, competence, and diligence
- (4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
- (5) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects, or if you do not know the principal's expectations, to act in the principal's best interest;
- (6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest; and
- (7) Account to the principal (or a person designated by the principal (if any)) in the Additional Provisions and Exclusions.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminated or revoked this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

- (1) ***Death of a principal -- (the power of attorney is not valid after the principal's death and you may not use it death!)***

- (2) The principal's revocation of the power of attorney or the termination of your authority;
- (3) The occurrence of a termination event stated in the power of attorney;
- (4) The purpose of the power of attorney is fully accomplished; or
- (5) If you are married to the principal, your divorce from the principal, unless the Additional Provisions and Exclusions in this power of attorney state that your divorce from the principal will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the North Carolina Uniform Power of Attorney Act. If you violate the North Carolina Uniform Power of Attorney Act or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

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/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)
<p>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.</p>		
<p>Who does the client want to make the determination? Name physician or “attending physician?”</p>		
Name of physician		Place of Employment
<p>Confirm that “doctor” is an MD, not Nurse Practitioner or Physician’s Assistant</p> <p><input type="checkbox"/> Yes, doctor is MD</p> <p><input type="checkbox"/> No, “doctor” is not MD (Client can name “attending physician for...”)</p> <p><input type="checkbox"/> Not sure (ask case manager or call clinic)</p>		
Limitations on Health Care Agent’s Authority		
<p>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:</p>		
<p>Mental Health Decisions: Does the client wish to place any limitations on health care agent’s authority to make mental health treatment decisions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the client have an Advance Instruction for Mental Health Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>Remains:</p> <p>Does the client wish to restrict health care agent’s authority to authorize an autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>Does client wish to be <input type="checkbox"/> buried or <input type="checkbox"/> cremated</p>		

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.

[Prepared by Duke Legal Assistance Project (919) 613-7169]

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.)

(Initial)

A. 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:

NOTE: DO NOT initial unless you insert a limitation.

(Initial)

B. Limitations About Artificial Nutrition and Hydration.
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.

(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:

_____ 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.

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.

- _____ (Initial) I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
- _____ (Initial) I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
- _____ (Initial) I suffer from advanced dementia or any other 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.

§ 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

(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.

(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).)

§ 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 Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

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

C. Name: _____
Home Address: _____

Home Telephone: _____
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.

Chapter 32C.

North Carolina Uniform Power of Attorney Act.

Article 1.

Definitions and General Provisions.

§ 32C-1-101. Short title.

This Chapter may be cited as the North Carolina Uniform Power of Attorney Act. (2017-153, s. 1.)

§ 32C-1-102. Definitions.

The following definitions apply in this Chapter:

- (1) Agent. – A person granted authority to act for a principal under a power of attorney, whether denominated an agent, attorney-in-fact, or otherwise. The term includes an original agent, coagent, successor agent, and a person to which an agent's authority is delegated.
- (2) Durable. – With respect to a power of attorney, the incapacity of the principal does not terminate the power of attorney.
- (3) Electronic. – Relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.
- (4) Entity. – A sole proprietorship, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, or any other legal or commercial entity whether or not organized for business purposes.
- (5) Good faith. – Honesty in fact.
- (6) Incapacity. – The inability of an individual to manage property or business affairs because the individual has any of the following statuses:
 - a. An impairment in the ability to receive and evaluate information or make or communicate decisions even with the use of technological assistance.
 - b. Is missing, detained, including incarcerated in a penal system, or outside the United States and unable to return.
- (7) Internal Revenue Code. – The Internal Revenue Code of 1986, as amended from time to time. Each reference to a provision of the Internal Revenue Code shall include any successor to that provision.
- (8) Person. – An individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
- (9) Power of attorney. – A writing or other record that grants authority to an agent to act in the place of the principal, whether or not the term power of attorney is used.
- (10) Reserved.
- (11) Principal. – An individual who grants authority to an agent in a power of attorney.
- (12) Property. – Anything that may be the subject of ownership, whether real or personal, or legal or equitable, or any interest or right therein.

- (13) Record. – Information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.
- (14) Sign. – With the present intent to authenticate or adopt a record, (i) to execute or adopt a tangible symbol or (ii) to attach to or logically associate with the record an electronic sound, symbol, or process.
- (15) State. – A state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.
- (16) Stocks and bonds. – Stocks, bonds, mutual funds, and all other types of securities and financial instruments, whether held directly, indirectly, or in any other manner. The term does not include commodity futures contracts and call or put options on stocks or stock indexes. (2017-153, s. 1.)

§ 32C-1-103. Applicability.

This Chapter applies to all powers of attorney except the following:

- (1) A power to the extent it is coupled with an interest in the subject of the power, including a power given to or for the benefit of a creditor in connection with a credit transaction.
- (2) A power to make health care decisions.
- (3) A proxy or other delegation to exercise voting rights or management rights with respect to an entity.
- (4) A power created on a form prescribed by a government or governmental subdivision, agency, or instrumentality for a governmental purpose. (2017-153, s. 1.)

§ 32C-1-104. Power of attorney; durability.

A power of attorney created pursuant to this Chapter is durable unless the instrument expressly provides that it is terminated by the incapacity of the principal. (2017-153, s. 1.)

§ 32C-1-105. Execution of power of attorney.

A power of attorney must be (i) signed by the principal or in the principal's conscious presence by another individual directed by the principal to sign the principal's name on the power of attorney and (ii) acknowledged. A signature on a power of attorney is presumed to be genuine if the principal acknowledges the signature before a notary public or other individual authorized by law to take acknowledgements. (2017-153, s. 1.)

§ 32C-1-106. Validity of power of attorney.

(a) A power of attorney executed in this State on or after January 1, 2018, is valid if its execution complies with G.S. 32C-1-105.

(b) A power of attorney executed in this State before January 1, 2018, the effective date of this Chapter is valid if its execution complied with the law of this State as it existed at the time of execution.

(c) A power of attorney executed other than in this State is valid in this State if, when the power of attorney was executed, the execution complied with any of the following:

- (1) The law of the jurisdiction that determines the meaning and effect of the power of attorney pursuant to G.S. 32C-1-107.

(2) The requirements for a military power of attorney pursuant to 10 U.S.C. § 1044b, as amended.

(d) Except as otherwise provided by statute other than this Chapter, a photocopy or electronically transmitted copy of an original power of attorney has the same effect as the original. (2017-153, s. 1.)

§ 32C-1-107. Meaning and effect of power of attorney.

The meaning and effect of a power of attorney is determined by the law of the jurisdiction indicated in the power of attorney and, in the absence of an indication of jurisdiction, by the law of the jurisdiction in which the power of attorney was executed. (2017-153, s. 1.)

§ 32C-1-108. Nomination of guardian; relation of agent to court-appointed fiduciary.

(a) In a power of attorney, a principal may nominate a guardian of the principal's estate, or guardian of the principal's person, or general guardian for consideration by the clerk of superior court if protective proceedings for the principal's estate or person are begun after the principal executes the power of attorney. Except for good cause shown or disqualification, the clerk of superior court shall make its appointment in accordance with the principal's most recent nomination. If a guardian of the principal's person is nominated in a health care power of attorney, that nomination shall control over the nomination, if any, in a power of attorney.

(b) If, after a principal executes a power of attorney, the clerk of superior court appoints a guardian of the principal's estate, or general guardian or other fiduciary charged with the management of some or all of the principal's property, the agent is accountable to the guardian or the fiduciary as well as to the principal. The power of attorney is not terminated and the agent's authority continues unless limited, suspended, or terminated by the court in accordance with this Chapter. (2017-153, s. 1.)

§ 32C-1-109. When power of attorney effective.

(a) A power of attorney is effective when executed unless the principal provides in the power of attorney that it becomes effective at a future date or upon the occurrence of a future event or contingency.

(b) If a power of attorney becomes effective upon the occurrence of a future event or contingency, the principal, in the power of attorney, may authorize one or more persons to determine in a writing or other record that the event or contingency has occurred.

(c) If a power of attorney becomes effective upon the principal's incapacity and the principal has not authorized a person to determine whether the principal is incapacitated, or the person authorized is unable or unwilling to make the determination, the power of attorney becomes effective upon a determination in a writing or other record in one of the following manners:

(1) After a personal examination of the principal, by two individuals who are either a physician, a licensed psychologist, or both, that the principal is incapacitated within the meaning of G.S. 32C-1-102(5)a.

(2) By an attorney-at-law, a judge, or an appropriate governmental official that the principal is incapacitated within the meaning of G.S. 32C-1-102(5)b.

