The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 312
INTRODUCER:	Senator Rodriguez
SUBJECT:	Patient-directed Medical Orders
DATE:	December 8, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rainer	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 312 creates a new type of advance directive called a "patient-directed medical order" (PDMO), which is a medical order developed between patient and a physician, a physician assistant, or autonomous[1] advanced practice registered nurse. The document is a medical order which deals with the immediate anticipated issues of end-of-life care. The bill harmonizes and coordinates this new advance directive order within the existing panoply of advance directives and other end-of-life legal instruments: living will, designation of health care surrogate, durable power of attorney, anatomical gifts, and do-not-resuscitate order (DNRO).

The bill provides an effective date of July 1, 2026.

II. Present Situation:

Advance Directives

Advance directives are legal instruments that are witnessed and can be either written or an oral statement. The purpose of an advance directive is to provide patients' desires concerning any aspect of their health care in the event they are incapacitated or incompetent, thereby providing real-time informed consent to medical treatment or protocols.[2] An advance directive may also

[1] An autonomous advanced practice registered nurse is licensed under ch. 464, F.S., and registered to practice primary care autonomously under s. 464.0123, F.S.

[2] Sections 765.101(1) and (10) ,and 765.102(2), F.S.

designate a person who can make health care decisions[3] or receive health care information[4] for the patient immediately or when the patient is incapacitated or incompetent.[5]

To validly create an advance directive, the patient must be competent.[6] A patient is deemed as having "incapacity" or being "incompetent" if he or she is "physically or mentally unable to communicate a willful and knowing health care decision."[7] The authorizations under ch. 765, F.S., which allow the withholding or withdrawing of life-prolonging procedures "do not apply to a person who never had capacity to designate a health care surrogate or execute a living will."[8]

To validly form a written advance directive, it must be signed by the patient in the presence of two subscribing adult witnesses.[9] For a living will, designation of health care surrogate, and anatomical gifts, one of the witnesses cannot be a spouse or blood relative of the patient.[10] For a designation of health care surrogate, neither witness may be the designated surrogate or alternate.[11] The patient's signature may be made to a living will or designation of health care surrogate by oral direction of the patient if they are physically unable to do so. One of the witnesses signs the patient name to the living will or designation of health care surrogate in the patient's presence and at the patient's direction.[12] For the designation of a health care surrogate for a minor, an advance directive must be signed by the natural guardian, legal custodian, or legal guardian, and can provide for a signature of such guardian in absentia if such guardian provides such instruction in the presence of the witnesses.[13]

Oral advance directives are generically recognized.[14] However, there is no specific statute which distinctly describes the requirements for an oral advance directive to be valid. Oral (as well as

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[3] Section 765.101(6), F.S. "health care decision" is defined as:
(a) informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures;
(b) the decision to apply for private, public, government, or veterans' benefits to defray the cost of health care;
(c) the right of access to health information of the principal reasonably necessary for a health care surrogate or proxy to make decisions involving health care and to apply for benefits; and
(d) the decision to make an anatomical gift pursuant to part V of this Chapter.

[4] Section 765.101(9), F.S. "health care information" is defined as: any information, whether oral or recorded in any form or medium, as defined in 45 C.F.R. s. 160.103 and the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d, as amended, that:
(a) Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
(b) Relates to the past, present, or future physical or mental health or condition of the principal; the provision of health care to the principal; or the past, present, or future payment for the provision of health care to the principal.

[5] Section 765.102(3), F.S.

[6] Sections 765.102(1) and (4), 765.204(1), F.S.

[7] Section 765.101(10), F.S. (for anatomical gifts death is defined as incapacity.)

[8] Section 765.107(2), F.S.

[9] Sections 709.2104, 765.202, 765.2035, 765.2038, 765.302(1), 765.303, 765.514(1)(a), F.S.

[10] Sections 765.302(1), 765.202(2), 765.516(1)(b), F.S.

[11] Sections 765.202(2), 765.2035(2), F.S.

[12] Sections 765.202(1), 765.302(1), F.S.

[13] Section 765.2035(1), F.S.

[14] Sections 765.101(1) and (13)(b), F.S. A living will is defined as "a witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures."

written) revocation and amendment is recognized for all forms of advance directives,[15] other than a durable power of attorney, which must be amended or revoked in writing. [16] For an oral (or written) revocation or amendment to be effective, it must be communicated to the surrogate, health care provider, or facility.[17,18]

Types of Advance Directives

Under ch. 765, F.S., there are described three types of advance directives: (1) designation of health care surrogate, (2) living will, and (3) anatomical gifts.[19] Chapter 765, F.S., also describes rights and procedures for a durable power of attorney under ch. 709, F.S.[20] Another type of advance directive document is a Do Not Resuscitate Order (DNRO) under the Raymond H. Alexander, M.D. Emergency Medical Services Transportation Act.

