Key Effects of Delaware's New Uniform Health-Care Decisions Act (2023) on DMOST Act

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This is a 10 Minute Introduction to:

- What could be a 3-hour presentation.
- Scope is limited to matters most impacting daily work of DMOST Steering Committee members.

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Health-Care Decisions Act (1993), enacted 1996

16 Del. C. Ch. 25

Effective Until 9/30/25

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Uniform Health-Care Decisions Act (2023), enacted 9/30/24

16 Del. C. Ch. 25

Effective 9/30/25

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Delaware Medical Orders for Scope of Treatment Act

16 Del. C. Ch. 25A

(Enacted 2015, Effective 2016)

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A Technical Difference
(but pretty much the same)

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Capacity To Make a DMOST v. to Make a Health-Care Decision/Instruction

DMOST 2503A(2) "Decision-making capacity" means a patient's ability to understand and appreciate the nature and consequences of a particular health-care decision, including the benefits and risks of that decision and alternatives to any proposed health care, and to reach an informed health-care decision.

- **Similar to but broader than UHCDA Section 2503(1) "Capacity" to make a "Health-Care Decision" or "Health-Care Instruction":**

"Understands the nature and consequences of the decision/instruction, including the primary risks and benefits of the decision."

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A Procedure-Changing Difference for Physician Offices:

It will be difficult (but not impossible) for DMOST professionals in the physician office to know who is the "Authorized Representative" to sign a DMOST on a patient's behalf.

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And … the DMOST Form Expressly Requires:

"If authorized representative signs, the medical record must document that a physician has determined the patient's incapacity & the authorized representative's authority, in accordance with DE law."

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Who is the "Authorized Representative" to sign a DMOST on a patient's behalf?

16 Del. C. 2503A(12): "Patient's authorized representative" or "authorized representative" means the individual signing a DMOST form on behalf of a patient without decision-making capacity, who has the highest priority to act for the patient under law, and who has the authority to make decisions with respect to the patient's health-care preferences being made on the DMOST form such individual is executing on behalf of the patient. The health-care practitioner shall determine the individual who is the patient's authorized representative by referencing the documentation giving such individual the required authority under law. …

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16 Del. C. 2503A (12) Cont'd

"Based on the documentation provided by such individual as evidence of his or her authority, the patient's authorized representative could be an individual designated by a patient under an advance health-care directive, an agent under a medical durable power of attorney for health-care decisions, a guardian of the person appointed pursuant to Chapters 39 and 39A of Title 12, in accordance with the authority granted by the appointing court, a surrogate appointed under Chapter 25 of this title, or an individual who is otherwise authorized under applicable law to make the healthcare decisions being made by execution of the DMOST form on the patient's behalf, if the patient lacks decision-making capacity." (See also 16 DE Admin. Code 4304, 4.9.)

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Reviewing the Health Care Directive alone might not be enough to know who is “Authorized Representative.”

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5 Reasons It Will Be Difficult to Know Who is a Patient's "Authorized Representative"

1. Who decides patient lacks capacity?

- Under the UHCDA, capacity is presumed. An agent only has authority to act when there is a finding a patient lacks capacity.
- Under the DMOST Act, an "Authorized Representative" may sign a DMOST only when: 1) the agent has authority "under law" (i.e., under the UHCDA); AND 2) the patient lacks capacity under the DMOST Act to sign the DMOST. Both statutes must be satisfied, as in the past, but the past HealthCare Decisions Act was easier to satisfy because it lacked a robust patient objection process.

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Who decides a patient lacks capacity?

Under the DMOST Act, a physician. 16 Del. C. 2518A(b).

Under the new UHCDA, any one in the following list:

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§ 2504. Presumption of capacity; overcoming presumption

(a) An individual is presumed to have capacity to make or revoke a health-care decision, health-care instruction, and power of attorney for health care unless either of the following:

(1) A court has found the individual lacks capacity to do so.

(2) The presumption is rebutted under subsection (b) of this section.

(b) Subject to §§ 2505 and 2506 of this title and subsection (c) of this section, a presumption under subsection (a) of this section may be rebutted by a finding that the individual lacks capacity:

(1) Made on the basis of a contemporaneous examination by **any** of the following individuals who must be licensed or otherwise authorized to practice in this State and must have training and expertise in the finding of lack of capacity:

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§ 2504 Cont.

a. A physician.

b. A psychologist.

c. A physician assistant.

d. An advanced practice registered nurse.

e. A licensed clinical social worker.

f. A responsible health-care professional not described in paragraphs (b)(1)a. through (b)(1)e. of this section if both of the following:

1. The individual about whom the finding is to be made is experiencing a health condition requiring a decision regarding health-care treatment to be made promptly to avoid loss of life or serious harm to the health of the individual.

2. An individual listed in paragraphs (b)(1)a. through (b)(1)e. of this section is not reasonably available.

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§ 2504 Cont.

(2) Made in accordance with accepted standards of the profession and the scope of practice of the individual making the finding and to a reasonable degree of certainty; and

(3) Documented in a record signed by the individual making the finding that includes an opinion of the cause, nature, extent, and probable duration of the lack of capacity.

(c) The finding under subsection (b) of this section may not be made by any of the following:

(1) A family member of the individual presumed to have capacity.

(2) The cohabitant of the individual or a descendant of the cohabitant.

(3) The individual's surrogate, a family member of the surrogate, or a descendant of the surrogate.

