Introduction
Patients have the right to accept or refuse health care treatment. For a patient to exercise that right, he or she must have the capacity to make health care decisions. If a patient lacks capacity, someone else must make these decisions for the patient. Advance directives allow patients (1) to appoint someone to make health care decisions on their behalf if they are unable to do so, and (2) to make some health care decisions in advance. An advance directive “speaks for” the patient when the patient cannot speak for himself.

Tennessee does not require any specific form to be used as an advance directive, but whatever form a patient chooses should comply with Tennessee law. To simplify matters, Tennessee has officially “approved” four different forms or documents that may be used as advance directives: (1) an Advance Care Plan, (2) a living will, (3) an appointment of a health care agent, and (4) a durable power of attorney for health care. The first two are documents a patient may use to accept or reject life sustaining treatment at the end of life. The latter two documents designate someone to make health care decisions on behalf of the patient when and if the patient lacks capacity to make health care decisions.

Tennessee Health Care Decisions Act
The Tennessee Health Care Decisions Act (HCDA) became effective on July 1, 2004. This law was intended to clarify and simplify advance directives and to give patients more flexibility in their choices for end-of-life care. Several model forms were created as a result of this law, including: (1) an Advance Care Plan, and (2) an appointment of a health care agent. The HCDA did not change the laws that existed prior to July 1, 2004, so a living will and durable power of attorney for health care are still available. This factsheet briefly explains all four documents.

Advance Care Plan
An Advance Care Plan (ACP) is a flexible document that gives a patient many options in planning for end-of-life care. With an ACP, a patient may accept or reject life sustaining treatment (CPR, life support, tube feeding and IV fluids) under the following conditions: (1) if the patient is in a permanent unconscious condition; (2) if the patient is suffering from permanent confusion; (3) if the patient becomes dependent in all activities of daily life; or (4) if the patient is in the end-stages of a disease. The patient may also use an ACP to designate a health care agent, decide how new medical conditions should be treated, give other instructions (such as hospice, burial arrangements, etc.), and make anatomical gifts.

A patient with capacity may revoke the designation of a health care agent in an ACP by either signing a written statement to that effect or by personally informing the supervising health care provider. A patient with capacity may revoke all or part of an ACP (other than the designation of a health care agent) at any time and in any manner that communicates an intent to revoke. If the health care provider knows that a patient has revoked all or part of an ACP, the
revocation should be noted in the patient’s medical chart as soon as possible. If a patient signs a new ACP without revoking a prior ACP, the most recently dated ACP controls.

Living Will
The living will was statutorily created under the Tennessee Right to Natural Death Act in 1985. A living will is the patient’s statement that he or she does not want to be kept alive by artificial means if the patient’s condition is terminal, and there is no reasonable medical expectation of recovery. A “terminal condition” is defined as any disease, illness, injury or condition, including but not limited to a coma or persistent vegetative state. Whether there is a reasonable medical expectation of recovery is determined by the attending physician.

With a living will, the patient requests only the administration of medications or the performance of procedures that are necessary to provide comfort care or alleviate pain. The patient also chooses whether he or she wants artificial nutrition or hydration under the stated conditions. A patient may also use a living will to make anatomical gifts.

A patient may revoke a living will at any time, without regard to the patient’s mental state or competency, by communicating to the attending physician or other concerned health care provider by either (1) a written dated and signed revocation, or (2) an oral revocation made to the attending physician. A revocation must be entered into the medical record as soon as possible.

Appointment of Health Care Agent
A patient may use an ACP to appoint a health care agent, but Tennessee provides a form that may be used solely for this purpose. The new form simply names a health care agent and an alternate health care agent in the event that the first named health care is not reasonably available.

A health care agent has the power to make any decision for the patient that the patient could make if able. A health care agent has no power unless the attending physician determines that the patient lacks the capacity to make health care decisions. The appointment of a health care agent may be revoked by the patient, so health care providers must be alert for the possibility of revocation.

Durable Power of Attorney for Health Care (DPAHC)
A durable power of attorney for health care appoints an “attorney-in-fact” who may make health care decisions on behalf of the patient if and when the patient lacks the capacity to do so. The Tennessee Health Care Decisions Act adopts the new terminology of “health care agent.”

A health care provider should read a DPAHC to see if there are any limitations on the agent’s power. A patient may also use a DPAHC to express his or her preferences as to any type of treatment he or she wants or does not want, so the health care provider should know if any such preferences are stated. An agent must act consistently with the patient’s desires as stated in the document.

Unless otherwise specified, a DPAHC gives the agent the power before and after the patient dies to (1) authorize an autopsy, (2) make anatomical gifts; and (3) direct the disposition of the patient’s remains.

A patient who has capacity to make health care decisions may revoke the authority of the agent either by notifying the agent or the health care provider. The notification may be oral or written. If given to the health care provider, he or she must make the revocation part of the medical record and must make a reasonable effort to notify the agent of the revocation.

How the Four Documents Work Together
An ACP may be used instead of a living will and a durable power of attorney for health care. The Appointment of a Health Care Agent form may be used instead of the durable power of attorney for health care. The new documents created under the HCDA replace the living will and durable power of attorney for health care with simpler, more flexible forms. However, Tennessee law gives people the option of using whichever of the four documents that they prefer, but it is not intended, nor recommended, that someone have all four documents.