Designation of Health Surrogate

The designation of a health surrogate is authorized under the Florida Health Care Surrogate Act, found in part II of ch. 765, F.S. It provides for the designation of an adult individual to make health care decisions and receive health care information for the signing patient. The Act contains suggested forms for designation of a surrogate for an adult[21] and for a minor.[22] The patient can designate whether the surrogate's authority operates immediately or upon the determination of incapacity by his or her primary physician.[23]

If the patient does not choose immediate authorization for the surrogate's authority, there must be a determination of incapacity before the designation becomes operative.[24] Without a determination of incapacity, the patient's wishes are controlling.[25] An inference of incapacity is not permitted from a patient's voluntary or involuntary hospitalization for mental illness or because the patient has intellectual disabilities.[26] Incapacity is determined by the primary or attending physician making an evaluation, and such physician must enter that evaluation into the patient's medical record. If the evaluating physician has a question as to whether the patient lacks capacity, another physician will also evaluate the patient. If both physicians agree, then that evaluation is entered into the medical record for the patient. The health care facility must then notify the applicable surrogate or delegated attorney in writing that his or her authority under the instrument has commenced.[27] The determination of incapacity is only as to health care decisions

[15] Section 765.104(1)(c), F.S.
[16] Section 709.2110(1), F.S.
[17] Section 765.104(3), F.S.
[18] Section 765.516(1)(b), F.S. To orally revoke anatomical gift, it must be revoked "in the presence of two witnesses (one who is not a family member) and is communicated to the donor's family, attorney or donee . . ."
[19] Section 765.101(1), F.S.
[20] Sections 765.101(17), 765.1103(1), 765.204(2) and (4), F.S.
[21] Section 765.203, F.S.
[22] Section 765.2038, F.S.
[23] Sections 765.202(6), 765.204(4), F.S.
[24] Sections 765.101(21), 765.204(2), F.S.
[25] Section 765.204(1), F.S.
[26] *Id.*
[27] Section 765.204(2), F.S.

and is not a finding as to capacity for other purposes.[28] If the patient regains capacity, the surrogacy or agency ceases.[29]

The surrogate's responsibility is to make decisions in accordance with the patient's instructions and limitations.[30] The surrogate, if there are no limitations, can make the full range of health care decisions for the patient.[31] This authority includes the ability to sign DNROs and provide informed consent for the patient.[32] The surrogate has also the full authority to all health information concerning the patient and to use such information to ensure continuity of care and as needed to provide for the admission, discharge, or transfer of the patient to any health care facility or other facility.[33] The surrogate also has authority to apply for public benefits, e.g. Medicare and Medicaid, on behalf of the patient. [34] The standards applicable to the surrogate's duties are: (1) to only make decisions which the surrogate believes the patient would make under the circumstances, or (2) if there is no indication of the patient's desires, then what is in the best interests of the patient.[35]

If there is no living will, and there is no limitation on the surrogate's authority to consent to withholding or withdrawing life-prolonging care, the surrogate is authorized to provide such informed consent. Prior to providing such health care decision, the surrogate must be satisfied that: (1) the patient has an end-stage condition, is in a persistent vegetative stage, or is terminally ill and (2) the patient has no reasonable medical probability of recovering the capacity to make his or her own decision.[36]

Living Will

Living wills are authorized under the Life-Prolonging Procedure Act, found in part III of ch. 765, F.S. This advance directive is a written declaration by the patient as to the providing, withholding, or withdrawal of life-prolonging care.[37] The Act provides for a statutory form of living will. [38] It is possible for the patient to designate in the living will his or her health care surrogate to provide express informed consent for withholding, withdrawal, or continuation of life-prolonging care. [39]

To become operative, a living will requires a determination that the patient (1) has a terminal condition, (2) has an end-stage condition, or (3) is in a persistent vegetative state.[40] Each of these terms is defined in the Act.[41] There must also be a determination that the patient does not have a

[28] Section 765.204(5), F.S.
[29] Section 765.204(3), F.S.
[30] Section 765.205(1), F.S.
[31] Section 765.205(1)(b), and (c), F.S.
[32] *Id.*
[33] Section 765.205(2), F.S.
[34] Section 765.205(1)(e), F.S.
[35] Section 765.205(1)(b), F.S.
[36] Section 765.305(2), F.S.
[37] Section 765.302(1), F.S.
[38] Section 765.303, F.S.
[39] *Id.*
[40] Section 765.306, F.S.
[41] Section 765.101(4), (15) and (22), F.S.

reasonable medical probability of regaining capacity sufficient to exercise his or her own decision making.[42] There must be a finding in the patient's medical record by the primary care physician and at least one other consulting physician that one or more of such conditions exist. Each physician must conduct a separate examination. [43] Once such examinations, findings, medical chart entries, and physician signatures are made, life-prolonging procedures may be withdrawn or withheld pursuant to the terms of the living will.

Anatomical Gifts

Anatomical gifts are authorized under part V of ch. 765, F.S. This advance directive consists of the patient making an anatomical gift of his or her entire body or parts of it.[44] Methods of making the gift are by (1) signing an organ or tissue donor card, (2) registering online with a donor registry, (3) signing an intent to donate on the patient's driver license or identification application, (4) expressing an intent to donate in a living will or other advance directive, (5) a will which includes a provision to donate, or (6) any other writing witnessed by two persons.[45] The Act provides a suggested form of "other writing" known as a Uniform Donor Card. [46] The patient may specifically designate an individual or procurement organization for the gift.[47]

The decision to make an anatomical gift, which is not revoked by the donor, cannot be overridden by any other person and is considered irrevocable.[48] If there is no designation of a gift or notice of a contrary indication by the donor/decedent, then the designated health care surrogate can make the gift.[49] And, if there is no designated health care surrogate, and no contrary indication by the donor/decedent, then in the following order of priority, the following persons can make the gift: (1) the spouse, (2) an adult son or daughter, (3) either parent, (4) an adult brother or sister, (5) an adult grandchild, (6) a grandparent, (7) a close personal friend as defined in s. 765.101(h), F.S., (8) a guardian of the decedent at the time of his or her death, or (9) a representative ad litem appointed by a court.[50]

