OVERVIEW OF HOUSE BILL 634*

JAMES E. CREAMER, JR. — WINSTON-SALEM
E. KNOX PROCTOR V — NEW BERN

Background on Project

Several North Carolina legislators expressed concerns in 2005, in light of constituent questions prompted by the Terri Schiavo case in Florida, about the clarity of North Carolina law on "living wills" and "health care powers of attorney." The North Carolina Bar Association and the North Carolina Medical Society established a working group to consider these concerns. Members of the working group included representatives of the Bar Association's Elder Law, Estate Planning and Health Law sections, and appropriate members of the North Carolina Medical Society. The working group also consulted with the North Carolina Hospital Association, the Carolinas Center for Hospice and End of Life Care, and the North Carolina Health Care Facilities Association.

It became clear that improvements and clarifications were sorely needed, and the working group became a drafting group. After more than a year of hard work, this drafting group prepared the proposal that became House Bill 634: An "Act to Clarify the Rights to Make Advance Directives and to Designate Health Care Agents and to Improve and Simplify the Means of Making these Directives and Designations."[1] The thrust of this bill is clarification of the law of living wills and health care powers of attorney. House Bill 634 also includes the North Carolina Medical Society's MOST medical order.

The drafting group was guided by the principle that the law should enhance, within North Carolina's traditional framework for advance health care directives, a person's ability to exercise rights of self-determination in end-of-life situations. Notwithstanding a lot of misinformation to the contrary, House Bill 634 is **not** a vast expansion of medical treatment withdrawal in end-of-life situations. Nor does it promote "euthanasia" or "assisted suicide."

No law or document can make end-of-life issues easy or painless. However, the clarified law, including the more user-friendly statutory forms, provides North Carolinians with more understandable means to exercise to exercise their self-determination rights and clearer ways to express their end-of-life wishes.

The Changed Statutes

House Bill 634 makes significant revisions to North Carolina's two basic General Statutes that govern end-of-life health care planning:

- Article 23 of Chapter 90, enacted in 1979,[2] which authorizes "declarations of a desire for a natural death," commonly known as "living wills,"[3] and specifies the procedures for withholding medical treatment in end-of-life situations when there is no advance

[1] Session Law 2007-502, effective October 1, 2007.
[2] N.C.G.S. §§ 90-320 *et seq.*
[3] N.C.G.S. § 90-321.

directive.[4] This Living Will statute was part of a first wave of end-of-life legislation enacted in response to the Karen Ann Quinlan case in New Jersey.

- Article 3 of Chapter 32A, enacted in 1991,[5] which authorizes the designation of a "health care agent" in a "health care power of attorney." This statute was part of a second wave of end-of-life legislation enacted in response to the Nancy Cruzan case in Missouri.

House Bill 634 also revises scattered statutes dealing with the effects of living wills and the authority of health care agents in various situations.

Summary of Provisions

House Bill 634 makes these changes:

- Conflicts Between Living Wills and Health Care Powers of Attorney: Allows North Carolinians to **choose** whether the authority of a health care agent, or the wishes stated in a Living Will, "trumps" in the event of a conflict. Current law may not.

- The "Shall" Option: Allows North Carolinians to **require** that their living will be honored.

- Clarification of Statutory Terms: Brings **consistency** to the terminology used in the living will and health care power of attorney statutes, and makes that terminology **clearer** to doctors and to patients.

- Improvements in Statutory Forms: Creates more "**user-friendly**" and **understandable** non-exclusive statutory forms, with more flexibility in exercising choices.

- Clarification of N.C.G.S. § 90-322: Clarifies, in a manner consistent with the other changes made by House Bill 634, the procedures for withholding life-prolonging measures when no living will or health care power of attorney applies.

- Miscellaneous Changes and Provisions. These provisions include:
  - Improvement in execution requirements
  - Clarification of revocation issues
  - Clarification of Advanced Directive Registry issues
  - Clarification of multi-jurisdictional effectiveness
  - Improvements in authority of guardians
  - Clarification of health care agent's authority for post-mortem decisions
  - Improvement of informed consent statute
  - Clarification of liabilities and responsibilities of health care providers

- MOST: Adoption of MOST, a new portable medical order.

[4] N.C.G.S. § 90-322.
[5] N.C.G.S. §§ 32A-15 *et seq.*

House Bill 634 also provides for two studies of health care issues.

Conflicts Between Living Wills and Health Care Powers of Attorney

The Ambiguity: When health care powers of attorney were authorized in 1991, many lawyers and health care providers thought these designations would replace the Living Will. It turns out, however, that many people execute both documents.

If a health care agent gives an instruction which that agent is authorized to give, but those instructions appear to be at odds with an instruction in a living will executed by the principal, which instruction prevails? People who execute both instruments may intend for the designated health care agent to have the final say. Others may wish the living will to control.

Under the old law, it is not clear which instruction controls. This lack of clarity was a major concern of some legislators who approached the Bar Association in 2005.

Argument that Living Will Prevails: It could be argued that Chapter 32A itself provides that the Living Will controls because it states: "[I]n the event of a conflict between the provisions of this Article and Article 23 of Chapter 90 [the living will statute], the provisions of Article 23 of Chapter 90 control."[6] Many lawyers who practice in this area and have studied this issue accept this argument.