Notwithstanding the subsequent capacity of the principal to manage property or business affairs, a power of attorney which becomes effective under this subsection shall remain effective

until its termination pursuant to G.S. 32C-1-110(a) or the agent's authority terminates pursuant to G.S. 32C-1-110(b).

(d) A person authorized by the principal in the power of attorney to determine that the principal is incapacitated may act as the principal's personal representative pursuant to the Health Insurance Portability and Accountability Act, §§ 1171 through 1179 of the Social Security Act, 42 U.S.C. § 1320d, as amended, and applicable regulations, to obtain access to the principal's health care information and communicate with the principal's health care provider. (2017-153, s. 1.)

§ 32C-1-110. Termination of power of attorney.

(a) A power of attorney terminates when any of the following occur:

- (1) The principal dies.
- (2) If the power of attorney is not durable, the principal becomes incapacitated.
- (3) The principal revokes the power of attorney.
- (4) The power of attorney provides that it terminates.
- (5) The purpose of the power of attorney is accomplished.
- (6) The principal revokes the agent's authority or the agent dies, becomes incapacitated, or resigns, and the power of attorney does not provide for another agent to act under the power of attorney.
- (7) A guardian of the principal's estate or general guardian terminates it.

(b) An agent's authority terminates when any of the following occur:

- (1) The principal revokes the authority in writing.
- (2) The agent dies, becomes incapacitated, resigns, or is removed.
- (3) The court enters a decree of divorce between the principal and the agent, unless the power of attorney otherwise provides.
- (4) The power of attorney terminates.
- (5) A guardian of the principal's estate or general guardian terminates the authority.

(c) Unless the power of attorney otherwise provides, an agent's authority is exercisable until the authority terminates under subsection (b) of this section, notwithstanding a lapse of time since the execution of the power of attorney.

(d) Termination of an agent's authority or of a power of attorney is not effective as to the agent or another person that, without actual knowledge of the termination, acts in good faith under the power of attorney. An act so performed, unless otherwise invalid or unenforceable, binds the principal and the principal's successors in interest.

(e) Incapacity of the principal of a power of attorney that is not durable does not revoke or terminate the power of attorney as to an agent or other person that, without actual knowledge of the incapacity, acts in good faith under the power of attorney. An act so performed, unless otherwise invalid or unenforceable, binds the principal and the principal's successors in interest.

(f) The execution of a power of attorney does not revoke a power of attorney previously executed by the principal unless the subsequent power of attorney provides that the previous power of attorney is revoked or that all other powers of attorney are revoked.

(g) A principal may revoke a power of attorney in one of the following manners:

- (1) If the power of attorney has been registered in an office of the register of deeds in this State, it shall be revoked by registration in that office by an instrument of revocation executed and acknowledged by the principal while

the principal is not incapacitated with proof of service on the agent in the manner prescribed for service under Rule 5 of the North Carolina Rules of Civil Procedure.

- (2) If the power of attorney has not been registered in an office of the register of deeds in this State, it may be revoked by one of the following methods:
 - a. A subsequent written revocatory document executed and acknowledged while not incapacitated.
 - b. Being burnt, torn, canceled, obliterated, or destroyed, with the intent and for the purpose of revoking it, by the principal or by another person in the principal's presence and at the principal's direction, while the principal is not incapacitated.

(h) A guardian of the principal's estate or general guardian terminates a power of attorney that has been registered in an office of the register of deeds in this State by registering in that office an instrument of revocation executed and acknowledged by such guardian and with proof of service on the agent in the manner prescribed for service under Rule 5 of the North Carolina Rules of Civil Procedure. (2017-153, s. 1.)

§ 32C-1-111. Coagents and successor agents.

(a) A principal may designate two or more persons to act as coagents. A principal may expressly require in the power of attorney that coagents act jointly. If a principal does not expressly require that coagents act jointly, each coagent may exercise the coagents' authority independently without the knowledge, consent, or joinder of any other coagent or coagents. Unless the power of attorney otherwise provides and if any one or more coagents resigns, dies, becomes incapacitated, or otherwise fails to act, the remaining agent or coagents may continue to act.

(b) A principal may designate one or more successor agents to act if an agent resigns, dies, becomes incapacitated, is not qualified to serve, or declines to serve. A principal may grant authority to designate one or more successor agents to an agent or other person designated by name, office, or function. Unless the power of attorney otherwise provides, a successor agent shall have the following powers and limitations:

- (1) The successor agent has the same authority as that granted to the original agent.
- (2) The successor agent may not act until all predecessor agents have resigned, died, become incapacitated, are no longer qualified to serve, or have declined to serve.

(c) Except as otherwise provided in the power of attorney, an agent that does not participate in or conceal a breach of fiduciary duty committed by another agent, including a predecessor agent, is not liable for the actions of the other agent.

(d) An agent that has actual knowledge of a breach or imminent breach of fiduciary duty by another agent shall notify the principal and, if the principal is incapacitated, take any action reasonably appropriate in the circumstances to safeguard the principal's best interest. An agent that fails to notify the principal or take action as required by this subsection is liable for the reasonably foreseeable damages that could have been avoided if the agent had notified the principal or taken such action. (2017-153, s. 1.)

§ 32C-1-112. Reimbursement and compensation of agent.

(a) If the terms of the power of attorney specify the amount or the way the compensation is to be determined, the agent is entitled to the compensation as specified.

(b) If the terms of the power of attorney do not specify the amount or the way the compensation is to be determined, and the principal thereafter becomes incapacitated, then subsequent to the principal's incapacity the agent is entitled to receive reasonable compensation as determined by the clerk of superior court in accordance with G.S. 32-59.

(c) Unless the power of attorney otherwise provides, an agent is entitled to be reimbursed for expenses properly incurred on behalf of the principal. (2017-153, s. 1.)

§ 32C-1-113. Agent's acceptance.

Except as otherwise provided in the power of attorney, a person accepts appointment as an agent under a power of attorney by exercising authority or performing duties as an agent or by any other assertion or conduct indicating acceptance. (2017-153, s. 1.)

§ 32C-1-114. Agent's duties.

(a) Notwithstanding provisions in the power of attorney, an agent that has accepted appointment, when exercising a power under the power of attorney shall do all of the following:

- (1) Act in accordance with the principal's reasonable expectations to the extent actually known by the agent and, otherwise, in the principal's best interest.
- (2) Act in good faith.
- (3) Act only within the scope of authority granted in the power of attorney.

(b) Except as otherwise provided in the power of attorney, an agent that has accepted appointment has no affirmative duty to exercise the powers or to continue to exercise the powers granted to the agent by the power of attorney, but if the agent exercises any of the granted powers, the agent shall, in the exercise of such powers, do all of the following:

- (1) Act loyally for the principal's benefit.
- (2) Act so as not to create a conflict of interest that impairs the agent's ability to act impartially in the principal's best interest.
- (3) Act with the care, competence, and diligence ordinarily exercised by agents in similar circumstances.
- (4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal.
- (5) Cooperate with a person that has authority to make health care decisions for the principal to carry out the principal's reasonable expectations to the extent actually known by the agent and, otherwise, act in the principal's best interest.
- (6) Attempt to preserve the principal's estate plan, to the extent actually known by the agent, if preserving the plan is consistent with the principal's best interest based on all relevant factors, including the following:
 - a. The value and nature of the principal's property.
 - b. The principal's foreseeable obligations and need for maintenance.
 - c. Minimization of taxes, including income, estate, inheritance, generation-skipping transfer, and gift taxes.
 - d. Eligibility for a benefit, a program, or assistance under a statute or regulation.
- (7) Account to the principal or a person designated by the principal in the power of attorney.

(c) When exercising a power under the power of attorney, an agent that acts in good faith is not liable to any beneficiary of the principal's estate plan for failure to preserve the plan.

(d) When exercising a power under the power of attorney, an act by an agent that is in good faith for the best interest of the principal is not voidable and the agent is not liable solely because the agent also benefits from the act or has an individual or conflicting interest in relation to the property or affairs of the principal.

(e) Reserved.

(f) Absent a breach of duty to the principal, an agent is not liable if the value of the principal's property declines.

(g) An agent that exercises authority to delegate to another person the authority granted by the principal or that engages another person on behalf of the principal is not liable for an act, error of judgment, or default of that person if the agent exercises care, competence, and diligence in selecting and monitoring the person.

(h) Except as otherwise provided in the power of attorney, an agent is not required to disclose receipts, disbursements, or transactions conducted on behalf of the principal unless ordered by a court or requested by the principal, a guardian of the estate, general guardian, or, upon the death of the principal, by the personal representative or successor in interest of the principal's estate. (2017-153, s. 1.)