Health care providers need to know that different rules apply to these documents. Which rules apply to the living will and DPAHC depend upon when the documents were signed and what law they specify, if any. A living will or DPAHC signed before July 1, 2004 should be interpreted under the law in effect prior to July 1, 2004. A living will or DPAHC signed on or after July 1, 2004 should be interpreted under the law that became effective on July 1, 2004, unless the document evidences an intent that it should be interpreted under the prior law. Legal counsel may be needed to help health care providers meet the challenge of interpreting one legal document under the rules written for another legal document.

Health Care Providers’ Obligations and Potential Liability
The patient or the patient’s representative is obligated to notify the health care provider of the existence of
an advance directive or of any changes or revocations. Once notified, the health care provider is obligated to put a copy of the advance directive and to note any changes or revocations in the patient's medical chart.

Under the HCDA, a health care provider is required to comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person authorized to make health care decisions for the patient. Health care providers are also required to comply with a health care decision made by an authorized person to the same extent as if the decision had been made by the patient. Failure to comply with a patient’s advance directive may result in disciplinary action against the health care provider by the appropriate licensing board, providing the health care provider had actual knowledge of the directive.

A health care provider may decline to comply with an individual instruction or health care decision on the following grounds: (1) for reasons of conscious, or (2) if it requires medically inappropriate health care or health care contrary to generally accepted health care standards. The noncompliant health care provider must transfer the patient to another health care provider, if possible. A refusal to comply requires (1) prompt notification to the patient or family; (2) continuing care until the transfer is effected, and (3) assistance in arranging the transfer. If transfer is not possible after making a good faith reasonable effort, the health care provider will not be forced to comply.

A health care provider who acts in good faith and in accordance with generally accepted health care standards will not be subject to civil or criminal liability or to discipline for unprofessional conduct for (1) complying with a health care decision of someone who appears to have authority to make a decision on behalf of the patient, including a decision to withhold or withdraw health care; (2) declining to comply with a health care decision of a person on the belief that the person lacked authority; or (3) complying with an advance directive and assuming that it was valid when signed and that it has not been revoked or terminated.

A health care provider who intentionally violates the law may be subject to damages of $2,500 (or more if actual damages are greater), plus attorney’s fees and costs. The withholding or withdrawal of medical care from a patient in accordance with a patient’s advance directive and in compliance with the law does not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

**Do Not Resuscitate Orders**

An ACP and a living will are statements of the patient’s preferences about what medical care they do or do not want at the end of life. Neither document orders the withdrawal or withholding of life sustaining measures. Physician involvement is necessary before that point is reached, and the attending physician must find that certain criteria (as specified in the documents) are met before entering an order that would withhold or withdraw life sustaining measures.

Neither document should be confused with a do not resuscitate order (DNR). A DNR order is entered by a physician that orders the withholding of cardiopulmonary resuscitation (CPR) if the patient’s heart stops beating or if the patient stops breathing.

The HCDA adopted a Universal DNR order (UDNR). A UDNR order is a written order that applies regardless of the treatment setting. It must be signed by the patient’s physician, and it states that in the event the patient suffers a cardiac or respiratory arrest, CPR should not be attempted.

To meet the requirements of the HCDA, a UDNR order:

1. Must be signed by a physician for a patient with whom there is a physician-patient relationship; and
2. May be entered only with the consent of the patient, or the patient’s health care agent, surrogate, or other authorized person.

If the patient is transferred to another facility, a copy of the UDNR order must accompany the patient, and upon admission, the receiving facility must make the UDNR order part of the patient’s record. The purpose of adopting a UDNR order was to have one form used by all health care entities in Tennessee that would stay with the patient even if transferred to another facility.

**Revocation of a UDNR order.** Any expression of a desire that the patient be resuscitated, either by the patient or by a person who is authorized to make this decision on behalf of a patient, revokes a UDNR order. However, a health care provider is not required to provide CPR of a patient if the physician has determined CPR would be medically inappropriate for that patient.

**POST (Physician Orders for Scope of Treatment)**

Another form that was created under the HCDA is a POST (Physician Orders for Scope of Treatment). A POST is a physician order sheet based upon the medical conditions and wishes of the patient. It is
A POST should include the following:
- The patient’s name and date of birth;
- The signature of the patient or health care representative, if possible;
- The physician’s orders;
- The basis for the orders; and
- Physician’s signature.

Part of the form may be completed by a nurse or a social worker who discusses end-of-life issues with the patient, but a physician must sign the POST and discuss the contents with the patient or patient representative. If the patient is transferred to another facility, the transferring facility must provide the receiving facility with a copy of the POST.

**Health Care Representative**
When a patient lacks the capacity to make health care decisions, someone else must make these decisions on the patient’s behalf. The Tennessee Health Care Decisions Act (HCDA) provides a comprehensive set of rules for determining who has this right. Health care providers must know the rules to ensure that the legally authorized person is giving consent for health care treatment on behalf of the patient. Failing to identify this person may give rise to a potential claim for medical battery or lack of informed consent. Below is a list, in the order or priority, of who has the legal right to make health care decisions for an incapacitated patient.