Argument that Health Care Agent Prevails: One can argue plausibly, however, that the health care agent's authority prevails. The health care power of attorney statute provides for "the fundamental right of an individual to control the decisions relating to his or her medical care," and states "that this right may be exercised on behalf of the individual by an agent chosen by the individual."[7] The stated goal of the health care power of attorney statute 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 . . . when the individual lacks sufficient understanding or capacity to make or communicate health care decisions."[8] Because only the health care power of attorney statute allows one to give consent to receive treatment, one can argue that no actual conflict exists in this situation. One making this argument would have to assert that the Chapter 32A conflicts rule does not apply to a conflict between instruments, but only to any inadvertent conflict between the two statutes.

Ambiguity Under Old Law Not Resolved: House Bill 634 does **not** clarify the ambiguity in the old statutes. After much discussion, the drafting group concluded that it would be inappropriate to resolve this ambiguity by retroactive legislation. Many people who executed both instruments may have done so with an understanding of which instrument prevailed in the event of a conflict, and it would not be appropriate for retroactive legislation to purport to determine a court's consideration of the legal arguments that can be made for both positions.

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[6] N.C.G.S. § 32A-15(c).
[7] N.C.G.S. § 32A-15(a).
[8] N.C.G.S. § 32A-15(b)(emphasis added).

House Bill 634 Amendment: House Bill 634 allows a person to designate whether a health care agent's authority or a living will provision controls in the event of a conflict. Section 1 of the bill adds the underlined language to the Chapter 32A conflict rule:

> 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. <u>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</u>.[9]

Under this amended statute, either the living will or the heath care power of attorney, or both, may specify which instrument prevails in the event of a conflict.

The new statutory living will form contains a section in which the declarant can make this choice. The drafters did not put the same choice in the statutory health care power of attorney because of the risk that a person using both forms would get confused and insert inconsistent directives about which document prevailed. The drafting group thought the living will form the better place for the choice. One reason is that the statutory living will form will be offered routinely to patients entering health care facilities.

The statutory living will form also specifies that the living will prevails if neither choice is specified.[10] Note that this provision in the new statutory form does not resolve the conflict for most older instruments. This rule will apply, however, to any instruments executed before October 1, 2007, that do specify whether the living will or the health care agent's authority prevailed in the event of a conflict. Although the old statutory forms did not make this specification, some older "custom" forms may have done so.

The "Shall" Option

The old living will statute provided that an attending physician had the option to withhold medical treatment in accordance with the patient's living will.[11] House Bill 634 now allows the patient the choice to either give the physician this option, as before, or to **require** the physician to withhold the treatments.[12]

An attending physician has broad discretion to determine whether the conditions required for withholding treatment actually exist. As a practical matter, this discretion gives the attending physician the ability to decide, in close cases, whether to follow a requirement that the instruction be honored. So, this option does not present a danger that an attending physician will be forced to order treatment withheld against his or her better judgment. But this requirement

[9] N.C.G.S. § 32A-15(c)(as amended by Section 1 of Session Law 2007-502, effective October 1, 2007).
[10] N.C.G.S. § 90-321(d1)(section 6 of statutory form)(added by Section 11(c) of Session Law 2007-502, effective October 1, 2007).
[11] N.C.G.S. § 90-321(b)(prior to amendment by Section 11(a) of Session Law 2007-502, effective October 1, 2007).
[12] N.C.G.S. § 90-321(b)(as amended by Section 11(a) of Session Law 2007-502, effective October 1, 2007).

can relieve the pressure that can be placed on an attending physician to follow a living will when relatives object based on different notions about appropriate cessation of life-prolonging measures. Conversely, when the attending physician is too timid about following the patient's wishes, the "shall" option can provide family members with some leverage, and the attending physician with some comfort.

House Bill 634 protects the rights of health care providers who object to withholding treatment on conscience grounds by allowing them to decline to participate. These health care providers must, however, reasonably cooperate to allow a non-objecting health care provider to carry out the patient's stated wishes.[13]

Clarifications of Statutory Terms

The old living will and health care power of attorney statutes used ambiguous, dated, and inconsistent terms to address (1) when treatments could be withheld and (2) what treatments could be withheld.

*Old Terms for **When** Treatment May be Withheld*: The old *living will* statute provided that certain treatments could be withheld if the attending physician determined, and a second physician confirmed, that a person's condition was either:

- terminal and incurable; or
- diagnosed as a persistent vegetative state.[14]

The statutory form in the old *health care power of attorney* statute gives the health care agent the power to withhold treatments when the patient's physician determines that the patient

- is terminally ill,
- is permanently in a coma,
- suffers severe dementia, or
- is in a persistent vegetative state.[15]

There were several problems with this language, shown by the following examples:

- *Inconsistency Between the Two Instruments*:
  - The living will statute and statutory form made no mention of severe dementia. Does that mean that severe dementia was a ground for withholding treatment under the old forms only if one appoints a health care agent?
  - Is a person in a "terminal and incurable" state, as used in the living will statute, also a person who is "terminally ill," as used in the health care power of attorney statute?
- *Ambiguity*: What comas are permanent? What is "severe" dementia? Is "terminal" illness to be tied to imminent death?

[13] N.C.G.S. § 90-321(k)(added by Section 11(e) of Session Law 2007-502, effective October 1, 2007).
[14] N.C.G.S. § 90-321(b)(prior to amendment by Section 11(a) of Session Law 2007-502, effective October 1, 2007).
[15] N.C.G.S. § 32A-25(section 3(G) of old statutory form)(prior to repeal by Section 6(a) of Session Law 2007-502, effective October 1, 2007).