Durable Power of Attorney

A durable power of attorney is not specifically defined in ch. 765, F.S. It is rather defined in the Florida Power of Attorney Act, found in part II of ch. 709, F.S. A power of attorney is broadly defined as "a writing that grants authority to an agent to act in the place of the principal, whether or not the term is used in that writing."[51] A power of attorney authorizes the adult person designated as an agent to make the same decisions and engage in the same actions as the principal as to the specific authority granted in written document. [52] A power of attorney

[42] Section 765.304(2)(a), F.S.
[43] Section 765.306, F.S.
[44] Section 765.512, F.S.
[45] Section 765.514(1), F.S.
[46] Section 765.514(1)(f), F.S.
[47] Section 765.514(2), F.S.
[48] Section 765.512(1)(a), F.S.
[49] Section 765.512(2), F.S.
[50] Section 765.512(3), F.S.
[51] Section 709.2102(9), F.S.
[52] Section 709.2201, F.S.

terminates if the principal becomes incapacitated.[53] However, a power of attorney which is "durable" does not terminate upon the principal's incapacity. [54] A power of attorney is deemed durable if it contains the words "This durable power of attorney is not terminated by subsequent incapacity of the principal except as provided in ch. 709, F.S.," or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's subsequent incapacity."[55]

For a power of attorney to be properly executed, it (1) must be signed by the principal, (2) witnessed by two disinterested subscribing witnesses, and (3) acknowledged before a notary public.[56] If the principal is physically unable to sign, the notary public who acknowledges the principal's acknowledgement may sign the principal's name on the instrument and make initials required to acknowledge specific powers.[57] The signing and initialing notary must write the statement "Signature or initials affixed by the notary pursuant to s. 709.2202(2), F.S.," below each signature or initial that the notary writes on behalf of the principal."[58]

The ability to make health decisions or obtain health information on behalf of the principal is recognized if enumerated in the durable power of attorney.[59] Chapter 765, F.S., recognizes durable powers of attorney and the authority of the designated agent.[60] The subsequent designation of health care surrogate does not revoke the decision making authority of an agent under a previous durable power of attorney, unless there is a conflict between the two, in which case the health care surrogate designation has priority.[61] If the durable power of attorney is executed after the designation of health care surrogate, then the durable power of attorney has priority. The power of attorney can also designate the order of priority between the two instruments.[62] A durable power of attorney can only be revoked in writing.[63]

Do-Not-Resuscitate Order (DNRO)

The DNRO is not specifically defined in ch. 765, F.S. It is rather defined in the Raymond H. Alexander, M.D. Emergency Medical Services Transportation Act, found in part III of ch. 401, F.S. This Act recognizes the circumstance and procedures by which emergency technicians may honor DNROs from a patient's physician. The Act directs the Department of Health (DOH) to adopt rules to provide such circumstances and procedures.[64] The Act also requires the DOH, in consultation with the Department of Elder Affairs and the Agency for Health Care Administration (AHCA), to "develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a

[53] Section 709.2109(1)(b), F.S.
[54] Section 709.2104, F.S.
[55] *Id.*
[56] Section 709.2105(2), F.S.
[57] Sections 709.2105(2), 709.2202, F.S.
[58] Section 709.2202(2)(c), F.S.
[59] Section 709.2201(2)(c), F.S.
[60] Sections 765.101(17), 765.1103(1), 765.204(2) and (4), F.S.
[61] Section 709.2109(3)(b), F.S.
[62] *Id.*
[63] Section 709.2110(1), F.S.
[64] Section 401.35(4), F.S.

patient for whom a physician or physician assistant has issued an order not to administer cardiopulmonary resuscitation." [65]

The DOH has adopted in rule a specific form that is required to be used.[66] The DOH rule states the form must be printed on yellow paper for it to be honored.[67, 68] The form also must be signed by the patient's physician, autonomous advanced practice registered nurse (APRN), or physician assistant, and the patient, patient's surrogate, proxy, minor's principal, a guardian under s. 744.102, F.S., or agent under a durable power of attorney.[69] There is no witness requirement or other execution formalities required. The patient has the ability to revoke the form orally, in writing, or by failing to present the form, or by physically destroying the form.[70] To satisfy the "identification with device" portion of the statute, there is a portion of the form that is a recognized wallet card, which is at the bottom of the form and states "Cut along line and fold in half to create DNRO Device (wallet card)."[71]

Absence of Advance Directive/Health Care Proxy

In the event a patient is incapacitated or is developmentally disabled and has no advance directive or the designated surrogate is no longer available (whether voluntarily or involuntarily), part IV of ch. 765, F.S., provides for the appointment of a proxy.[72] The statute provides the following individuals in descending order of priority may be deemed appointed to make health care decisions and receive health care information on behalf of the patient:

- The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, F.S., who has been authorized to consent to medical treatment, if such guardian has previously been appointed; however, this paragraph shall not be construed to require such appointment before a treatment decision can be made under this subsection;
- The patient's spouse;
- An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
- A parent of the patient;
- The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;
- An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs;
- A close friend of the patient; or
- A clinical social worker licensed pursuant to ch. 491, F.S., or who is a graduate of a court-approved guardianship program.

