

# NATIONAL ADVANCE DIRECTIVES: ONE ATTEMPT TO SCALE THE BARRIERS

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Mrs. Clark is a 75-year-old widow. She lives part of the year in her condominium in Northern Virginia and spends a large portion of time each year living in turn with each of her three children and their families, located in Florida, Indiana, and Nevada. She wants to do a health care advance directive that she can be confident will be respected in all four jurisdictions. After doing some legal research, you conclude that one advance directive would probably suffice for Virginia and Florida, since their laws are similar enough, but that Indiana and Nevada have some unique features that would best be addressed by doing a separate advance directive for each of them. Those two states also appear to lack clear statutory recognition of out-of-state advance directives. Thus, you tell Mrs. Clark that you will be happy to collaborate with elder law attorneys in the three other states to have the documents properly drafted. Not surprisingly, Mrs.

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1. The views expressed in this article are solely the author’s and do not necessarily reflect the views or policies of the American Bar Association.

Clark rails against the thought of doing three advance directives and especially against the thought of paying four lawyers to get the job done!

Mrs. Clark is not alone. Many commentators have been critical of the over-legalization and Balkanization of advance directive laws.<sup>2</sup> After more than 25 years of legislating health care advance directive laws, the nation has not achieved a collective uniformity or simplicity in our laws that might better encourage advance planning. This article will use a widely available advance directive form – known as *Five Wishes* – to provide a focused analysis of what it would take, at a minimum, to overcome that Balkanization.

## I. BACKGROUND

While about 16 states have adopted combined or comprehensive advance directive laws, the majority still have at least two statutes – one covering “living wills” (i.e., a written statement regarding the use of life-prolonging medical treatment) and the other covering durable powers of attorney for health care (i.e., designation of a health care agent, proxy, or representative).<sup>3</sup> The Uniform Health-Care Decisions Act, adopted in 1993 set an admirable benchmark for simplicity and flexibility, but it has not transformed the essential fragmentation of state law.<sup>4</sup> Seven states have adopted versions of the act,<sup>5</sup> but in every case legislatures added conventional legal formalities back in, such as special witnessing qualifications.

Congress could address the issue, if it chose, by legislating an advance directive that all states must recognize, but that would probably face considerable political resistance as an overstepping of states’ rights. In addition, the effect of a federally sanctioned advance directive form might not be positive. It risks an unintended consequence of further legalizing a task that is fundamentally very personal and intimate. In practice, it could become yet another legal Procrustean bed through which individual beliefs and wishes are homogenized by simple check-off options. Nevertheless, proposals have been made in the past. In 1999, Sen. Arlen Specter of Pennsylvania introduced a broad health care reform bill – “The Health Care Assurance Act of 1999”—that included the following provision:

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2. Bernard Lo and Robert Steinbrook, *Resuscitating Advance Directives*, 164 *Arch Intern Med.* 1501 (July 26, 2004); Angela Fagerlin and Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 *Hastings Center Report* 30 (March-April 2004); National Association of Attorneys General, *Will My Wishes Be Known and Honored? Policy and Practice Perspectives, in Improving End-of-Life Care: The Role of Attorneys General*, 35-46 (2003); David Orentlicher, *The Limitations Of Legislation*, 53 *Md. L. Rev.* 1255 (1994).
  3. Charles P. Sabatino, *De-Balkanizing State Advance Directive Law*, 13 *Pub. Policy and Aging Report* 1 (Winter 2003) (a publication of the National Academy on an Aging Society, Washington, DC).
  4. National Conference of Commissioners on Uniform State Laws, *Uniform Health-Care Decisions Act* (1993) <<http://www.law.upenn.edu/bl/ulc/fnact99/1990s/uhcda93.htm>>.
  5. Cal. Probate Code §§4600 to –4948 (West 2004); Del. Code Ann. tit. 16, §§2501 to 2518 (2004); Hawaii Rev. Stat. §§327E-1 to –16 (2004); Me. Rev. Stat. Ann. tit. 18A, §§5-801 to §5-817 (West 2004); Miss. Code Ann. §§41-41-201 to –229 (West 2004); N.M. Stat. Ann. §§24-7A-1 to –18 (West 2004); and Tenn. Code Ann §68-11-1801 to –1815 (2004).

- (ii) NATIONAL DURABLE POWER OF ATTORNEY FORM- The Secretary, in consultation with the Attorney General, shall develop a national durable power of attorney form for health care . The form shall provide a means for any adult to designate another adult or adults to exercise the same decision making would otherwise be exercised by the patient if the patient were competent.
- (iii) HONORED BY ALL HEALTH CARE PROVIDERS- The national advance directive and durable power of attorney forms developed by the Secretary shall be honored by all health care providers.<sup>6</sup>

In both 1999 and 2002, West Virginia's Senator Jay Rockefeller introduced the "Advance Planning and Compassionate Care Act" that would have amended the federal Patient Self-Determination Act<sup>7</sup> by, among other things, mandating the Secretary of Health and Human Services to conduct a study regarding the establishment and implementation of a national uniform policy on advance directives.<sup>8</sup> In 2004, Florida's Senator Bill Nelson introduced the "Advance Directives Improvement And Education Act" which included a required study by the Comptroller General of the United States on "the effectiveness of advance directives in making patients' wishes known and honored by health care providers" and "the feasibility of a national registry for advance directives..."<sup>9</sup> None of these bills came close to passage, but they do signal recurring interest by some members of Congress to push for greater uniformity in advance directive policy.