§ 32C-1-115. Exoneration of agent.

A provision in a power of attorney relieving an agent of liability for breach of duty is binding on the principal and the principal's successors in interest except to the extent the provision relieves the agent of liability for breach of duty committed (i) in bad faith or (ii) with reckless indifference to the purposes of the power of attorney or the best interest of the principal. (2017-153, s. 1.)

§ 32C-1-116. Judicial relief.

(a) The clerks of superior court of this State shall have original jurisdiction of proceedings under this Chapter. Except as provided in subdivision (4) of this subsection, the clerk of superior court's jurisdiction is exclusive. The following proceedings are included:

- (1) To compel an accounting by the agent, including the power to compel the production of evidence substantiating any expenditure made by the agent from the principal's assets.
- (2) To terminate a power of attorney or to limit, suspend, or terminate the authority of an agent where a guardian of the estate or a general guardian has been appointed.
- (3) To determine compensation for an agent under G.S. 32C-1-112(b).
- (4) To determine an agent's authority and powers, to construe the terms of a power of attorney created or governed by this Chapter, and to determine any question arising in the performance by an agent of the agent's powers and authority under a power of attorney governed by this Chapter, including, but not limited to, the following proceedings:
 - a. To determine whether and to what extent an agent holds a specific grant of authority under G.S. 32C-2-201.

- b. To approve an agent's ability to make a gift on behalf of the principal where the gift is governed by G.S. 32C-2-217 because the power of attorney grants the agent only general authority with respect to gifts.
- c. To authorize the agent to make a gift of the principal's property under G.S. 32C-2-218.
- d. To authorize the agent to do an act described in G.S. 32C-2-201(a), other than the act to make a gift, under G.S. 32C-2-219.
- e. To determine whether and to what extent acceptance of a power of attorney shall be mandated under G.S. 32C-1-120(f).

Any party may file a notice of transfer of a proceeding pursuant to this subdivision to the superior court division of the General Court of Justice as provided in G.S. 28A-2-6(h). In the absence of a removal to superior court, Article 26 of Chapter 1 of the General Statutes shall apply to a proceeding commenced under this Chapter to the extent consistent with this subsection.

(b) Without otherwise limiting the jurisdiction of the superior court division of the General Court of Justice, the clerk of superior court shall not have jurisdiction under this subsection over the following actions:

- (1) To modify or amend a power of attorney instrument.
- (2) By or against creditors or debtors of an agent or principal.
- (3) Involving claims for monetary damages, including claims for breach of fiduciary duty, fraud, and negligence.
- (4) To set aside a power of attorney based on undue influence or lack of capacity.
- (5) For the recovery of property transferred or conveyed by an agent on behalf of a principal with intent to hinder, delay, or defraud the principal's creditors.

(c) Proceedings brought under the provisions of subsection (a) of this section shall be commenced as prescribed for in estate proceedings under G.S. 28A-2-6 and may be brought by the following persons:

- (1) The principal or the agent.
- (2) A general guardian, guardian of the principal's estate, or guardian of the principal's person.
- (3) The personal representative of the estate of a deceased principal.
- (4) A person authorized to make health care decisions for the principal.
- (5) Any other interested person, including a person asked to accept a power of attorney.

(d) Venue of any proceeding brought under subsection (a) of this section, is proper in any of the following:

- (1) The county in which the principal resides or domiciled.
- (2) Any county in which an agent resides.
- (3) Any county in which property of the principal is located.

(e) Nothing in this section shall affect the right of a person to file an action in the Superior Court Division of the General Court of Justice for declaratory relief under Article 26 of Chapter 1 of the General Statutes.

(f) Upon motion by the principal, the clerk of superior court shall dismiss a petition filed under subsection (a) of this section, unless the clerk of superior court determines the principal is incapacitated within the meaning of G.S. 32C-1-102(5).

(g) Any party adversely affected by an order of the clerk of superior court in a proceeding commenced under subsection (a) of this section may appeal the clerk's order as provided in G.S. 1-301.3. (2017-153, s. 1.)

§ 32C-1-117. Agent's liability.

(a) A violation by an agent of this Chapter is a breach of fiduciary duty.

(b) To remedy a breach of fiduciary duty that has occurred or may occur involving a power of attorney, the court may do the following:

- (1) Enjoin an agent from committing a breach of fiduciary duty.
- (2) Compel an agent to redress a breach of fiduciary duty by paying money, restoring property, or other means.
- (3) Order an agent to account.
- (4) Appoint a special fiduciary to take possession of the property subject to the power of attorney and administer that property.
- (5) Suspend an agent.
- (6) Remove an agent.
- (7) Reduce or deny compensation to or reimbursement of an agent.
- (8) Subject to G.S. 32C-1-119 and other laws governing the rights of third persons dealing in good faith with an agent, void an act of an agent, impose a lien or a constructive trust on property subject to the power of attorney, or trace property wrongfully disposed by an agent and recover the property or its proceeds.
- (9) Order any other appropriate relief.

(c) The court may, for good cause shown, relieve an agent from liability for any breach of fiduciary duty under a power of attorney, or wholly or partly excuse an agent who has acted honestly and reasonably from liability for a breach of fiduciary duty under a power of attorney.

(d) An agent who commits a breach of fiduciary duty under a power of attorney is liable for the following:

- (1) The amount required to restore the value of the property subject to the power of attorney and distributions from that property to what they would have been had the breach not occurred; and
- (2) The profit the agent made by reason of the breach.

(e) Except as otherwise provided in this subsection, if more than one agent is liable for a breach of fiduciary duty under a power of attorney, an agent is entitled to contribution from the other agent or agents. An agent is not entitled to contribution if the agent was substantially more at fault than another agent or if the agent committed the breach of fiduciary duty in bad faith or with reckless indifference to the purposes of the power of attorney or the best interests of the principal. An agent who received a benefit from the breach of fiduciary duty is not entitled to contribution from another agent to the extent of the benefit received.

(f) An agent is liable for any profit made by the agent arising from dealings with property subject to the power of attorney, even absent a breach of fiduciary duty. Nothing in this section limits an agent's right to compensation under G.S. 32C-1-112.

(g) Absent a breach of fiduciary duty under a power of attorney, an agent is not liable for a loss or depreciation in the value of property subject to the power of attorney or for not having made a profit.

(h) In a judicial proceeding involving a claim for breach of fiduciary duty under a power of attorney, the court may award costs and expenses, including reasonable attorneys' fees, as provided in G.S. 6-21(2). (2017-153, s. 1.)

§ 32C-1-118. Agent's resignation; notice.

Unless the power of attorney provides a different method for an agent's resignation, an agent may resign by giving written notice of resignation to the following:

- (1) To the principal if the principal is not incapacitated.
- (2) If the principal is incapacitated, to (i) the guardian of the principal's estate, the guardian of the principal's person, or general guardian, if one has been appointed, and (ii) any coagent or, if none, the successor agent next designated. (2017-153, s. 1.)

§ 32C-1-119. Acceptance of and reliance upon power of attorney.

(a) For purposes of this section and G.S. 32C-1-120, the term "acknowledged" means purportedly verified before a notary public or other individual authorized to take acknowledgements.

(b) A person that in good faith accepts an acknowledged power of attorney without actual knowledge that the signature is not genuine may rely upon the presumption under G.S. 32C-1-105 that the signature is genuine.

(c) A person that in good faith accepts a power of attorney without actual knowledge that the power of attorney is void, invalid, or terminated, that the purported agent's authority is void, invalid, or terminated, or that the agent is exceeding or improperly exercising the agent's authority (i) may rely upon the power of attorney as if the power of attorney were genuine, valid and still in effect, the agent's authority were genuine, valid and still in effect, and the agent had not exceeded and had properly exercised the authority and (ii) shall not be held responsible for any breach of fiduciary duty by the agent, including any breach of loyalty, any act of self-dealing, or any misapplication of money or other property paid or transferred as directed by the agent. This subsection applies without regard to whether or not the person dealing with the agent demands or receives a certification under subsection (d) of this section.

(d) A person that is asked to accept a power of attorney may request, and rely upon, without further investigation, any one or more of the following:

- (1) A certification executed by the agent to the effect that the agent did not have actual knowledge at the time of the presentation of the power of attorney to the person (i) that the power of attorney is void, invalid, or terminated; (ii) that the agent's authority is void, invalid, or terminated; or (iii) of facts that would cause the agent to question the authenticity or validity of the power of attorney. A certification meeting the requirements of this subdivision shall be sufficient proof to the requesting person that (i) the power of attorney is authentic and valid and has not been terminated, (ii) the agent's authority is valid and has not been terminated, and (iii) other factual matters stated in the certification regarding the principal, agent, or power of attorney are true. If the exercise of the power of attorney requires execution and delivery of an instrument that is recordable, the person accepting the certification may require that the certification be prepared and executed so as to be recordable. A certification in the form described in G.S. 32C-3-302 shall be deemed to

meet the requirements of this subsection but shall not be the sole means of meeting those requirements.