- *Datedness*: For example: What does "persistent" vegetative state mean now that physicians use that term to refer to an intermediate condition of being vegetative for longer than one month as "persistent" use the word "permanent" to refer to a more prolonged vegetative that is probably not reversible?[16]

*New Terms for **When** Treatment May be Withheld*: A person who executes a living will may *choose* to specify that treatment may be withheld when *any, some, or all* of the following conditions exist:

- The declarant has an incurable or irreversible condition that will result in the declarant's death within a relatively short period of time; or
- The declarant becomes unconscious and, to a high degree of medical certainty, will never regain consciousness; or
- 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.

No terms are perfect, and terms can be "overdefined." The drafting group believes these terms are a vast improvement because they are:

- Not tied to current medical jargon: there is no use of terms like "persistent vegetative state";
- Not confusing to the average person: unlike the word "coma," the phrase "unconscious and . . . will never regain consciousness" does not send the attentive client to the home medical encyclopedia;
- Tied temporally to imminent death: "death within a relatively short period of time" is preferable to "terminal"; and
- Not susceptible to the unintended expansion feared by some. For example, the qualifier "high degree of medical certainty" is inserted, and the phrases "advanced dementia" and "substantial loss of cognitive ability" are better than "severe dementia."

The new health care power of attorney statute and the new statutory form do not include these conditions. The theory of the drafting group was that a person designated as a health care agent, like a person designated an agent in a regular power of attorney is a trusted fiduciary so that the statutory form did not need these explicit standards. But a person could choose to specify in a health care power of attorney that the agent could withhold treatment only under certain conditions, including those described in the living will statute. Some lawyers will no doubt adapt these forms to do so. These materials include a form health care power of attorney form that allows the principal to choose any, some, or all of the three new living will conditions.

[16] American Academy of Neurology, Practice Parameters: Assessment and Management of Patients in a Persistent Vegetative State (1994).

*Old Terms for **What** Treatments May be Withheld*: The old *living will* statute provided that either "extraordinary means" **or** "artificial nutrition and hydration" could be withheld in appropriate circumstances.[17] The term "extraordinary means" was "defined as any medical procedure or intervention 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."[18] The term "artificial nutrition and hydration" was **not defined**.

The old *health care power of attorney* statute allowed a person to grant a health care agent the authority to withhold "life-sustaining procedures,"[19] defined as "those forms of care or treatment which only serve to artificially prolong the dying process 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."[20]

The fundamental problem with the living will statute was the distinction between "extraordinary means" and the undefined term "artificial nutrition and hydration." This distinction reflects a belief of some Roman Catholic and evangelical Christians that "food and water" should be provided until the "very end," and that even food and water provided through tubes should never be considered an extraordinary medical intervention. (See discussion below under "Improvements in Non-Exclusive Statutory Forms — Artificial Nutrition and Hydration").

The old health care power of attorney statute included artificial nutrition and hydration as one of many examples of "life-sustaining procedures." This inclusion reflected the understanding among most health care providers that artificial nutrition and hydration is an invasive medical procedure. What, these health care providers would ask rhetorically, is the fundamental difference between a feeding tube and a mechanical ventilator? Isn't air just as fundamental to life as food and water? Or, is dialysis "extraordinary" in an otherwise healthy kidney patient just because dialysis is more complicated than nutrition and hydration? The obvious response to these rhetorical questions is: the issue in determining whether treatment is extraordinary depends not only on what technology the procedure may involve, but also on the situation of the patient.

The different terms used in the old instruments could lead to great confusion, especially when a patient had executed both instruments. Are "life-sustaining procedures" (health care power of attorney) different from "extraordinary means" (living will)? This is hard to know given the different wording of the definitions and especially given the inclusion of artificial nutrition and hydration among "life-sustaining procedures" but not among "extraordinary means."

[17] N.C.G.S. § 90-321(b)(prior to amendment by Section 11(a) of Session Law 2007-502, effective October 1, 2007).
[18] N.C.G.S. § 90-321(a)(2)(prior to amendment by Section 11(a) of Session Law 2007-502, effective October 1, 2007).
[19] N.C.G.S. § 32A-19(a)(prior to amendment by Section 3 of Session Law 2007-502, effective October 1, 2007).
[20] N.C.G.S. § 32A-16(4)(prior to amendment by Section 2 of Session Law 2007-502, effective October 1, 2007).

*New Terms for **What** Treatments May be Withheld*: The definition of the new term "life-prolonging measures," used in both the living will and health care power of attorney statutes for the treatments that may be withheld, is basically a refinement of the "life-sustaining procedures" definition in the old health care power of attorney statute:

> 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.[21]

The drafting group substituted the phrase "life-prolonging" for "life-sustaining" because the verb "prolong" connotes the concept of artificial postponement of death better than does the verb "sustain."

Although artificial nutrition and hydration are now included as "life-prolonging measures," a person may give special instructions about them. As discussed below, the statutory forms have sections that accommodate special instructions for artificial nutrition and hydration.

Improvements in Non-Exclusive Statutory Forms

General Approach

The drafting group recognized that the vast majority of living wills, and many health care powers of attorney, are executed without the assistance of lawyers. Many health care professionals and patient advocates believe patients (a) pay too little attention to the content of these documents, and (b) have trouble understanding them when they do pay attention.

The drafting group redesigned the numbering and captions of the forms so that their provisions will draw a patient's attention to the separate provisions of the forms. And these forms use the better terminology discussed elsewhere in this paper, so that they are more comprehensible.