[65] Section 401.45(3)(c), F.S.
[66] The DNRO form is *available at:* https://www.floridahealth.gov/about/patient-rights-and-safety/do-not-resuscitate/_documents/dnro.pdf (last visited Dec. 04, 2025).
[67] Rule 64J-2.018(5)(a), F.A.C.
[68] Rule 64B8-9.016, the Board of Medicine recognizes that a doctor can rely and implement such a DNRO.
[69] Rule 64J-2.018(6), F.A.C.
[70] Rule 64J-2.018(9), F.A.C.
[71] Rule 64J-2.018(1)(b), F.A.C.
[72] Section 765.401, F.S.

Such a proxy must be selected by the facility's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. The proxy will be notified that, upon request, the provider will make available a second physician, not involved in the patient's care, to assist the proxy in evaluating treatment.[73,74] The facility's bioethics committee will review any decision to withdraw or withhold life-prolonging procedures. The medical record of the patient must contain documentation of efforts to locate proxies of higher priority.[75]

The responsibility and authority of the proxy is the same as a health care surrogate.[76] The proxy, in making health care decisions, is to follow the following standards: (1) based on informed consent, (2) what the proxy reasonably believes would have been the patient's decision under the circumstances, and (3) if there is no indication on what the patient would choose, then what is in the patient's best interest.[77] For decisions to withhold or withdraw life-prolonging procedures, the proxy's standards are clear and convincing evidence of what the patient would have chosen or, if there is no indication what the patient would choose, what is in the best interest of the patient.[78] The proxy must also have the findings of the primary physician and other consulting physician of (1) a terminal condition, an end-stage condition, or the patient is in a persistent vegetative state, and (2) the patient has no reasonable medical probability of recovering the capacity to make his or her own decision.[79]

Persistent Vegetative State

A patient is in a "persistent vegetative state" when he or she is in a permanent and irreversible condition of unconsciousness in which there is:

- The absence of voluntary action or cognitive behavior of any kind.
- An inability to communicate or interact purposefully with the environment."[80]

This finding is to be determined by the person's primary physician utilizing currently accepted medical standards.[81] If such a person does not have any advance directive, there is no evidence of what the person would want under such situation, and, after reasonable diligent inquiry, no family or friends can be made available as a proxy, then the following procedures are to be followed:

- A guardian is appointed by a court, with authority to make medical decisions and who is charged to consider the best interests of the patient.

[73] Section 765.401(1), F.S.
[74] For a minor the order of priority is: The stepparent; the grandparent of the minor; an adult brother or sister of the minor; an adult aunt or uncle of the minor. *See* ss. 765.401(4) and 743.0645(2)(a), F.S.
[75] Section 765.401(1)(h), F.S.
[76] Section 765.401(3), F.S.
[77] Section 765.401(2), F.S.
[78] Section 765.401(3), F.S.
[79] *Id*.
[80] Section 765.101(15), F.S.
[81] Section 765.404, F.S.

- The guardian and bioethics committee of the health care facility, in consultation with the primary physician, may conclude the patient's condition is permanent, there is no reasonable medical probability of recovery, and it is in the best interests of the patient to withdraw or withhold life-prolonging procedures.[82,83]

Civil and Other liability

Health care practitioners and health care facilities are protected from any civil or other legal jeopardy by following the instructions in an advance directive.[84] A surrogate, health care provider, or health care facility is not subject to civil or criminal liability for failing to act on an advance directive, amendment or revocation, unless they have actual notice of such document.[85] The responsibility to provide notice of the existence of an advance directive is on the patient,[86] provided, however, such documentation may be delivered by any other person if the patient is incapacitated. While a health care provider or health care facility cannot require a patient to sign an advance directive, they are required to document and place in the patient's record any advance directive and have such advance directive travel with the patient's medical record.[87]

For a durable power of attorney, there is no specific statutory protection for civil or other liability.[88] The agent is deemed to be acting as a fiduciary.[89]

If presented with the DNRO form on yellow paper, emergency medical staff and physicians are recognized as not subject to criminal or civil liability.[90]

There is also immunity for carrying out any instruction in connection with health care decisions on a patient's behalf by a surrogate or proxy which is in compliance with the provisions of ch. 765, F.S.,[91] i.e. in compliance with a written advance directive, if any, and the requisite standards of wishes of the patient (if known), determination of incapacity, and findings to support a denial or withdrawal of life-prolonging care. Also, there is immunity for a health care facility and individual members of its ethics committee on the decision to withhold or withdraw life-prolonging care when a person is in a persistent vegetative state.[92]

However, if it can be shown by a preponderance of evidence that the person or facility did not act in good faith, then the immunity from liability may not be available.[93]

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[82] Section 765.404(1) and (2), F.S.
[83] If there is no medical ethics committee at the facility, the facility must have an arrangement with the medical ethics committee of another facility or with a community-based ethics committee approved by the Florida Bioethics Network. *See* s. 765.404(2)(h), F.S.
[84] Sections 765.109(1), 765.302(2), 765.517(5), F.S.
[85] Section 765.104(3), F.S.
[86] Sections 765.302(2), 765.512(1)(a), F.S.
[87] Sections 765.110(1) and (2), 765.302(2), F.S.
[88] Section 709.2119(5), F.S. A third party who acts on reliance on a durable power of attorney is to be held harmless by the principal or principal's estate. Section 765.109, F.S., may provide some health care provider or facility immunity, if implementing portions of ch. 765, F.S., as to durable powers of attorney.
[89] Section 709.2114(1), F.S.
[90] Section 401.45(3)(b), F.S.
[91] Section 765.109(1), F.S.
[92] Section 765.404(2), F.S.
[93] Section 765.109(2), F.S.