- (2) An English translation of the power of attorney if the power of attorney contains, in whole or in part, language other than English.
- (3) An opinion of counsel as to any matter of law concerning the power of attorney if the person making the request provides in a writing or other record the reason for the request.

(e) An English translation or an opinion of counsel requested under this section must be provided at the principal's expense unless the request is made more than seven business days after the power of attorney is presented for acceptance.

(f) For purposes of this section and G.S. 32C-1-120, a person that conducts activities through employees is without actual knowledge of a fact relating to a power of attorney, a principal, or an agent if the employee conducting the transaction involving the power of attorney is without actual knowledge of the fact.

(g) 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. (2017-153, s. 1.)

§ 32C-1-120. Liability for refusal to accept acknowledged power of attorney.

(a) A person is not required to accept, and is not liable for refusing to accept, a power of attorney that has not been duly acknowledged.

(b) Except as otherwise provided in this section:

- (1) No later than seven business days after presentation of an acknowledged power of attorney for acceptance, a person shall (i) accept the power of attorney; (ii) refuse to accept the power of attorney pursuant to subsections (c) and (d) of this section; or (iii) request a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d).
- (2) If a person requests a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d), then within five business days after receipt of the requested items in reasonably satisfactory form, the person shall either (i) accept the power of attorney or (ii) refuse to accept the power of attorney pursuant to subsections (c) and (d) of this section.
- (3) A person may not require an additional or different form of power of attorney if the power of attorney presented reasonably appears to authorize the agent to conduct the business the agent desires to conduct.

(c) A person is not required to accept an acknowledged power of attorney if any of the following circumstances exist:

- (1) The person is not otherwise required to engage in a transaction with the principal in the same circumstances.
- (2) Engaging in a transaction with the agent or the principal in the same circumstances would be inconsistent with applicable federal law.
- (3) The person has actual knowledge of the termination of the agent's authority or of the power of attorney before exercise of the power.
- (4) A request for a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d) is refused.

- (5) The person requesting a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d) does not receive the requested items in reasonably satisfactory form within a reasonable period of time.
 - (6) The person in good faith believes that the power is not valid or that the agent does not have the authority to perform the act requested, whether or not a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d) has been requested or provided.
 - (7) The person has reasonable cause to question the authenticity or validity of the power of attorney or the appropriateness of its exercise by the agent.
 - (8) The agent or principal has previously breached any agreement with the person, whether in an individual or fiduciary capacity.
 - (9) The person makes, or has actual knowledge that another person has made, a report to the local adult protective services office or law enforcement stating a good faith belief that the principal may be subject to physical or financial abuse, neglect, exploitation, or abandonment by the agent or a person acting for or with the agent.
- (d) Without limiting the generality of subsection (c) of this section, nothing in this Chapter requires a person to do any of the following:
- (1) Open an account for a principal at the request of an agent if the principal is not currently a customer of the person.
 - (2) Make a loan to the principal at the request of the agent.
 - (3) Permit an agent to conduct business not authorized by the terms of the power of attorney, or otherwise not permitted by applicable statute or regulation.
- (e) A person that refuses in violation of this section to accept an acknowledged power of attorney is subject to all of the following:
- (1) A court order mandating acceptance of the power of attorney.
 - (2) Liability for reasonable attorney's fees and costs incurred in any action or proceeding that mandates acceptance of the power of attorney.
 - (3) Any other remedy available under applicable law.
- (f) The principal, the agent, or a person presented with a power of attorney may initiate a proceeding to determine whether and to what extent acceptance of a power of attorney shall be mandated. The court may award costs and expenses, including reasonable attorneys' fees in its discretion, but may award attorneys' fees to the agent only where the proceeding has substantial merit.
- (g) Nothing in this Chapter amends or modifies the rights of banks and other depository institutions to terminate any deposit account in accordance with applicable law.
- (h) 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.
- (i) A person who promptly requests a certification, a translation, or an opinion of counsel pursuant to G.S. 32C-1-119(d) is not deemed to have unreasonably refused to accept a power of attorney prior to receipt of the requested items in reasonably acceptable form. (2017-153, s. 1.)

§ 32C-1-121. Principles of law and equity.

The common law, including the common law of agency, and principles of equity supplement this Chapter, except to the extent modified by this Chapter or another provision of the General Statutes. (2017-153, s. 1.)

§ 32C-1-122. Laws applicable to financial institutions and other entities.

This Chapter does not supersede any other law applicable to financial institutions or other entities, and the other law controls if inconsistent with the provisions of this Chapter. (2017-153, s. 1.)

§ 32C-1-123. Remedies under other law.

The remedies under this Chapter are not exclusive and do not abrogate any right or remedy under the law of this State, other than this Chapter. (2017-153, s. 1.)

Article 2.

Authority.

§ 32C-2-201. Authority requiring specific grant; grant of general authority.

(a) Unless the exercise of the authority by an agent under a power of attorney is not otherwise prohibited by another agreement or instrument to which the authority or property is subject, then the following apply:

- (1) An agent may do the following on behalf of the principal or with the principal's property only if the power of attorney expressly grants the agent that authority:
 - a. Make a gift.
 - b. Create or change rights of survivorship.
 - c. Create or change a beneficiary designation.
 - d. Delegate authority granted under the power of attorney.
 - e. Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan.
 - f. Exercise fiduciary powers that the principal has authority to delegate.
 - g. Renounce or disclaim property, including a power of appointment.
 - h. Exercise authority over the content of electronic communication, as defined in 18 U.S.C. § 2510(12), sent or received by the principal.
- (2) An agent may do the following only if the power of attorney or terms of the trust expressly grants the agent that authority:
 - a. Exercise the powers of the principal as settlor of a revocable trust in accordance with G.S. 36C-6-602.1.
 - b. Exercise the powers of the principal as settlor of an irrevocable trust to consent to the trust's modification or termination in accordance with G.S. 36C-4-411(a).

(b) Notwithstanding a grant of authority to do an act described in subsection (a) of this section, an agent may exercise such authority only as the agent determines is consistent with the principal's objectives if actually known by the agent and, if unknown, as the agent determines is consistent with the principal's best interest based on all relevant factors, which may include the following:

- (1) The value and nature of the principal's property.

- (2) The principal's foreseeable obligations and need for maintenance.
- (3) Minimization of taxes, including income, estate, inheritance, generation-skipping transfer, and gift taxes.
- (4) Eligibility for a benefit, a program, or assistance under a statute or regulation.
- (5) The principal's personal history of making or joining in making gifts.
- (6) The principal's existing estate plan.

(c) Notwithstanding a grant of authority to do an act described in subsection (a) of this section, unless the power of attorney otherwise provides, an agent may not exercise authority under a power of attorney to create in the agent, or in an individual to whom the agent owes a legal obligation of support, an interest in the principal's property, whether by gift, right of survivorship, beneficiary designation, disclaimer, or otherwise.

(d) Subject to subsections (a), (b), (c), (e), and (f) of this section, if a power of attorney grants to an agent authority to do all acts that a principal could do, the agent has the general authority described in G.S. 32C-2-204 through G.S. 32C-2-216 and G.S. 32C-2-220.

(e) Unless the power of attorney otherwise provides, a grant of authority to make a gift is subject to subsections (b) and (c) of this section and G.S. 32C-2-217.

(f) Subject to subsections (a), (b), (c), and (e) of this section, if the subjects over which authority is granted in a power of attorney are similar or overlap, the broadest authority controls.

(g) Authority granted in a power of attorney is exercisable with respect to property that the principal has when the power of attorney is executed or acquires later, whether or not the property is located in this State and whether or not the authority is exercised or the power of attorney is executed in this State.

(h) An act performed by an agent pursuant to a power of attorney has the same effect and inures to the benefit of and binds the principal and the principal's successors in interest as if the principal had performed the act. (2017-153, s. 1.)

§ 32C-2-202. Incorporation of authority.

(a) An agent has authority described in this Chapter if the power of attorney refers to general authority with respect to the descriptive term for the subjects stated in G.S. 32C-2-204 through G.S. 32C-2-217 and G.S. 32C-2-220 or cites the section in which the authority is described.