To maximize self-determination, the forms include more choices. The drafting group tried to strike a balance in preparing the statutory forms: the new forms should provide more meaningful choices, but not so many choices that the forms became too confusing or laborious to use without counsel.

The drafting group also required the person executing the new forms to initial certain choices. This approach requires more attention by the patient and may cause the patient to ask questions about the choices. This approach was intentional. People who execute these forms are supposed to think about them and understand them. If people dealing with these forms are not advised by a lawyer, then the form itself needs to provide guidance or at least prompt questions.

[21] N.C.G.S. § 32A-16(4)(as amended by Section 2 of Session Law 2007-502, effective October 1, 2007).

Artificial Nutrition and Hydration

One big drafting issue, for both forms, involved choices for "artificial nutrition and hydration." The 1977 living will forms treated these procedures separately from "extraordinary" interventions, giving rise to a number of entrenched beliefs about artificial nutrition and hydration. These beliefs cause many to choose to receive artificial nutrition and hydration even though they reject other interventions, often based on the advice of clergy.

Some very knowledgeable members of the drafting group made a very compelling case that the statutory forms should not have separate choices for artificial nutrition and hydration. They reasoned that some people may not understand that providing water and food through tubes is a quite invasive procedure, and argued that this choice should require specially written exceptions in blank spaces rather than a pre-printed choice that could be initialed. That is a very valid point.

After lengthy consideration, the majority of the drafting group chose to (1) continue to make these option explicit in the living will form, and (2) add those explicit options to the health care power of attorney form, and (3) make abundantly clear in both statutory forms that choosing artificial nutrition and hydration entailed tubes or other invasive mechanisms. This decision choice should accommodate the settled expectations of a substantial number of people, while clarifying for people what this selection involves. This clarity may cause some people to "think twice" about whether they want to "opt in" to artificial nutrition and hydration.

Non-Exclusive Statutory Living Will Form

The new statutory living will form[22] allows one to:

- Elect the "shall" option for withholding life-prolonging measures in certain situations, addressing a common concern that end-of-life wishes will not be followed (see discussion above under "The 'Shall' Option").
- Choose whether a health care agent can override the living will or whether the living will prevails in the event of any conflict.

The new living will form includes these clarifications:

- More informative instructions;
- Reference in the instructions to the Advance Health Care Directive Registry;
- Numbered sections that highlight important provisions for the patient;
- "Blocked off" sections that render each category of limitations more user-friendly;
- Statement that patient wishes to be kept comfortable and free of pain, addressing a common concern of patients;
- Explanation that health care providers may rely on the living will;
- Statement that the patient wants the living will to be effective in any jurisdiction; and
- Explanation that the patient may revoke the living will.

[22] N.C.G.S. § 90-321(d1)(added by section 11(c) of Session Law 2007-502, effective October 1, 2007).

Typographical Error: There is a glitch in the new statutory living will form: Paragraph 1 of the form instructs the patient that he may initial "any **and** all" of the conditions when a living will may be effective; this should have read "any **or** all." The statutory living will form provided in your materials corrects that typographical error.

Non-Exclusive Statutory Health Care Power of Attorney Form

The new statutory health care power of attorney form[23] changes includes these improvements:

- More informative instructions;
- Reference to the Advance Health Care Directive Registry;
- Numbered sections that highlight important provisions for the patient;
- "Blocked off" sections that render each category of limitations more user-friendly;
- Statement that the patient wants the health care power of attorney to be effective in any jurisdiction;
- Provision allowing the health care agent to be reimbursed for reasonable expenses incurred; and
- Clarification that if no physician is named, the determination that the patient lacks the ability to make or communicate health care decisions will be made by the attending physician.

Anatomical Gifts: The new statutory health care power of attorney, unlike the old statutory power, requires the principal to affirmatively choose to give a health care agent the authority to make anatomical gifts.

Typographical Error: There is a glitch in the new statutory health care power of attorney form. The first line of paragraph 4 refers to "the restrictions set forth in paragraph 6"; that phrase should read: "the restrictions set forth in paragraph **5**." The statutory health care power of attorney form provided in your materials corrects that typographical error.

Custom Forms

The new statutory forms are **not** exclusive. The old statutory forms also were not exclusive, but this point sometimes was not clear to health care providers. The drafting group put additional language in statutes adopting both statutory forms to make this point clear,[24] and to make clear, as discussed below under "Liabilities and Responsibilities of Health Care Providers," that health care providers may rely without liability on non-statutory forms.

Despite those additional provisions, lawyers who prepare custom forms should expect a degree of additional scrutiny commensurate with the degree to which their forms depart from the statutory examples. For this reason, many lawyers will no doubt continue to prepare "custom" forms that resemble statutory forms.

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[23] N.C.G.S. 32A-25.1(a)(added by section 6(b) of Session Law 2007-502, effective October 1, 2007).

[24] N.C.G.S. § 32A-25.1(b)(added by section 6(b) of Session Law 2007-502, effective October 1, 2007)(health care powers of attorney); N.C.G.S. § 90-321(i)(as amended by section 11(d) of Session Law 2007-502, effective October 1, 2007)(living will).