The terms of a living will establish a rebuttable presumption of clear and convincing evidence of the patient's wishes.[94] A written designation of an adult or minor health care surrogate establishes a clear and rebuttable presumption of the patient's designation of the surrogate.[95]

There is an affirmative duty by the health care practitioner and health care facility to inform and comply with instructions of the patient, surrogate, proxy, court appointed guardian, agent under a durable power of attorney, or patient's physician as to pain management and palliative care.[96]

Court Intervention and Review

Generally, the provisions of the various acts are self-operating and operationalized among the parties. However, there are procedures for court appointed guardians or judicial review of document interpretations or decisions made.

A court appointed guardian must be specifically delegated authority by the court to make health care decisions on behalf of the patient.[97] For purposes of mental health treatment, a surrogate may be separately designated by the patient; however, unless the designation states otherwise, the designated surrogate has the authority to make choices as mental health treatment.[98] Nevertheless, before a surrogate's consent to mental health treatment is effective, there must be a court determination of incompetency and appointment of a guardian advocate under s. 394.4598, F.S.[99]

In addition, health care decision as to abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56, voluntary admission to a mental health facility, or withholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability as defined in s. 390.0111(4), F.S., can only be made by a surrogate or proxy, with approval of a court, and if the patient originally authorized such decision making in writing [100] In all instances, the court may appoint a guardian in addition to a surrogate; however, the surrogate can continue to make health care decisions unless the court modifies or revokes the authority of the surrogate, and the court may require reporting of the

[94] Section 765.302(3), F.S.
[95] Sections 765.202(8) and 765.2035(7), F.S.
[96] Section 765.1103, F.S.
[97] Sections 765.1103(1), 765.404(1), F.S. In addition, unless a patient authorizes, in writing: Abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56, voluntary admission to a mental health facility, or withholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability as defined in s. 390.0111(4), such health care decisions can only be made by a surrogate or proxy, with approval of a court.
[98] Section 765.202(5), F.S. The same applies to minors. *See* section 765.2035(5), F.S.
[99] Section 765.202(5), F.S.
[100] Section 765.113, F.S.

patient's health care status to the guardian.[101] A court may also appoint a representative ad litem for purposes of resolving issues concerning anatomical gifts.[102,103]

There is always the general ability to seek judicial review in probate court or other court of competent jurisdiction as to documentation and decisions.[104] Specific authorization is also provided to pursue a probate petition under Rule 5.900, Florida Rules of Probate Procedures.[105] The category of matters which may pursued under such a petition are:

- The surrogate or proxy's decision is not in accord with the patient's known desires or ch. 765, F.S.;
- The advance directive is ambiguous, or the patient has changed his or her mind after execution of the advance directive;
- The surrogate or proxy was improperly designated or appointed, or the designation of the surrogate is no longer effective or has been revoked;
- The surrogate or proxy has failed to discharge duties, or incapacity or illness renders the surrogate or proxy incapable of discharging duties;
- The surrogate or proxy has abused his or her powers; or
- The patient has sufficient capacity to make his or her own health care decisions.

Section 765.105, F.S., is not available to contest a decision of a surrogate who has immediate authority and the patient is not incapacitated.[106] The petition may be pursued by "[t]he patient's family, the health care facility, or the primary physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy's decision . . ."[107]

For living wills, it is recognized that the primary physician may proceed in accordance with such living will as to matters concerning life-prolonging procedures and the consent of a designated health care surrogate if one is appointed. However, if there is a dispute, the primary physician cannot take any action to withdraw the life-prolonging procedures for seven days to allow the filing of probate petition. If a probate petition is not filed, then the physician may proceed with implementing the living will.[108]

Medical Records and Orders

Medical professionals are required to keep medical records of the patients they serve. Medical records as defined by statute are required to identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories;

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[101] Section 765.205(3), F.S.
[102] Section 765.512(3)(i), F.S.
[103] In addition, a qualified individual of an anatomical gift may bring an action for injunctive or equitable relief against the health care practitioner, health care facility or other entity responsible for acquisition, delivery or allocation of the anatomical gifts. *See* section 765.523(6), F.S.
[104] Section 765.106. F.S. *See* also, Fla. Prob. R. 5.900, Expedited Judicial Intervention Concerning Medical Treatment.
[105] Section 765.105(1), F.S.
[106] Section 765.105(2), F.S.
[107] Section 765.105(1), F.S.
[108] Section 765.304(1), F.S.

examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.[109]

The purpose of patient/medical records are to:

- Serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
- Furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition.
- Document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient's care.
- Assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.