(b) A reference in a power of attorney to general authority with respect to the descriptive term for a subject in G.S. 32C-2-204 through G.S. 32C-2-217 and G.S. 32C-2-220 or a citation to G.S. 32C-2-204 through G.S. 32C-2-217 and G.S. 32C-2-220 incorporates the entire section as if it were set out in full in the power of attorney.

(c) A principal may modify authority incorporated by reference. (2017-153, s. 1.)

§ 32C-2-203. Construction of authority, generally.

Except as otherwise provided in the power of attorney, by executing a power of attorney that incorporates by reference a subject described in G.S. 32C-2-204 through G.S. 32C-2-217 and G.S. 32C-2-220 or that grants to an agent authority to do all acts that a principal could do pursuant to G.S. 32C-2-201(d), a principal authorizes the agent, with respect to that subject, to do all of the following:

- (1) Demand, receive, and obtain by litigation or otherwise, money or another thing of value to which the principal is, may become, or claims to be entitled,

- and conserve, invest, disburse, or use anything so received or obtained for the purposes intended.
- (2) Contract in any manner with any person, on terms agreeable to the agent, to accomplish a purpose of a transaction and perform, rescind, cancel, terminate, reform, restate, release, or modify the contract or another contract made by or on behalf of the principal.
 - (3) Execute, acknowledge, seal, deliver, file, or record any instrument or communication the agent considers desirable to accomplish a purpose of a transaction, including creating at any time a schedule listing some or all of the principal's property and attaching it to the power of attorney.
 - (4) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to a claim existing in favor of or against the principal or intervene in litigation relating to the claim.
 - (5) Seek on the principal's behalf the assistance of a court or other governmental agency to carry out an act authorized in the power of attorney.
 - (6) Engage, compensate, and discharge an attorney, accountant, discretionary investment manager, expert witness, or other advisor.
 - (7) Prepare, execute, and file a record, report, or other document to safeguard or promote the principal's interest under a statute or regulation.
 - (8) Communicate with any representative or employee of a government or governmental subdivision, agency, or instrumentality, on behalf of the principal.
 - (9) Access communications intended for, and communicate on behalf of the principal, whether by mail, electronic transmission, telephone, or other means.
 - (10) Do any lawful act with respect to the subject and all property related to the subject. (2017-153, s. 1.)

§ 32C-2-204. Real property.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to real property authorizes the agent to do all of the following:

- (1) Demand, buy, lease, receive, accept as a gift or as security for an extension of credit, or otherwise acquire or reject an interest in real property or a right incident to real property.
- (2) Sell; exchange; convey with or without covenants, representations, or warranties; quitclaim; release; surrender; retain title for security; encumber; partition; consent to partitioning; subject to an easement or covenant; subdivide; apply for zoning or other governmental permits; plat or consent to platting; develop; grant an option concerning; lease; sublease; contribute to an entity in exchange for an interest in that entity; or otherwise grant or dispose of an interest in real property or a right incident to real property.
- (3) Pledge or encumber an interest in real property or right incident to real property as security for the principal or any entity in which the principal has an ownership interest to borrow money or to pay, renew, or extend the time of payment of (i) a debt of the principal, (ii) or a debt guaranteed by the principal, (iii) a debt of any entity in which the principal has an ownership

- interest, or (iv) a debt guaranteed by any entity in which the principal has an ownership interest.
- (4) Release, assign, satisfy, or enforce by litigation or otherwise a mortgage, deed of trust, conditional sale contract, encumbrance, lien, or other claim to real property which exists or is asserted.
 - (5) Manage or conserve an interest in real property or a right incident to real property owned or claimed to be owned by the principal or to be acquired by the principal, including all of the following:
 - a. Insuring against liability or casualty or other loss.
 - b. Obtaining or regaining possession of or protecting the interest or right by litigation or otherwise.
 - c. Paying, assessing, compromising, or contesting taxes or assessments or applying for and receiving refunds in connection with them.
 - d. Purchasing supplies, hiring assistance or labor, and making repairs or alterations to the real property.
 - e. Obtaining title insurance for the benefit of the principal and/or any lender that has or will obtain a mortgage or deed of trust encumbering the real property.
 - (6) Use, develop, alter, replace, remove, erect, or install structures or other improvements upon real property in or incident to which the principal has, or claims to have, an interest or right.
 - (7) Participate in a reorganization with respect to real property or an entity that owns an interest in or right incident to real property and receive, hold, and act with respect to stocks and bonds or other property received in a plan of reorganization, including all of the following:
 - a. Selling or otherwise disposing of them.
 - b. Exercising or selling an option, right of conversion, or similar right with respect to them.
 - c. Exercising any voting rights in person or by proxy.
 - (8) Change the form of title of an interest in or right incident to real property.
 - (9) Dedicate to public use, with or without consideration, easements or other real property in which the principal has, or claims to have, an interest.
 - (10) With respect to any real property owned or claimed to be owned by the principal's spouse and in which the principal's only interest is a marital interest, waive, release, or subordinate the principal's inchoate right pursuant to G.S. 29-30 to claim an elective life estate in the real property, regardless of whether the waiver, release, or subordination will benefit the agent or a person to whom the agent owes an obligation of support. (2017-153, s. 1.)

§ 32C-2-205. Tangible personal property.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to tangible personal property authorizes the agent to do all of the following:

- (1) Demand, buy, receive, accept as a gift or as security for an extension of credit, or otherwise acquire or reject ownership or possession of tangible personal property or an interest in tangible personal property.

- (2) Sell; exchange; convey with or without covenants, representations, or warranties; quitclaim; release; surrender; create a security interest in; grant options concerning; lease; sublease; or, otherwise dispose of tangible personal property or an interest in tangible personal property.
- (3) Grant a security interest in tangible personal property or an interest in tangible personal property as security for the principal or any entity in which the principal has an ownership interest to borrow money or to pay, renew, or extend the time of payment of (i) a debt of the principal, (ii) a debt guaranteed by the principal, (iii) a debt of any entity in which the principal has an ownership interest, or (iv) a debt guaranteed by any entity in which the principal has an ownership interest.
- (4) Release, assign, satisfy, or enforce by litigation or otherwise, a security interest, lien, or other claim on behalf of the principal, with respect to tangible personal property or an interest in tangible personal property.
- (5) Manage or conserve tangible personal property or an interest in tangible personal property on behalf of the principal, including all of the following:
 - a. Insuring against liability or casualty or other loss.
 - b. Obtaining or regaining possession of or protecting the property or interest, by litigation or otherwise.
 - c. Paying, assessing, compromising, or contesting taxes or assessments or applying for and receiving refunds in connection with taxes or assessments.
 - d. Moving the property from place to place.
 - e. Storing the property for hire or on a gratuitous bailment.
 - f. Using and making repairs, alterations, or improvements to the property.
- (6) Change the form of title of an interest in tangible personal property. (2017-153, s. 1.)

§ 32C-2-206. Stocks and bonds.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to stocks and bonds authorizes the agent to do all of the following:

- (1) Buy, sell, and exchange stocks and bonds.
- (2) Establish, continue, modify, or terminate an account with respect to stocks and bonds.
- (3) Pledge stocks and bonds as security for the principal or any entity in which the principal has an ownership interest to borrow money, or to pay, renew, or extend the time of payment of (i) a debt of the principal, (ii) a debt guaranteed by the principal, (iii) a debt of any entity in which the principal has an ownership interest, or (iv) a debt guaranteed by any entity in which the principal has an ownership interest.
- (4) Receive certificates and other evidences of ownership with respect to stocks and bonds.
- (5) Exercise voting rights with respect to stocks and bonds in person or by proxy, enter into voting trusts, and consent to limitations on the right to vote. (2017-153, s. 1.)

§ 32C-2-207. Commodities and options.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to commodities and options authorizes the agent to do all of the following:

- (1) Buy, sell, exchange, assign, settle, and exercise commodity futures contracts and call or put options on stocks or stock indexes traded on a regulated option exchange.
- (2) Establish, continue, modify, and terminate option accounts. (2017-153, s. 1.)