Permissible Variations: There are few restrictions on custom forms. The statutes impose the execution requirements of two qualified witnesses and a notarial acknowledgment.[25] Beyond those requirements:

- A "custom" health care power of attorney need only authorize an agent to make health care decisions for the principal;[26] and
- A "custom" living will must offer one, some, or all of the three statutory conditions under which treatment may be withheld.[27]

Within these confines, a person is free to add any special instructions, limitations, conditions, or other provisions they desire. And the two forms may be combined.[28]

Many lawyers equipped to provide patients with meaningful guidance concerning their rights may choose some combination of these types of variations:

- "Streamlining" the forms they proffer to most clients, perhaps eliminating initial requirements for certain choices and making those choices the default;
- Creating additional choices or limitations;
- Eliminating certain choices altogether;
- Eliminating the blanks for handwritten limitations;
- Adding provisions; and
- Combining the health care power of attorney and living will forms.

Old Forms Still Valid: Nothing in House Bill 634 invalidates old statutory forms or old "custom" forms. Those forms will still apply according to those terms. Clients who have executed forms under the old statutes may, of course, wish to consider executing new forms to more clearly express their intent.

Clarification of N.C.G.S. § 90-322

N.C.G.S. § 90-322 specifies procedures for withholding treatment at end of life when there is no living will or health care agent. The attending physician may withhold treatment in certain circumstances with the concurrence of a patient's family members or other representatives or, may act alone in those rare cases when no relatives or representatives are available. House Bill 634 improves the provisions of N.C.G.S. § 90-322 on (a) when treatment may be withheld, and (b) what persons are required to concur in the decision to withhold treatment.

*Old Provisions for **When** Treatment Could be Withheld*: The old statute provided that certain treatments could be withheld, with the consent of a patient's family or other representatives or family, if an attending physician determined, and another physician confirmed, that:

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[25] N.C.G.S. § 32A-16(3)(as amended by Section 2 of Session Law 2007-502, effective October 1, 2007)(health care power of attorney); N.C.G.S. § 90-321(c)(3)(as amended by Section 11(a) of Session Law 2007-502, effective October 1, 2007)(living will).
[26] N.C.G.S. § 32A-16(3)(as amended by Section 2 of Session Law 2007-502, effective October 1, 2007).
[27] N.C.G.S. § 90-321(c)(1)(as amended by Section 11(a) of Session Law 2007-502, effective October 1, 2007).
[28] N.C.G.S. §§ 32A-26 and 90-321(j).

- A person was either:
  - "comatose and there is no reasonable possibility that he will return to a cognitive sapient state" or
  - "mentally incapacitated"; AND
- The person's present state was either:
  - terminal and incurable; or
  - diagnosed as a persistent vegetative state; AND
- Either
  - a vital function of the person could be restored by extraordinary means or a vital function of the person is being sustained by extraordinary means; OR
  - the life of the person could be or is being sustained by artificial nutrition or hydration.[29]

This statute had ambiguity issues similar to, but even worse than, those contained in the old living will statute. (See discussion above under "Clarifications of Statutory Terms — *Old Terms for **When** Treatment May be Withheld*"). It was worse because it:

- Added the medical jargon "comatose" and "cognitive sapient state";
- Added "mentally incapacitated" as an alternative to "comatose," leaving one to wonder if the conditions for withholding treatment in this statute were not very broad indeed; and
- Perpetuated the confusion between "extraordinary means" and "artificial nutrition and hydration," which could be especially confusing for family members when the patient had given no guidance about those treatments.

*New Provisions for **When** Treatment May be Withheld*: House Bill 634 changes N.C.G.S. § 90-322 to provide:

> 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:
>
> (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

[29] N.C.G.S. § 90-322(a)(prior to amendment by Section 12 of Session Law 2007-502, effective October 1, 2007).

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;

then, life-prolonging measures may be withheld or discontinued in accordance with subsection (b) of this section.[30]

NOTE that the drafting group did not include "advanced dementia" as a condition that would allow withholding of treatment in this statute, though it was allowed as an option for patients to choose when they executed documents. The drafting group did not think this condition was appropriate for a person who had executed no instrument.

*Old Provisions on **What** Treatments Could be Withheld*: N.C.G.S. § 90-322 used the same "extraordinary means" and "artificial nutrition and hydration" terms for treatments that could be withheld as were used in the old living will statute. (See discussion above under "Clarifications of Statutory Terms — *Old Terms for **What** Treatments May be Withheld.*")

*New Provisions on **What** Treatments Could be Withheld*: House Bill 634 authorizes "life-prolonging measures" to be withheld, using the same terms for both the living will and the health care power of attorney. (See discussion above under "Clarifications of Statutory Terms — *New Terms for **What** Treatments May be Withheld.*")

*Old Provisions on **Persons to Concur** in Decision to Withholding Treatment*: The old statute also was very unclear about the order of priority of persons with whom the attending physician would consult. It included guardians, spouses, and a "majority of relatives of the first degree."[31] It gave no specification about how to conduct the "voting" that would determine the will of a majority of the "first degree" relatives. Because determination of the degree of kinship would require use of North Carolina's statutory definitions of lineal and collateral kinship,[32] and made no distinction between minor descendants and adult ancestors, the reference to relatives "of the first degree" was so ambiguous as to be at best confusing.

*New Provisions on **Persons to Concur** in Decision to Withholding Treatment*: House Bill 634 creates a new statutory order, which also applies in other statutes the bill revises:

> If a person's condition has been determined to meet the conditions [for when treatment may be withheld] 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:

[30] N.C.G.S. § 90-322(a)(as amended by Section 12 of Session Law 2007-502, effective October 1, 2007).
[31] N.C.G.S. § 90-322(a)(prior to amendment by Section 12 of Session Law 2007-502, effective October 1, 2007).
[32] N.C.G.S. § 104A-1.