(d) If the finding under subsection (b) of this section was based on a condition the individual no longer has or a responsible health-care professional subsequently has good cause to believe the individual has capacity, the individual is presumed to have capacity unless a court finds the individual lacks capacity or the presumption is rebutted under subsection (b) of this section.

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2. UHCDA Different Capacity Definitions for Different Choices

The new UHCDA creates a lower capacity standard for choosing AND REVOKING an agent: 1) recognize identity; and 2) understand relationship.

For decision/instruction making, standard is similar to past statute and to DMOST Act.

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§ 2503. Capacity.

(a) An individual has capacity … if the individual is willing and able to communicate a decision independently or with appropriate services, technological assistance, supported decision making, or other reasonable accommodation and in making or revoking:

(1) A health-care decision, understands the nature and consequences of the decision, including the primary risks and benefits of the decision.

(2) A health-care instruction, understands the nature and consequences of the instruction, including the primary risks and benefits of the choices expressed in the instruction.

(3) An appointment of an agent under a health-care power of attorney or identification of a default surrogate …, recognizes the identity of the individual … and understands the general nature of the relationship ….

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3. Where does the objection process stand?

The UHCDA creates a new process for a patient to object to a finding of incapacity. A finding of incapacity is not final until that process is complete.

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§ 2505. Notice of finding of lack of capacity; right to object.

(a) As soon as reasonably feasible, an individual who makes a finding under § 2504(b) of this title shall inform the individual about whom the finding was made or the individual's responsible health-care professional of the finding.

(b) As soon as reasonably feasible, a responsible health-care professional who is informed of a finding under § 2504(b) of this title shall inform the individual about whom the finding was made and the individual's surrogate.

(c) An individual found under § 2504(b) of this title to lack capacity may object to the finding in any of the following ways:

(1) By orally informing a responsible health-care professional.

(2) In a record provided to a responsible health-care professional or the health-care institution in which the individual resides or is receiving care.

(3) By another act that clearly indicates the individual's objection.

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§ 2505. Cont.

(d) If the individual objects under subsection (c) of this section, the finding under § 2504(b) of this title is not sufficient to rebut a presumption of capacity in § 2504(a) of this title and the individual must be treated as having capacity unless any of the following:

(1) The individual withdraws the objection.

(2) A court finds the individual lacks the presumed capacity.

(3) The individual is experiencing a health condition requiring a decision regarding health-care treatment to be made promptly to avoid imminent loss of life or serious harm to the health of the individual.

(4) Subject to subsection (e) of this section, the finding is confirmed by a second finding made by an individual authorized under § 2504(b)(1) of this title who satisfies all of the following:

a. Did not make the first finding.

b. Is not a family member of the individual who made the first finding.

c. Is not the cohabitant of the individual who made the first finding or a descendant of the cohabitant.

d. Paragraphs 2504(b)(2) through (b)(3) of this title.

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§ 2505. Cont.

(e) A second finding that the individual lacks capacity under paragraph (d)(4) of this section is not sufficient to rebut the presumption of capacity if the individual is requesting the provision or continuation of life-sustaining treatment and the finding is being used to make a decision to withhold or withdraw the treatment.

(f) As soon as reasonably feasible, a health-care professional who is informed of an objection under subsection (c) of this section shall do both of the following:

(1) Communicate the objection to a responsible health-care professional.

(2) Document the objection and the date of the objection in the individual's medical record or communicate the objection and the date of the objection to an administrator with responsibility for medical records of the health-care institution providing health care to the individual, who shall document the objection and the date of the objection in the individual's medical record.

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§ 2506. Judicial review of finding of lack of capacity.

(a) An individual found under § 2504(b) of this title to lack capacity, a responsible health-care professional, the health-care institution providing health care to the individual, or a person interested in the welfare of the individual may petition the Court of Chancery in the county in which the individual resides or is located to determine whether the individual lacks capacity.

(b) The court in which a petition under subsection (a) of this section is filed shall appoint an attorney ad litem. The court shall hear the petition on an expedited basis. The court shall determine whether the individual lacks capacity on an expedited basis. The court may determine the individual lacks capacity only if the court finds by clear and convincing evidence that the individual lacks capacity.

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4. Is the agent really the agent?

Under the new UHCDA:

1. **Oral revocation of agent is still permitted. 16 Del. C. 2515(b).**
2. **No capacity is needed to disqualify a default statutory surrogate. 16 Del. C. 2514(a).**

5. No capacity is needed to continue life-sustaining treatment.

An individual's request to continue life-sustaining treatment must be honored regardless of capacity, unless a court decides otherwise.

See 16 Del. C. 2505(e): "A second finding that the individual lacks capacity under paragraph (d)(4) of this section is not sufficient to rebut the presumption of capacity if the individual is requesting the provision or continuation of life-sustaining treatment and the finding is being used to make a decision to withhold or withdraw the treatment."

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UHCDA Immunity & Reliance Provisions

UHCDA contains immunity and reliance provisions, e.g., 2523 (Immunity for health-care professional or health-care institution), 2516(b) (reliance by persons without inquiry), subject to "reasonable belief", and absent "good cause" to the contrary, standards. Both terms are undefined.

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Summary:
UHCDA is embedded in DMOST in at least the following ways:

- Determining "Authorized Representative" to sign DMOST.
- No capacity needed to continue life-sustaining treatment, pending court decision. 16 Del. C. 2505(e).

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Where does UHCDA stand?

- 6 months to implement (9/30/25 effective date)

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