§ 32C-2-208. Banks and other financial institutions.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to banks and other financial institutions authorizes the agent to do all of the following:

- (1) Continue, modify, and terminate an account or other banking arrangement made by or on behalf of the principal.
- (2) Establish, modify, and terminate an account or other banking arrangement with a bank, trust company, savings and loan association, credit union, thrift company, brokerage firm, or other financial institution selected by the agent.
- (3) Contract for services available from a financial institution, including renting a safe deposit box or space in a vault, and continue, modify, and terminate any such services.
- (4) Withdraw, by check, order, electronic funds transfer, or otherwise, money or property of the principal deposited with or left in the custody of a financial institution.
- (5) Receive statements of account, vouchers, notices, and similar documents from a financial institution and act with respect to them.
- (6) Enter a safe deposit box or vault and withdraw or add to the contents.
- (7) Borrow money and pledge as security personal property of the principal necessary to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal.
- (7a) Guarantee any obligation necessary for any entity in which the principal has an ownership interest to borrow money or to pay, renew, or extend the time of payment of a debt.
- (7b) Pledge as security personal property of the principal necessary for any entity in which the principal has an ownership interest to borrow money or to pay, renew, or extend the time of payment of a debt.
- (8) Make, assign, draw, endorse, discount, guarantee, and negotiate promissory notes, checks, drafts, and other negotiable or nonnegotiable paper of the principal or payable to the principal or the principal's order, transfer money, receive the cash or other proceeds of those transactions, and accept a draft drawn by a person upon the principal and pay it when due.
- (9) Receive for the principal and act upon a sight draft, warehouse receipt, or other document of title, whether tangible or electronic, or other negotiable or nonnegotiable instrument.

- (10) Apply for, receive, and use letters of credit, credit and debit cards, electronic transaction authorizations, and traveler's checks from a financial institution and give an indemnity or other agreement in connection with letters of credit.
- (11) Consent to an extension of the time of payment with respect to commercial paper or a financial transaction with a financial institution.
- (12) Establish, modify, and terminate an ABLE account as defined under section 529A of the Internal Revenue Code with any State or financial institution selected by the agent and have the same authority over the ABLE account as the agent has with regard to any other account with a bank or other financial institution. (2017-153, s. 1.)

§ 32C-2-209. Operation of entity.

Subject to the terms of a document or an agreement governing an entity or an entity ownership interest, and unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to operation of an entity authorizes the agent to do all of the following:

- (1) Operate, buy, sell, enlarge, reduce, or terminate an ownership interest.
- (2) Perform a duty or discharge a liability and exercise in person or by proxy a right, power, privilege, or option that the principal has, may have, or claims to have.
- (3) Enforce the terms of an ownership agreement.
- (4) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to which the principal is a party because of an ownership interest.
- (5) Exercise in person or by proxy, or enforce by litigation or otherwise, a right, power, privilege, or option the principal has or claims to have as the holder of stocks and bonds.
- (6) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to which the principal is a party concerning stocks and bonds.
- (7) With respect to an entity owned solely by the principal:
 - a. Continue, modify, renegotiate, extend, and terminate a contract made by or on behalf of the principal with respect to the entity before execution of the power of attorney.
 - b. Determine all of the following:
 1. The location of its operation.
 2. The nature and extent of its business.
 3. The methods of manufacturing, selling, merchandising, financing, accounting, and advertising employed in its operation.
 4. The amount and types of insurance carried.
 5. The mode of engaging, compensating, and dealing with its employees and accountants, attorneys, or other advisors.
 - c. Change the name or form of organization under which the entity is operated and enter into an ownership agreement with other persons to take over all or part of the operation of the entity.

- d. Demand and receive money due or claimed by the principal or on the principal's behalf in the operation of the entity and control and disburse the money in the operation of the entity.
- (8) Put additional capital into an entity in which the principal has an interest.
- (9) Join in a plan of reorganization, consolidation, conversion, domestication, or merger of the entity.
- (10) Sell or liquidate all or part of an entity.
- (11) Establish the value of an entity under a buyout agreement to which the principal is a party.
- (12) Prepare, sign, file, and deliver reports, compilations of information, returns, or other papers with respect to an entity and make related payments.
- (13) Pay, compromise, or contest taxes, assessments, fines, or penalties and perform any other act to protect the principal from illegal or unnecessary taxation, assessments, fines, or penalties, with respect to an entity, including attempts to recover, in any manner permitted by law, money paid before or after the execution of the power of attorney. (2017-153, s. 1.)

§ 32C-2-210. Insurance and annuities.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to insurance and annuities authorizes the agent to do all of the following:

- (1) Continue, pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract procured by or on behalf of the principal which insures or provides an annuity to either the principal or another person, whether or not the principal is a beneficiary under the contract.
- (2) Procure new, different, and additional contracts of insurance and annuities for the principal and the principal's spouse, children, and other dependents, and select the amount, type of insurance or annuity, and mode of payment.
- (3) Pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract of insurance or annuity procured by the agent.
- (4) Apply for and receive a loan secured by a contract of insurance or annuity.
- (5) Surrender and receive the cash surrender value on a contract of insurance or annuity.
- (6) Exercise an election.
- (7) Exercise investment powers available under a contract of insurance or annuity.
- (8) Change the manner of paying premiums on a contract of insurance or annuity.
- (9) Change or convert the type of insurance or annuity with respect to which the principal has or claims to have authority described in this section.
- (10) Apply for and procure a benefit or assistance under a statute or regulation to guarantee or pay premiums of a contract of insurance on the life of the principal.
- (11) Collect, sell, assign, hypothecate, borrow against, or pledge the interest of the principal in a contract of insurance or annuity.

- (12) Select the form and timing of the payment of proceeds from a contract of insurance or annuity.
- (13) Pay, from proceeds or otherwise, compromise or contest, and apply for refunds in connection with a tax or assessment levied by a taxing authority with respect to a contract of insurance or annuity or its proceeds or liability accruing by reason of the tax or assessment.
- (14) Change the beneficiary to a state or other government entity to qualify the principal for medical assistance or other benefits notwithstanding G.S. 32C-2-201(a)(4) requiring an express grant of authority to change a beneficiary. (2017-153, s. 1.)

§ 32C-2-211. Estates, trusts, and other beneficial interests.

(a) In this section, the term "estate, trust, or other beneficial interest" means a trust, probate estate, guardianship, conservatorship, escrow, or custodianship or a fund from which the principal is, may become, or claims to be, entitled to a share or payment.

(b) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to estates, trusts, and other beneficial interests authorizes the agent to do all of the following:

- (1) Accept, receive, receipt for, sell, assign, pledge, or exchange a share in or payment from an estate, trust, or other beneficial interest.
- (2) Demand or obtain money or another thing of value to which the principal is, may become, or claims to be, entitled by reason of an estate, trust, or other beneficial interest, by litigation or otherwise.
- (3) Exercise for the benefit of the principal a presently exercisable general power of appointment held by the principal.
- (4) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to ascertain the meaning, validity, or effect of a deed, will, declaration of trust, or other instrument or transaction affecting the interest of the principal.
- (5) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to remove, substitute, or surcharge a fiduciary.
- (6) Conserve, invest, disburse, or use anything received for an authorized purpose.
- (7) Transfer an interest of the principal in real property, stocks and bonds, accounts with financial institutions or securities intermediaries, insurance, annuities, and other property to the trustee of a revocable trust created by the principal as settlor. (2017-153, s. 1.)

§ 32C-2-212. Claims and litigation.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to claims and litigation authorizes the agent to do all of the following:

- (1) Assert and maintain before a court or administrative agency a claim, claim for relief, cause of action, counterclaim, offset, recoupment, or defense, including an action to recover property or other thing of value, recover damages

- sustained by the principal, eliminate or modify tax liability, or seek an injunction, specific performance, or other relief.
- (2) Bring an action to determine adverse claims or intervene or otherwise participate in litigation.
 - (3) Seek an attachment, garnishment, order of arrest, or other preliminary, provisional, or intermediate relief and use an available procedure to effect or satisfy a judgment, order, or decree.
 - (4) Make or accept a tender, offer of judgment, or admission of facts, submit a controversy on an agreed statement of facts, consent to examination, and bind the principal in litigation.
 - (5) Submit to alternative dispute resolution, settle, and propose or accept a compromise.
 - (6) Waive the issuance and service of process upon the principal, accept service of process, appear for the principal, designate persons upon which process directed to the principal may be served, execute and file or deliver stipulations on the principal's behalf, verify pleadings, seek appellate review, procure and give surety and indemnity bonds, contract and pay for the preparation and printing of records and briefs, receive, execute, and file or deliver a consent, waiver, release, confession of judgment, satisfaction of judgment, notice, agreement, or other instrument in connection with the prosecution, settlement, or defense of a claim or litigation.
 - (7) Act for the principal with respect to bankruptcy or insolvency, whether voluntary or involuntary, concerning the principal or some other person, or with respect to a reorganization, receivership, or application for the appointment of a receiver or trustee which affects an interest of the principal in property or other thing of value.
 - (8) Pay a judgment, award, or order against the principal or a settlement made in connection with a claim or litigation.
 - (9) Receive money or other thing of value paid in settlement of or as proceeds of a claim or litigation. (2017-153, s. 1.)