(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.[33]

Note that item (3) addresses a "regular" power of attorney that includes health care powers. A "regular" power of attorney that authorizes health care decisions and meets the execution requirements for a health care power of attorney (two qualified witnesses and notary acknowledgment) actually is a "custom" health care power of attorney that does not follow the statutory form. So, item (3) actually addresses only a "regular" power of attorney that includes health care powers but does **not** meet the health care power of attorney execution requirements.

[33] N.C.G.S. § 90-322(b)(as amended by Section 12 of Session Law 2007-502, effective October 1, 2007).

Item (3) only authorizes the holder of such a power of attorney to act under this statute. This statute does **not** convert such a power of attorney into a health care power of attorney.

Note, however: a "regular" power of attorney with health care powers that was executed **before** October 1, 1991, remains valid, presumably as a health care power of attorney, based on a savings provision in the health care power of attorney statute as originally enacted in 1991.[34]

Miscellaneous Improvements and Clarifications

House Bill 634 made a number of miscellaneous clarifications and improvements. These provisions apply to all health care powers of attorney, including those executed before House Bill 634 became effective.

Execution Requirements

The witness requirements in the health care power of attorney and living will statutes were amended to make clear that only paid employees of health care facilities, and not unpaid volunteers, are ineligible to witness these instruments.[35] Family members and health care facilities employees are excluded as qualified witnesses because they may have an interest in withholding treatment. Because both groups are excluded, it often can be difficult to find qualified witnesses once a person has entered a health care facility.

Unpaid volunteers are often available as witnesses, and they have no "stake" in withholding treatment. Some lawyers have been concerned that unpaid volunteers might be considered employees. This clarification should make it easier for lawyers to have these instruments executed in health care facilities.[36]

House Bill 634 also makes clear that the acknowledging notary, as opposed to the witnesses, may be an employee of a health care facility.[37] Some health care facilities had incorrectly applied the "not an employee" rule to the notary as well as the witnesses.

Revocation Issues

Health Care Agent's Revocation of Living Will: Conflicts sometimes arise when a health care agent purports to revoke the principal's living will. House Bill 634 provides that a health care agent may not revoke a living will unless the health care power of attorney "explicitly authorizes that revocation."[38]

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[34] N.C.G.S. § 32A-19(e).

[35] N.C.G.S. § 32A-16(6) (as amended by Section 2 of Session Law 2007-502, effective October 1, 2007)(health care power of attorney); N.C.G.S. § 90-321(c)(3)(as amended by Section 11(a) of Session Law 2007-502, effective October 1, 2007)(living will).

[36] The drafting group initially proposed requiring only one witness for a health care power of attorney, but this proposal was withdrawn due to a preference for the traditional two witness requirement.

[37] N.C.G.S. § 32A-16(3) (as amended by Section 2 of Session Law 2007-502, effective October 1, 2007)(health care power of attorney) and N.C.G.S. § 90-321(c)(4)(as amended by Section 11(a) of Session Law 2007-502, effective October 1, 2007)(living will).

[38] N.C.G.S. § 90-321(e)(as amended by Section 11(d) of Session Law 2007-502, effective October 1, 2007).

A health care agent's revocation of a living will, which is no longer allowed if it ever was, differs from a health care agent's decision under a clause in either a living will or a health care power of attorney specifying that the health care agent's authority prevails in the event of a conflict with a living will provision. (See discussion above under "Conflicts Between Living Wills and Health Care Powers of Attorney").

Patient's Revocation of Living Will Without Regard to Competence: It may seem strange that, under both the old and the new statutes, a person can revoke a living will "without regard to the declarant's mental or physical condition."[39] The drafting group discussed at length whether to retain this provision in the living will statute. Incompetent people ordinarily are not allowed to revoke decisions they made when competent. The drafting group decided to continue to err on the side of presuming that a patient who announces that he or she wishes to revoke a living will is "competent enough" to make his or her own decision under new circumstances. This provision does run some risk that a family member of friend who simply opposes living wills may thwart the patient's intent by manipulating a patient previously declared incompetent into making a revocation.

This provision was not extended to health care powers of attorney because the designation of a trusted agent is more reliable than the living will declaration. Of course, if a person declared incompetent announces an intent to revoke a health care power, that statement would not be lightly dismissed. And House Bill 634 provides for proceedings for a guardian to seek an order from the Clerk suspending a health care agent's authority. (See "Authority of Guardians" below).

Advanced Directive Registry

The Secretary of State maintains an internet directory of advance directives.[40] House Bill 634 corrects a "glitch" so that one may remove a document from that registry without revoking that document.[41]

Multi-Jurisdictional Effectiveness

House Bill 634 provides that health care powers of attorney and living wills executed in other jurisdictions are valid in North Carolina "if they appear to have been executed in accordance with the applicable requirements of that jurisdiction ***or*** of this state."[42]

So, if an instrument executed in Ruritania has only one witness, and it appears to the health care provider (or the provider's counsel) that Ruritanian law only requires one witness, then that instrument is valid in North Carolina despite the two witness requirement of North Carolina law.

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[39] *Id.*
[40] N.C.G.S. §§ 130A-465 *et seq.* (Article 23 of Chapter 130A).
[41] N.C.G.S. § 130A-468(c) and (d)(as amended by Section 16 of Session Law 2007-502, effective October 1, 2007).
[42] N.C.G.S. § 32A-27(added by Section 7 of Session Law 2007-502, effective October 1, 2007))(emphasis added)(health care powers of attorney); N.C.G.S. § 90-321(l)(added by Section 11(e) of Session Law 2007-502, effective October 1, 2007)(emphasis added)(living wills).