**First priority (health care agent).** If the patient lacks capacity to make health care decisions, the health care provider should look first for someone who has been formally appointed by the patient. Under Tennessee law, a patient may formally appoint a health care agent in one of three ways:
- Advance Care Plan,
- Appointment of Health Care Agent. or
- Durable Power of Attorney for Health Care.

**Second priority (judicially appointed guardian).** If the patient has not formally appointed a health care agent (or if this person is not reasonably available), the health care provider should next turn to a person who has been judicially appointed as the patient’s guardian (also known as a conservator). A judicially appointed guardian does not take precedence over a health care agent unless ordered by the court.

**Note:** Being “reasonably available” means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient’s health care needs. Such availability includes availability by telephone.

**Third priority (patient designated surrogate).** If there is no health care agent appointed by the patient and if there is no judicially appointed guardian (or neither is reasonably available), the third person the health care provider should turn to is someone who has been informally appointed by the patient, called a “patient designated surrogate.” A patient informally designates a surrogate by personally informing the supervising health care provider. The designation may be oral or in writing and should be noted in the medical record.

**Physician Designated Surrogate.** If the patient lacks capacity, has not appointed a health care agent, has not designated a surrogate, and does not have a judicially appointed guardian, (or none of them are reasonably available), the supervising health care provider must choose the patient’s surrogate decision-maker and document the choice in the clinical record. Tennessee provides a checklist to guide the supervising health care provider in choosing a surrogate who meets the following criteria.

The surrogate must be an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, who is reasonably available, and who is willing to serve. The supervising health care provider may consider the following people to serve as surrogate in order of descending preference (not priority):
- The patient’s spouse, unless legally separated;
- The patient’s adult child;
- The patient’s parent;
- The patient’s adult sibling;
- Any other adult relative of the patient; or
- Any other adult who satisfies the listed criteria.
The supervising health care provider must use the following criteria to determine who is the best person to serve as the patient’s surrogate. Ideally, the proposed surrogate:

- Has the ability to make decisions in accordance with the known wishes of the patient or in accordance with the patient’s best interests;
- Has had regular contact with the patient prior to and during the incapacitating illness;
- Demonstrates care and concern for the patient;
- Is available to visit the patient during his or her illness; and
- Is available to engage in face-to-face contact with the health care providers for the purpose of fully participating in the decision-making process.

If the physician’s choice of surrogate is challenged, there is a rebuttable presumption that the choice is valid. The burden of proving the invalidity of the selection is on the person who challenges the selection. The physician who chooses the surrogate in good faith is not subject to civil or criminal liability or to discipline for unprofessional conduct.

**Designated Physician.** If none of the people eligible to act as the surrogate are reasonably available, the designated physician (the physician who has primary responsibility for the patient’s health care) may make health care decisions for the patient after the designated physician either (1) consults with and obtains the recommendations of the facility’s ethics committee, or (2) obtains concurrence from an independent, nontreating physician.

**Agent’s or Surrogate’s Authority.** As long as a patient has capacity to make health care decisions, an agent or surrogate has no authority. The agent’s or surrogate’s authority is triggered when the attending physician determines that the patient lacks capacity. An agent or surrogate must make decisions based upon what the patient would want, if known, or if not known, what is in the patient’s best interest. An agent or surrogate does not have authority to make decisions that are contrary to the known wishes of the patient. An agent or surrogate is legally bound to make decisions based upon (in the order of descending priority):

- the patient’s individual instructions, if any,
- other wishes of the patient to the extent known to the agent or surrogate, and
- the patient’s best interest, after considering the patient’s personal values to the extent known to the agent or surrogate.

A surrogate appointed by someone other than the patient may make all health care decisions for the patient that the patient could make if able, except for the withdrawal or withholding of artificial nutrition or hydration. In this case, artificial nutrition or hydration may be withheld or withdrawn with the consent of the surrogate only if the designated physician and a second independent physician certifies in the patient’s medical record that the continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions. Some states require a second physician’s concurrence to terminate life support systems under all circumstances.

**Conclusion**

Advance directives are often forms that patients fill out on their own without fully understanding what the documents mean. Health care providers can provide a valuable service to their patients by encouraging discussion and promoting patient understanding of the medical ramifications of having, or not having, advance directives.

For more information see: http://health.state.tn.us/Boards/AdvanceDirectives/index.htm

**Disclaimer:** The information contained in this factsheet is educational in nature and provided as a public service. It is neither a comprehensive statement of the law nor intended as legal advice, and it should not be relied upon as such. The information is based upon Tennessee law, and the law in other states may be different. Laws may change without notice, rendering the information contained in this factsheet inaccurate. If you have specific legal questions, please consult an attorney.

**Written by:** Carol A. Schwab, J.D., LL.M., Director of Medical/Legal Education, Office of Academic, Faculty & Student Affairs, Professor, College of Pharmacy, University of Tennessee Health Science Center, Memphis, TN.

**Revised:** May 2009