§ 32C-2-213. Personal and family maintenance.

(a) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to personal and family maintenance authorizes the agent to do all of the following:

- (1) Perform the acts necessary to maintain the customary standard of living of the principal, the principal's spouse, and the following individuals, whether living when the power of attorney is executed or later born:
 - a. The principal's children who are legally entitled to be supported by the principal.
 - b. Other individuals legally entitled to be supported by the principal.
 - c. The individuals whom the principal has customarily supported or indicated the intent to support.
- (2) Make periodic payments of child support and other family maintenance required by a court or governmental agency or an agreement to which the principal is a party.

- (3) Provide living quarters for the individuals described in subdivision (1) of this subsection by the following means:
 - a. Purchase, lease, or other contract.
 - b. Paying the operating costs, including interest, amortization payments, repairs, improvements, and taxes, for premises owned by the principal or occupied by those individuals.
- (4) Provide normal domestic help, usual vacations and travel expenses, and funds for shelter, clothing, food, appropriate education, including postsecondary and vocational education, and other current living costs for the individuals described in subdivision (1) of this subsection.
- (5) Pay expenses for necessary health care and custodial care on behalf of the individuals described in subdivision (1) of this subsection.
- (6) Act as the principal's personal representative pursuant to the Health Insurance Portability and Accountability Act, §§ 1171 through 1179 of the Social Security Act, 42 U.S.C. § 1320d, as amended, and applicable regulations, in making decisions related to the past, present, or future payment for the provision of health care consented to by the principal or anyone authorized under the law of this state to consent to health care on behalf of the principal.
- (7) Continue any provision made by the principal for automobiles or other means of transportation, including registering, licensing, insuring, and replacing them, for the individuals described in subdivision (1) of this subsection.
- (8) Maintain credit and debit accounts for the convenience of the individuals described in subdivision (1) of this subsection and open new accounts.
- (9) Continue payments incidental to the membership or affiliation of the principal in a religious institution, club, society, order, or other organization or to continue contributions to those organizations.

(b) Authority with respect to personal and family maintenance is neither dependent upon, nor limited by, authority that an agent may or may not have with respect to gifts under this Chapter. (2017-153, s. 1.)

§ 32C-2-214. Benefits from governmental programs or civil or military service.

(a) In this section, the term "benefits from governmental programs or civil or military service" means any benefit, program, or assistance provided under a statute or regulation including Social Security, Medicare, and Medicaid.

(b) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to benefits from governmental programs or civil or military service authorizes the agent to do all of the following:

- (1) Execute vouchers in the name of the principal for allowances and reimbursements payable by the United States or a foreign government or by a state or subdivision of a state to the principal, including allowances and reimbursements for transportation of the individuals described in G.S. 32C-2-213(a)(1), and for shipment of their household effects.
- (2) Take possession and order the removal and shipment of property of the principal from a post, warehouse, depot, dock, or other place of storage or safekeeping, either governmental or private, and execute and deliver a release,

voucher, receipt, bill of lading, shipping ticket, certificate, or other instrument for that purpose.

- (3) Enroll in, apply for, select, reject, change, amend, or discontinue, on the principal's behalf, a benefit or program.
- (4) Prepare, file, and maintain a claim of the principal for a benefit or assistance, financial or otherwise, to which the principal may be entitled under a statute or regulation.
- (5) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation concerning any benefit or assistance the principal may be entitled to receive under a statute or regulation.
- (6) Receive the financial proceeds of a claim described in subdivision (4) of this subsection and conserve, invest, disburse, or use for a lawful purpose anything so received.
- (7) Make elections under the Survivor Benefit Plan as defined under Subchapter II of Title 10 of the United States Code, as amended, including the authority to elect that benefits be paid to a supplemental or special needs trust for a disabled child. (2017-153, s. 1.)

§ 32C-2-215. Retirement plans.

(a) In this section, the term "retirement plan" means a plan or account created by an employer, the principal, or another individual to provide retirement benefits or deferred compensation of which the principal is a participant, beneficiary, or owner, including a plan or account under the following sections of the Internal Revenue Code:

- (1) An individual retirement account under section 408 of the Internal Revenue Code.
- (2) A Roth individual retirement account under section 408A of the Internal Revenue Code.
- (3) A deemed individual retirement account under section 408(q) of the Internal Revenue Code.
- (4) An annuity or mutual fund custodial account under section 403(b) of the Internal Revenue Code.
- (5) A pension, profit sharing, stock bonus, or other retirement plan qualified under section 401(a) of the Internal Revenue Code.
- (6) A plan under sections 457(b) and (f) of the Internal Revenue Code.
- (7) A nonqualified deferred compensation plan under section 409A of the Internal Revenue Code.

(b) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to retirement plans authorizes the agent to do all of the following:

- (1) Select the form and timing of payments under a retirement plan and withdraw benefits from a plan.
- (2) Make a rollover, including a direct trustee-to-trustee rollover, of benefits from one retirement plan to another.
- (3) Establish a retirement plan in the principal's name.
- (4) Make contributions to a retirement plan.

- (5) Exercise investment powers available under a retirement plan.
- (6) Borrow from, sell assets to, or purchase assets from a retirement plan. (2017-153, s. 1.)

§ 32C-2-216. Taxes.

Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to taxes authorizes the agent to do all of the following:

- (1) Prepare, sign, and file federal, State, local, and foreign income, gift, payroll, property, Federal Insurance Contributions Act, and other tax returns, claims for refunds, requests for extension of time, petitions regarding tax matters, and any other tax-related documents, including receipts, offers, waivers, consents, including consents and agreements under section 2032A of the Internal Revenue Code, closing agreements, and any power of attorney required by the Internal Revenue Service or other taxing authority with respect to a tax year upon which the statute of limitations has not run and the following 25 tax years.
- (2) Pay taxes due, collect refunds, post bonds, receive confidential information, and contest deficiencies determined by the Internal Revenue Service or other taxing authority.
- (3) Exercise any election available to the principal under federal, State, local, or foreign tax law.
- (4) Act for the principal in all tax matters for all periods before the Internal Revenue Service, or other taxing authority. (2017-153, s. 1.)

§ 32C-2-217. Gifts authorized by general authority.

(a) In this section, a gift "for the benefit of" an individual includes a gift to a trust, an account under the Uniform Transfers to Minors Act, a tuition savings account or prepaid tuition plan as defined under section 529 of the Internal Revenue Code, and an ABLE account as defined under section 529A of the Internal Revenue Code.

(b) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to gifts authorizes the agent only to do the following:

- (1) Make a gift of any of the principal's property, including by the exercise of a presently exercisable general power of appointment held by the principal for the following purposes:
 - a. To or for the benefit of an individual so long as the value of the gift does not exceed the greater of (i) the amount determined to be in accordance with the principal's history of making or joining in the making of gifts or (ii) the annual dollar limit of the federal gift tax exclusion under section 2503(b) of the Internal Revenue Code without regard to whether the federal gift tax exclusion applies to the gift, or if the principal's spouse agrees to consent to the split gift pursuant to section 2513 of the Internal Revenue Code in an amount per donee not to exceed twice the annual federal gift tax exclusion limit.
 - b. To any organization described in sections 170(c) and 2522(a) of the Internal Revenue Code in accordance with the principal's history of making or joining in the making of gifts.

- (2) Consent, pursuant to section 2513 of the Internal Revenue Code to the splitting of a gift made by the principal's spouse with respect to gifts described in subdivision (1) of this subsection. (2017-153, s. 1.)

§ 32C-2-218. Gifts authorized by court order.

An agent may petition the court for an order authorizing the agent to make a gift of the principal's property that is reasonable under the circumstances, including a gift that is in addition to, or that otherwise differs from, the gifts authorized by the power of attorney. (2017-153, s. 1.)

§ 32C-2-219. Certain acts authorized by the court.

(a) Except as provided in subsection (b) of this section, an agent under a power of attorney that does not expressly grant the agent the authority to do an act described in G.S. 32C-2-201(a) may petition the court for authority to do the act described in G.S. 32C-2-201(a) that is reasonable under the circumstances.

(b) This section shall not apply to the authority of an agent to make a gift pursuant to G.S. 32C-2-218. (2017-153, s. 1.)

Article 3.

Statutory Forms.

§ 32C-3-301. Statutory form power of attorney.

As a nonexclusive method to grant a power of attorney, a document substantially in the following form may be used to create a statutory form power of attorney that has the meaning and effect prescribed by this Chapter:

"NORTH CAROLINA

STATUTORY SHORT FORM POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN CHAPTER 32C 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.