Conversely, if an instrument executed in Lemuria has two witnesses, but it appears that Lemurian law requires three witnesses, that instrument also will be valid in North Carolina because it satisfied North Carolina's execution requirements even though it did not satisfy those of Lemuria.

House Bill 634 also makes clear that a "military advanced medical directive executed in accordance with 10 U.S.C. § 1044 or other applicable law is valid in" North Carolina.[43]

Authority of Guardians

A potential for conflict arises when a court appoints a guardian for a person who has executed a living will and/or designated a health care agent. The guardian may issue directives that differ from the Living Will, and/or may seek to revoke a living will or a health care power of attorney. Sometimes, a family member may seek appointment as guardian to thwart the patient's wishes expressed in a living will or the decisions of a health care agent.

Both the old and new statutory health care power of attorney forms give the principal an opportunity to try to avoid this conflict by nominating the health care agent as guardian should one be needed.[44] But those nominations do not prevent someone else from seeking to be appointed guardian, nor do they guarantee that the Clerk will appoint the health care agent if the Clerk finds the principal to be incompetent.

House Bill 634 provides that a guardian does not have authority to revoke a living will.[45]

House Bill 634 also provides that a designated health care agent, to the extent authorized in the health care power of attorney, controls over a guardian of the person or general guardian in

- making a decision about withholding treatment under the health care power of attorney; and
- giving informed consent to medical care when a patient cannot understand and/or communicate health care choices;

unless the Clerk of Court has authorized that guardian to suspend the authority of the health care agent.[46]

The Clerk of Court may suspend a health care agent's authority only in an order setting forth specific findings of fact and conclusions of law. The order also must specify whether the guardian must act consistently with the power of attorney or whether and to what extent the guardian may deviate from the health care power of attorney.[47]

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[43] N.C.G.S. § 90-320(a)(as amended by Section 10 of Session Law 2007-502, effective October 1, 2007).
[44] N.C.G.S. § 32A-25.1(a)(section 7 of sample form)(added by Section 6(b) of Session Law 2007-502, effective October 1, 2007); for the old provision, see Section 5 of sample form in N.C.G.S. § 32A-25 (repealed by Section 6(a) of Session Law 2007-502, effective October 1, 2007).
[45] N.C.G.S. § 35A-1208(b)(added by Section 8 of Session Law 2007-502, effective October 1, 2007).
[46] N.C.G.S. § 35A-1241(a)(3)(as amended by Section 9 of Session Law 2007-502, effective October 1, 2007).
[47] N.C.G.S. § 32A-22(a)(as amended by Section 4 of Session Law 2007-502, effective October 1, 2007).

Health Care Agent's Authority for Post-Mortem Decisions

Changes relating to the health care agent's authority for post-mortem decisions will be discussed in the presentation and paper on organ donation and funeral statutes.

Informed Consent Statute

The informed consent statute[48] covers consent to providing treatment, rather than withholding it. It suffered, however, from the same lack of clarity about the order of priority of persons with whom the attending physician would consult as the old version of N.C.G.S. § 90-322. (See discussion above under "Clarification of N.C.G.S. § 90-322 — *Old Provisions on* ***Persons to Concur*** *in Decision to Withholding Treatment*").

House Bill 634 amends this statute by creating the same order of priority for consenting to provision of treatment as for consenting to withholding treatment.[49] (See discussion above under "Clarification of N.C.G.S. § 90-322 — *New Provisions on* ***Persons to Concur*** *in Decision to Withholding Treatment*").

Liabilities and Responsibilities of Health Care Providers

House Bill 634 makes these improvements in the statutory provisions protecting health care providers from liability for following a patient's living will or health care power of attorney by clarifying that these protections extend to health care providers that honor:

- Any valid health care power of attorney or living will, not just documents that follow the statutory forms;
- Valid health care powers of attorney or living wills that are not on file in the Secretary of State's Advance Directive Registry;
- Any document when advised by legal counsel that the document appears to meet the statutory requirements to be a valid health care power of attorney or living will;
- A document valid as a health care power of attorney or living will under the law of another jurisdiction;[50]
- A revoked document if they have no actual notice of the revocation;[51] and
- A health care power of attorney as to which the health care agent's authority has been suspended, if they have no actual notice of the suspension.[52]

[48] N.C.G.S. § 90-21.13.
[49] *Id*. (as amended by Section 13 of Session Law 2007-502, effective October 1, 2007).
[50] N.C.G.S. § 32A-24(d)(added by Section 5(b) of Session Law 2007-502, effective October 1, 2007)(health care powers of attorney); N.C.G.S. § 90-321(h)(as amended by Section 11(d) of Session Law 2007-502, effective October 1, 2007)(living wills).
[51] N.C.G.S. § 32A-24(d)(added by Section 5(b) of Session Law 2007-502, effective October 1, 2007)(health care powers of attorney); N.C.G.S. § 90-321(e)(as amended by Section 11(d) of Session Law 2007-502, effective October 1, 2007)(living wills).
[52] N.C.G.S. § 32A-22(a)(as amended by Section 4 of Session Law 2007-502, effective October 1, 2007).

The statutory forms of health care power of attorney and living will contain recitals about the liability of health are providers.[53] However, inclusion of such recitals in a form is not required for protection of health care providers. A form that purported to change the statutory protections, of course, might well concern a health care provider.