A licensed physician must maintain patient medical records in English, in a legible manner, and with sufficient detail to clearly demonstrate why a course of treatment was undertaken.[110]

Advance directives must be maintained in medical records if a health care facility or practitioner is made aware of the advance directive by the patient or another person.[111]

When a patient is in a health care facility, what normally occurs with most end-of-life care is as a result of physician orders and established clinical protocols. It has been recognized by the federal Centers for Medicare & Medicaid Services that health care providers can deliver services, pursuant to "standing orders" placed in the medical record.[112] Standing orders are acceptable and can be part of the medical record if they improve efficiency in care delivery, reduce delays in treatment, and enhance patient safety.[113] Standing orders must be evidence-based or follow nationally recognized guidelines, approved by medical staff and clinical leadership, and signed, dated, and authenticated by the ordering physician; and there must be documentation of compliance and periodic review.[114]

Patient-Directed Medical Order (PDMO)

There has been an evolving trend to recognize as an advance directive a comprehensive standing medical order that is developed for an individual facing a serious end-of-life scenario, a chronic

[109] Section 458.331(1)(m), F.S., (as to physicians); section 459.015(1)(o), F.S., (as to osteopathic physicians); section 464.018(1)(s)(5), F.S., (as to advanced registered nurse practitioners); section 464.2035(3), F.S., (as to certified nursing assistant); section 395.3015, F.S., and Rule 59A-3.270 F.A.C. (as to hospitals); section 400.141(1)(j), F.S., and Rule 59A-118, F.A.C. (as to nursing homes).
[110] Rule 64B8-9.003, F.A.C.
[111] Sections 765.110(1) and (2), 765.302(2), F.S. *See* also Patient Self- Determination Act of 1990, 42 U.S.C. §1395cc(f) (as to Medicare providers) and 42 U.S.C §1396a(w) (as to state Medicaid Plans), section 765.110, F.S., essentially incorporates and operationalizes these federal requirements.
[112] Centers for Medicare & Medicaid Services, State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 75, Tag A-409, (Effective 2-21-20), *available at:* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf (last visited Dec. 04, 2025).
[113] NCQAC Advisory Opinion 6.0 Standing Orders and Verbal Orders (2014), *available at:* https://doh.wa.gov/sites/default/files/legacy/Documents/6000/StandingAndVerbalOrders.pdf (last visited Dec. 04, 2025).
[114] 42 C.F.R. § 482.24(c)(3), Condition of Participation: Medical record services.

condition, or because of advanced frailty.[115] The differences between the advance directives described above and a PDMO are in timing and form of creation.

The timing of a PDMO is close to the medical needs that justify its creation. It is meant to be a set of medical orders based on a person's current health care condition and prognosis. The PDMO is created between the patient (or surrogate, proxy or agent) and the primary physician. Advance directives are usually prepared by the patient, often when there are no immediate medical concerns. The PDMO is meant to complement advance directives and convert broad preferences into definitive orders signed by a health care provider with specific treatments and activities delineated for the conditions that present at that time in the person's life.[116]

Another reason for the need for this type of advance directive is the changing nature of the physician-patient relationship. In the past, many were cared for upon death by a lifelong family physician. Such physician was usually familiar with the patient and his or her family members and would take care of the patient in the appropriate local health care setting. Now, it is not uncommon for a patient to be cared for by a hospitalist or health care provider they are meeting for the first time when facing an end-of-life scenario. The PDMO is a response by which these important discussions can take place and be documented.[117]

There has also been a recognition that most persons do not execute advance directives. Most studies put the range of failure to have advance directives at approximately 66 percent.[118] Also, it is not uncommon that when patients do have advance directives, they are not explicit enough to provide health care professionals with the instructions needed for decisions at that time in the patient's life.[119]

The PDMO requires the health care provider to have a current and detailed discussion of the person's medical condition and options and tends to be a better expression of the patient's current convictions to withholding or withdrawing end-of-life care. It focuses on high-probability events and decisions that need to be made as to the patient's current condition. It may complement an advance directive or operate as the advance directive for individuals who do not already have one. The PDMO is comprehensive as opposed to single-intervention medical orders, e.g. DNRO.[120]

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[115] Gov Facts, DNR Orders and Living Wills: What Every Patient Should Know, *available at:* https://govfacts.org/health-healthcare/patient-rights-advocacy/advance-directives/dnr-orders-and-living-wills-what-every-patient-should-know/, (*last updated Nov. 24, 2025)* (last visited Dec. 04, 2025).
[116] *Id.*
[117] Hickner, MD, Getting it Right at the End of Life, Journal of Family Practice, vol. 66, no. 8 (Aug. 2017).
[118] *Id.* Citing, Yadav Kn, Gabler NB, Cooney E, et al, Approximately One in Three US Adults Completes Any Type of Advance Directive For End-of-Life Care, Health Affairs, 2017;36:1244-1251.
[119] Bomba P, Sabatino C., POLST: An Emerging Model for End-of-Life Care Planning, The Elder Law Report, v. XX, No. 7 (Feb, 2009)
[120] Mitchell J, POLST Complement Advance Directives to Better Honor Patients' Preferences for End-of-Life Care, One Connect, January 2011.

Emerging Trend

California was the first state to pass an advance directive act in 1976. In the early 1990's, the federal government passed the Patient Self- Determination Act of 1990.[121] This federal law has long required health care providers to discuss the availability of advance directives with their patients. It has become a standard part of health care provider and facility medical discussions with patients as to advance directives.[122]

Florida has implemented the communication and availability requirements of the federal Act. Health care providers and facilities have an obligation to inquire of the patient whether they have an advance directive and document such in the medical record.[123] While a health facility or provider must make the patient aware of the availability of advance directives and the facility's policies as to such directives, a health care provider or facility may not condition treatment or admission on the execution or waiver of advance directives or using a particular form.[124] If a health care provider or facility conditions treatment or admission on the signing or waiver of an advance directive, they are subject to discipline of revocation of licensure and a $1,000 fine per violation.[125]