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the North Carolina Uniform Power of Attorney Act.

This power of attorney does not authorize the agent to make health care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Additional Provisions and Exclusions.

This form provides for designation of one agent, successor agent, and second successor agent. If you wish to name more than one agent, successor agent, and second successor agent, you may name a coagent, successor coagent, or second successor coagent in the Additional Provisions and Exclusions. Coagents, successor coagents, or second successor coagents are not required to act together unless you include that requirement in the Additional Provisions and Exclusions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I, _____, name the following person as my agent:
Name of Agent:

_____ (Name of Principal).

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent:

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

Name of Second Successor Agent:

INITIAL below if you want to give an agent the power to name a successor agent.

(_____) I give to my acting agent the full power to appoint another to act as my agent, and full power to revoke such appointment, if no agent named by me above is willing or able to act.

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the North Carolina Uniform Power of Attorney Act, Chapter 32C of the General Statutes:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

- Real Property
- Tangible Personal Property
- Stocks and Bonds
- Commodities and Options
- Banks and Other Financial Institutions
- Operation of Entity or Business
- Insurance and Annuities
- Estates, Trusts, and Other Beneficial Interests
- Claims and Litigation
- Personal and Family Maintenance
- Benefits from Governmental Programs or Civil or Military Service
- Retirement Plans
- Taxes
- All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

- Make a gift, subject to the limitations provided in G.S. 32C-2-217
- Create or change rights of survivorship
- Create or change a beneficiary designation
- Authorize another person to exercise the authority granted under this power of attorney
- Waive my right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
- Exercise fiduciary powers that I have authority to delegate
- Disclaim or refuse an interest in property, including a power of appointment
- Access the content of electronic communications.

EXERCISE OF SPECIFIC AUTHORITY IN FAVOR OF AGENT

(OPTIONAL)

(_____) UNLESS INITIALED, an agent MAY NOT exercise any of the grants of specific authority initialed above in favor of the agent or an individual to whom the agent owes a legal obligation of support.

ADDITIONAL PROVISIONS AND EXCLUSIONS
(OPTIONAL)

(_____) _____

EFFECTIVE DATE

This power of attorney is effective immediately.

NOMINATION OF GUARDIAN
(OPTIONAL)

INITIAL below ONLY if you WANT your acting agent to be your Guardian.

(_____) If it becomes necessary for a court to appoint a guardian of my estate or a general guardian, I nominate my agent acting under this power of attorney to be the guardian to serve without bond or other security.

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

MEANING AND EFFECT

The meaning and effect of this power of attorney shall for all purposes be determined by the law of the State of North Carolina.

SIGNATURE AND ACKNOWLEDGMENT

Your Signature

Date

Your Name Printed

State of _____, County of _____.

I certify that the following person personally appeared before me this day, acknowledging to me that he or she signed the foregoing document: _____.

Date: _____

Signature of Notary Public

(Official Seal)

_____, Notary Public
Printed or typed name

My commission expires: _____

"IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or your authority is terminated or the power of attorney is terminated or revoked. You must:

- (1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
- (2) Act in good faith;
- (3) Do nothing beyond the authority granted in this power of attorney; and
- (4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: (Principal's Name) by (Your Signature) as Agent.

Unless the Additional Provisions and Exclusions in this power of attorney state otherwise, you must also:

- (1) Act loyally for the principal's benefit;
- (2) Avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) Act with care, competence, and diligence;

- (4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
- (5) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects, or if you do not know the principal's expectations, to act in the principal's best interest;
- (6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest; and
- (7) Account to the principal (or a person designated by the principal (if any)) in the Additional Provisions and Exclusions.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminated or revoked this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

- (1) Death of a principal;
- (2) The principal's revocation of the power of attorney or the termination of your authority;
- (3) The occurrence of a termination event stated in the power of attorney;
- (4) The purpose of the power of attorney is fully accomplished; or
- (5) If you are married to the principal, your divorce from the principal, unless the Additional Provisions and Exclusions in this power of attorney state that your divorce from the principal will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the North Carolina Uniform Power of Attorney Act. If you violate the North Carolina Uniform Power of Attorney Act or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice." (2017-153, s. 1.)

§ 32C-3-302. Agent's certification.

The following optional form may be used by an agent to certify facts concerning a power of attorney:

"AGENT'S CERTIFICATION AS TO THE VALIDITY OF
POWER OF ATTORNEY AND AGENT'S AUTHORITY
(G.S. 32C-3-302)

I, _____ (Name of Agent), do hereby state and affirm the following under penalty of perjury:

Date: _____

Signature of Notary Public

(Official Seal)

_____, Notary Public
Printed or typed name

My commission expires: _____"

(2017-153, s. 1.)

§ 32C-3-303. Limited power of attorney for real property.

While no particular phrasing is required for a limited power of attorney for transactions involving the purchase, sale, or financing of real property or tangible personal property related to real property, the following form may be used to create a limited power of attorney for transactions involving the purchase, sale, or financing of designated real property or tangible personal property related to the designated real property. The following form has as the meaning and effect prescribed by this Chapter:

"Return to:

NORTH CAROLINA
LIMITED POWER OF ATTORNEY FOR REAL PROPERTY

I, _____, name the following person as my agent:

(Name of Principal)

Name of Agent: _____

For purposes of this power of attorney, the "Property" is all of that real property located in _____ County, North Carolina, and known or identified as follows:

GRANT OF AUTHORITY

I grant my agent general authority to act for me with respect to the Property, all tangible personal property related to the Property, and all financial transactions relating to the Property. The authority granted to my agent pursuant to this power of attorney expressly includes the following:

- (1) The authority to act with respect to real property as set forth in Section 32C-2-204 of the North Carolina General Statutes;
- (2) The authority to act with respect to tangible personal property as set forth in Section 32C-2-205 of the North Carolina General Statutes; and
- (3) The authority to act with respect to banks and other financial institutions as set forth in Section 32C-2-208 of the North Carolina General Statutes.

(Official Seal)

_____, Notary Public
Printed or typed name"

(2017-153, s. 1.)

Article 4.

Miscellaneous Provisions.

§ 32C-4-401. Uniformity of application and construction.

In applying and construing this Chapter, consideration may be given to the need to promote uniformity of the law with respect to its subject matter among the states that enact it. (2017-153, s. 1.)

§ 32C-4-402. Relation to Electronic Signatures in Global and National Commerce Act.

The provisions of this Chapter governing the legal effect, validity, or enforceability of electronic records or electronic signatures, and of contracts formed or performed with the use of those records or signatures, conform to the requirements of Section 102 of the Electronic Signatures in Global and National Commerce Act (15 U.S.C. § 7002) and supersede, modify, and limit the requirements of the Electronic Signatures in Global and National Commerce Act. (2017-153, s. 1.)

§ 32C-4-403. Effect on existing powers of attorney.

(a) Except as otherwise provided in this Chapter, the following apply on January 1, 2018.

- (1) This Chapter applies to a power of attorney created before, on, or after January 1, 2018, unless there is clear indication of a contrary intent in the terms of a power of attorney or unless application of a particular provision of this Chapter would substantially impair rights of a party.
- (2) This Chapter applies to a judicial proceeding concerning a power of attorney commenced on or after January 1, 2018.
- (3) This Chapter applies to a judicial proceeding concerning a power of attorney commenced before January 1, 2018, unless the court finds that application of a provision of this Chapter would substantially interfere with the effective conduct of the judicial proceeding or prejudice the rights of a party, in which case that the particular provision of this Chapter does not apply and the superseded law applies.
- (4) A rule of construction or presumption provided by this Chapter applies to powers of attorney executed before January 1, 2018, unless there is a clear indication of a contrary intent in the terms of a power of attorney or unless the application of the rule of construction or presumption would substantially impair rights of a party created under North Carolina law in effect prior to January 1, 2018, in which case the rule of construction or presumption does not apply and the superseded rule of construction or presumption applies.

(b) If a right is acquired, extinguished, or banned upon the expiration of a prescribed period that commenced under law of this State other than this Chapter before January 1, 2018, that statute continues to apply to the right even if it has been repealed or superseded.

(c) References to prior statutes and powers of attorney, whether executed on or after the adoption of this Chapter shall be deemed to refer to the corresponding provisions this Chapter unless application of the rule of construction would substantially impair substantial rights of a party.

(d) Notwithstanding the provisions of this Chapter, the powers conferred by former G.S. 32A-2 shall apply to a Statutory Short Form Power of Attorney that was created in accordance with former G.S. 32A-1 prior to January 1, 2018. (2017-153, s. 1.)