House Bill 634 updates the protections for physicians by including a provision that honoring a living will, like honoring a health care power of attorney under the newer law for health care powers, shall not be considered to constitute a "lack of professional competence."[54]

House Bill 634 also makes clear that an attending physician may decline to follow a living will "if after reasonable inquiry there are reasonable grounds to question the genuineness or validity of" a living will. It also makes clear, however, that an attending physician has no duty to verify a living will's genuineness or validity.[55]

MOST

This important new change will be covered in detail in the presentation by Dr. Marsha Fretwell and Ms. Melanie Phelps.

This overview simply notes that a MOST is not a patient instrument, like a health care power of attorney or living will, but a physician's order that the patient or the patient's representative signs to clearly convey the wishes of a seriously ill patient at the end of life. It is similar to a portable DNR form, but provides a range of options for cardiopulmonary resuscitation, medical interventions, and antibiotics, as well as medically administered fluids and nutrition.

Like the other changes in House Bill 634, the MOST form promotes patient self-determination at the end of life within North Carolina's traditional framework for those decisions.

Studies

As a result of questions raised in the legislative process leading to its enactment, House Bill 634 authorizes two studies.

2008 Study

House Bill 634 authorizes a Legislative Research Commission study to make recommendations to the 2008 short session. The question to be studied is "whether North Carolina law should be amended to allow a person to require life-prolonging measures," and "all stakeholders" are to be represented.[56]

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[53] N.C.G.S. § 32A-25.1(added by Section 6(b) of Session Law 2007-502, effective October 1, 2007)(paragraphs 9(C) and (D) of statutory health care power of attorney form); N.C.G.S. § 90-321(d1)(added by Section 11(c) of Session Law 2007-502, effective October 1, 2007)(paragraph 7 of statutory living will form).
[54] N.C.G.S. § 90-321(h)(as amended by Section 11(d) of Session Law 2007-502, effective October 1, 2007); *cf.* N.C.G.S. § 32A-24(c)(same phrase for health care powers of attorney).
[55] N.C.G.S. § 90-321(k)(2)(added by Section 11(e) of Session Law 2007-502, effective October 1, 2007).
[56] Session Law 2007-502, Section 18.

North Carolina's traditional framework assumes that treatment will be provided unless it is withheld under (1) a living will, (2) the directions of a health care agent, or (3) the procedures in N.C.G.S. 90-322. North Carolina Right to Life has pointed out that no North Carolina law specifically requires health care providers to honor the request of a person or a person's agent to provide life-prolonging measures. Right to Life is concerned that people who indicate that they wish to continue to receive life-prolonging measures be enabled to do so. National Right to Life and North Carolina Right to Life have developed a North Carolina "Will to Live" form. This "Will to Live" actually is a health care power of attorney that instructs the agent to direct health care providers to continue to provide such procedures as mechanical ventilation and artificial nutrition and hydration.[57]

Of course, if the General Assembly decides to move beyond North Carolina's traditional framework, and legislatively mandate that health care providers provide all life-prolonging treatments requested by a patient, it also will have to consider such issues as bed space and non-payment by patients and their insurers. Logically, a mandate made after consideration of these issues also would provide for balanced limitations on these obligations.

Based on what Right to Life proposed for consideration by the 2007 General Assembly, what could be considered includes (1) some form of "futility statute," which affirmatively authorizes health care providers to cease to provide treatment they deem futile, along with (2) "treatment pending transfer" provisions that require the provision of life prolonging measures pending the patient's transfer to a health care provider that will continue to life-prolonging measures. National Right to Life's paper on the subject opines that states provide different levels of protection for "treatment pending transfer."[58] It also notes that North Carolina is apparently the only state in the country without a "futility statute."[59] Right to Life apparently would accept adoption of a futility statute, which seems contradictory to its policies, in order to assure that statutes protecting "treatment pending transfer" were adopted.

It also appears that Right to Life might propose to amend the statutory forms to insert options to initial that would require treatment to be provided. A statement that requested life-prolonging measures would be quite confusing in a form titled "declaration of a desire for a natural death."

2013 Study

The North Carolina Institute of Medicine, a non-profit health policy analysis organization chartered by the General Assembly, is to "study issues related to the provision of end-of-life medical care in North Carolina." It is to retrieve "nonidentifying information regarding claims and complaints related to end-of-life medical treatment by health care providers that was contrary to the express wishes of either the patient or a person authorized by law to make treatment decisions on behalf of the patient" from the Division of Health Service Regulation of the Department of Health and Human Services, and from the North Carolina Board of Medicine. "The purpose of this study is to determine whether statutory changes related to advance

[57] http://www.nrlc.org/euthanasia/willtolive/docs/north.carolina.rev0206.pdf (September 30, 2007).
[58] "Will Your Advance Directive be Followed?," Robert Powell Center for Medical Ethics of the National Right to Life Committee, April 15, 2005 (no longer available on National Right to Life web site as of September 30, 2007).
[59] See *Id.*, page A4 (North Carolina "[h]as no apparently relevant provision").

directives and health care powers of attorney impact the type and quantity of end-of-life medical care provided to patients, whether the patient's or patient representative's express wishes regarding the provision of treatment at the end of life are being honored, and whether there is any change in the number of persons who request continued treatment at the end of their lives, but do not receive that treatment."[60]

The wording of this section reflects the concerns aroused in some legislators by anecdotal claims bruited by opponents of House Bill 634.

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[60] Session Law 2007-502, Section 19.