While most, if not all, states have living wills, health care surrogates, or proxies, many states have also adopted the PDMO as an advance directive. Various states have given it the different monikers, such as Physician Orders for Life-Sustaining Treatment (POLST), MOLST (Medical Orders for Life-Sustaining Treatment), POST (Physician Orders for Scope of Treatment), or COLST (Clinician Orders for Life-Sustaining Treatment). Despite the different nomenclature, they are all functionally the same. To date, 32 states have adopted a PDMO-type of advance directive.[126]

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[121] 42 U.S.C. §1395cc(f) (as to Medicare providers) and 42 U.S.C §1396a(w) (as to state Medicaid Plans).
[122] Florida's Medicaid State Plan, has had the same statement of Requirements for Advance Directive, since October of 1991, *available at:* https://ahca.myflorida.com/content/download/4964/file/attachment_4-34-A.pdf (last visited Dec. 04, 2025).
[123] Section 765.110(1), F.S.
[124] Section 765.110(1) and (2), F.S.
[125] Section 765.110(3), F.S.
[126] The following 32 states have adopted similar statutes or regulations: *Alabama* (2016 SB 138, 2018 HB 194, 2018 HB202); *Arkansas* (2017 SB 356); *California* (2008 AB 3000, 2015 SB19, 2015 AB 637); *Colorado* (2010 HB 10-1122, 2013 HB 13-1202, 2019 SB 19-073) ; *Delaware* (2015 HB 64); *District of Columbia* (2015 ACT 21-247); *Georgia* (2015 SB 109); *Hawaii* (2009 HB 1379, 2014 HB 2052); *Idaho* (Idaho Code 39-4515, Idaho Code 39-4516, 2007 39-4512A); *Iowa* (2012 HF 2165); *Illinois* (2014 SB 3076, 2015 SB 1466); *Indiana* (2013 HB 1182, 2018 HB 1119); *Kentucky* (2015 SB 77); *Louisiana* (2010 HB 1485, 2916 SB 360); *Maryland* (2011HB 82); *Massachusetts* (Chapter 268 of the Acts of 2022); *Mississippi* (2014 HB 1014); *Nevada* (2017 NV POLST Legislation); *New Hampshire* (2015 Title X POLST Registry Act); *New Jersey* (2011 Physician Order for Life Sustaining Treatment Act); *New Mexico* (2015 Uniform Health Decisions Act); *New York* (New York MOLST Ethics and Law); *North Carolina* (2007 § 90-21.17); *Ohio* (2016 Use of Medical Order for Life-Sustaining Treatment); *Oklahoma* (2016 HB 3017); *Oregon* (2009 HB 2009, 2017 SB 856); *Rhode Island* (RIGL 23-4.11-1; 2013 R23-4.11); *South Carolina* (2019 Act No. 89); *Tennessee* (2014 Title 68); *Utah* (Rule 31 Provider Order for Life-Sustaining Treatment); *Vermont* (§9708); *Virginia* (Administrative Code 12VAC5-66); *West Virginia* (2016 HB 4334, 2017 SB 1014); *Wyoming* (2015 HB 0162). *available at:* https://polst.org/state-polst-programs/ (last visited Dec. 4, 2025).

III. Effect of Proposed Changes:

Section 1 amends s. 765.101, F.S., and provides that the definition of "advance directive" includes a patient-directed medical order (PDMO).

The bill also defines "patient-directed medical order" to mean a medical order created by the principal (patient) in collaboration with a physician, a physician assistant, or an autonomous APRN which is portable across health care settings and accessible in a voluntary online registry.

The definition of "health care facility" is amended to add an assisted living facility or adult family-care home licensed under ch. 429, F.S.

Section 2 amends the legislative intent provision within s. 765.102, F.S. Current law provides a definition of what palliative care *must* include and specifies 11 required elements. The bill changes "must" to "may" for each of the existing 11 elements and adds that an order not to resuscitate and a PDMO will be respected regardless of the location of care.

Section 3 creates s. 765.3041, F.S., entitled "Patient-directed medical orders."

Form of Order

The bill requires the form for a PDMO to be developed by rule of the DOH. The form may be combined with a DNRO. The form must address medical interventions that may be withheld or withdrawn if they only serve to artificially prolong the process of dying.

The form must clearly express the principal's preferences and instructions for care. The treatments which may be included are all that are available, modified treatments that are not prolonged or burdensome, and comfort measures that do not pursue or continue interventions.

Health care services which provide for care, comfort, or to alleviate pain may not be withheld or withdrawn.

Signature Requirements

The form is to be signed by the principal and the principal's physician, physician assistant or autonomous APRN. There is a substitute signature procedure for a physically-unable principal, the same as provided for the other advance directives authorized under ch. 765, F.S. The principal's signature can be subscribed (in the presence and direction of the principal) by the physician, physician assistant, or autonomous APRN.

If the principal is completely incapacitated, the form may be signed by the principal's surrogate, proxy, attorney in fact under a durable power of attorney, or an appointed guardian with authority to make health care decisions.

The bill authorizes the use of telehealth to provide for the substituted signature of a physically-unable principal. The physician, physician assistant, or autonomous APRN may be present at either location where the telehealth is being conducted.

For any party, electronic signatures are authorized under the bill.

Communications

The bill requires the principal and his or her physician, physician assistant, or autonomous APRN to discuss the principal's medical treatment wishes for withholding or withdrawing medical interventions, and the principal's values and preferences in the event he or she becomes unable to make decisions. These preferences must be included in the form. The discussion must be held in person or using telehealth.

Civil, Criminal and Disciplinary Liability

The bill provides that any physician, physician assistant, or autonomous APRN is not subject to civil, criminal, or disciplinary action or liability for withdrawing or withhold cardiopulmonary resuscitation or other life-prolonging procedure pursuant to a PDMO or DNRO. The bill also provides that such behavior does not constitute negligent or unprofessional conduct.

Section 4 amends s. 395.1041, F.S. to provide that hospital personnel may withhold or withdraw any life-prolonging procedures if presented with a PDMO containing a DNRO or an order to withhold or withdraw such care. The bill also adds such behavior to existing provisions for hospitals and hospital personnel relating to immunity from criminal or civil liability and negligent or unprofessional conduct.

Section 5 amends s. 400.142, F.S., relating to nursing homes to add similar provisions for those facilities and their personnel as the bill adds for hospitals and hospital personnel in Section 4 of the bill.

Section 6 amends s. 400.487, F.S., relating to home health agencies to add similar provisions for those agencies and their personnel as the bill adds for hospitals, hospital personnel, nursing homes, and nursing home personnel in Section 4 and Section 5 of the bill

S**ection 7** amends s. 400.605, F.S., relating to the AHCA's rule-making requirements for hospice services. The bill requires that such rules must include procedures relating to the implementation of a PDMO and a DNRO.

Section 8 amends s. 400.6095, F.S., relating to hospice services to add similar provisions for hospice services personnel as the bill adds for hospital personnel, nursing home personnel, and home health agency personnel in Section 4, Section 5, and Section 6 of the bill.

Section 9 amends s. 400.611, F.S., relating to hospices to make technical and conforming changes.

Section 10 amends s. 401.35, F.S. relating to emergency medical services (EMS) to require the DOH to adopt rules relating to EMS personnel and PDMOs as provided in Section 11 of the bill.

Section 11 amends s. 401.45, F.S., relating to EMS services to add similar provisions for EMS personnel as the bill adds for hospital personnel, nursing home personnel, home health agency personnel, and hospice services personnel in Section 4, Section 5, Section 6, and Section 8 of the

bill. The bill also adds the signature of an autonomous APRN as an appropriate signatory to conform to the bill's earlier provisions relating to autonomous APRNs.

Section 12 amends s. 429.255, F.S., relating to assisted living facilities (ALF) to add similar provisions for those facilities and their personnel as the bill adds for hospitals, hospital personnel, nursing homes, and nursing home personnel in Section 4 and Section 5 of the bill.

S**ection 13** amends s. 429.73, F.S., relating to adult family-care homes to add similar provisions for a person who is licensed to operate an adult family-care home as the bill adds for hospital personnel, nursing home personnel, home health agency personnel, hospice services personnel, and EMS personnel in Section 4, Section 5, Section 6, Section 8, and Section 11 of the bill. The bill embeds these provisions for persons licensed to operate adult family-care homes in the AHCA's existing rule-making requirements for regulating such homes.

Section 14 amends s. 744.4431, F.S., relating to professional guardians to add PDMOs to existing provisions relating to withholding or withdrawing life-prolonging care or executing a DNRO.

Section 15 amends s. 752.001, F.S., to make a technical amendment to the definition of "persistent vegetative state."

Section 16 amends s. 765.110, F.S., to add PDMOs and DNROs to existing requirements for health care facilities to provide each patient with written information concerning the individual's rights relating to advance directives. The bill also adds ALFs and adult family-care homes to the list of entities for which the AHCA is required to adopt rules relating to the implementation of s. 765.110, F.S.

Section 17 amends s. 765.204, F.S., to make technical and conforming changes.

Section 18 amends s. 765.205, F.S., relating to surrogates to create a surrogate's authority to provide written consent to a DNRO or a PDMO.

Section 19 amends s. 765.305, F.S., relating to the standards for a surrogate's authority to act in the absence of a living will. The bill requires that before a DNRO or a PDMO may be exercised to forego treatment, the surrogate must be satisfied that the patient has an end-stage condition, has a chronic illness, or is in a persistent vegetative state; and does not have a reasonable medical probability of recovering the capacity to forego treatment on his or her own.

Section 20 creates a non-statutory provision of law requiring the AHCA to create and update a database by which PDMOs may be stored in electronic form by the AHCA if the principal wishes his or her PDMO to be stored in this fashion.

Section 21 provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill requires rulemaking by the DOH to create and adopt the PDMO form. The bill creates a negative fiscal impact relating to the requirement for the AHCA to create and maintain a database for the electronic storage of PDMOs. Neither agency has provided an estimate of fiscal impact, as of this writing.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 20 of the bill requires the AHCA to create and maintain a database for the electronic storage of PDMOs. Such documents might contain sensitive personal information regarding private individuals, and it is not clear whether the bill intends for such documents to be part of the public record after the AHCA takes possession of them. As of this writing, no corresponding public record exemption bill has been filed.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 765.101, 765.102, , 395.1041, 400.142, 400.487, 400.605, 400.6095, 400.611, 401.35, 401.45, 429.255, 429.73, 744.4431, 752.001, 765.110, 765.204, 765.205, 765.305.

This bill creates section 765.3041 of the Florida Statutes.

This bill creates one non-statutory section of the Laws of Florida.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.