Given the state-level locus of advance directive policy, we are led to ask the basic question: what would it take to move state public policy to a point that would support the use of national or universal advance directives – that is, documents that unquestionably meet the statutory requirements in every state for an advance directive? This article examines one such attempt at achieving that goal – the *Five Wishes* advance directive created by the non-profit organization Aging with Dignity, Inc.<sup>10</sup> Indeed, Aging with Dignity has been the only organization to date that has actively pursued the goal of distributing one form as a national advance directive. By

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6. The Health Care Assurance Act of 1999, Sen. 24, 106th Cong. (1999).

7. The Patient Self-Determination Act was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Pub. L. No. 101-508, §§4206 and 4751 (Medicare and Medicaid, respectively), codified in part at 42 U.S.C. §§1395cc(a)(1)(Q), 1395cc(f), 1395mm(c)(8), 1396a(a)(57), 1396a(a)58, 1396a(w). The law is an information and education mandate that requires hospitals, nursing homes and other providers in Medicare or Medicaid to: (1) give all adults at admission written info about their health care decision-making rights under state law; (2) ask at admission if the patient has an advance directive and document it in the medical record; and (3) provide education to the staff and community on advance directive and health care decision-making. In addition, it includes a prohibition against discriminating on the basis of whether one has an advance directive.

8. Advance Planning and Compassionate Care Act, Sen. 628, 106th Cong. (1999), and Sen. 2857, 107th Cong. (2001).

9. Advance Directives Improvement And Education Act, Sen. 2545, 108th Cong. (2003).

10. Aging with Dignity, Inc., is a non-profit group that assists families with end-of-life issues. Aging with Dignity reports that it has distributed over four million copies of *Five Wishes* nationally . For more information, see <<http://www.agingwithdignity.org>>.

comparing *Five Wishes* to the statutory requirements in all 50 states and the District of Columbia, this article will identify the principal barriers to universality and suggest the necessary steps needed to remove those barriers, not only for *Five Wishes*, but for any advance planning document that seeks to be usable nationally.

As a preliminary question, one may ask why it is not sufficient to assume simply that all states will recognize a directive executed in another state under constitutional or legislatively enacted principles of comity or reciprocity. The ABA's Commission on Law and Aging legislative summary<sup>11</sup> lists 44 states as having provisions in their advance directive laws recognizing out-of-state directives. These are often referred to as portability provisions. They typically grant recognition to a directive from another state if the directive meets the requirements of the law of either the originating state or the state where presented. The shortcoming of this approach is that it presumes that someone on the healthcare team has the knowledge and information to perform the necessary dual state legal analysis. It raises the specter of legal delays to enable, for example, hospital counsel or some other legal authority to review the document. This gives little comfort to persons like Mrs. Clark who want to be sure that her directive will be legally sufficient without review by a bevy of lawyers. Suggestions to mandate portability by federal law, using the same kind of language, would have the same potential shortcoming.

The methodology of this study is straightforward. The advance directive laws of the 50 states and the District of Columbia, in existence as of July 2004, were compiled and reviewed for compatibility with the 2004 version of *Five Wishes*. The Appendix to this article summarizes the key features of those laws, as they affect *Five Wishes*. The findings and analysis are based on interpretation of black letter state law in a way that is consistent and academically sound, but should not be read as equivalent to a legal opinion about the use of *Five Wishes* under the law of any particular state. Indeed, with respect to any state's advance directive law, there can be very different legal opinions about what the law permits or does not permit. This study strives primarily to discern important multi-state patterns of advance directive policy.

Throughout this article, we use the term "living will" to refer to an instructional directive regardless of its statutory name (e.g., declaration, directive to physicians) and the term "health care power of attorney" to any written designation of a surrogate decision-maker, likewise regardless of its statutory name (e.g., durable power of attorney for health care, proxy directive, appointment of health care representative).

## II. TOUR OF FIVE WISHES

The *Five Wishes* Form was created by Aging with Dignity, Inc., as a Florida advance directive in 1997. A year later, the organization released a revised 12-page version for national distribution with the help of grant support from the Robert Wood Johnson Foundation.<sup>12</sup> The form reviewed is that in use as of September 2004.<sup>13</sup>

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11. Available at <<http://www.abanet.org/aging/HCPA-CHT04.pdf>>.

12. Established in 1972, The Robert Wood Johnson Foundation, based in Princeton, N.J. is the largest philanthropy devoted exclusively to health and health care in the United States.

*Five Wishes* has received favorable coverage from a wide spectrum of media, including the Today Show, the Wall Street Journal, and the AARP Bulletin.<sup>14</sup> A large part of its appeal comes from the fact that it is non-legalistic in its language, and it addresses not only the appointment of a proxy and instructions relating to life support, but also other personal, emotional, and spiritual matters relating to the quality of life and the quality of relationships.

Each of the five wishes, listed below, contains a number of simply written choices that users can leave as is, cross out, or supplement to indicate their wishes about end-of-life care. The first two wishes cover the conventional two tasks of advance directives:

*Wish 1: The person I want to make care decisions for me when I can't.* This section gives guidance on whom to pick as an agent and includes a list of powers of the agent.

*Wish 2: My wish for the kind of medical treatment I want or don't want.* This section describes what "life-support treatment" means, and addresses whether one wants it or does not want it under four circumstances described in more detail in the form:

- Close to death
- In a coma and not expected to wake up or recover
- Permanent and severe brain damage and not expected to recover
- In another condition under which the individual does not wish to be kept alive – this part describes "end-stage condition" as an example and provides space to fill in any instructions desired.

The other three wishes address more personal matters:

*Wish 3: My wish for how comfortable I want to be.* This section addresses comfort steps such as massage, music, and warm baths, along with pain and symptom management.

*Wish 4: My wish for how I want people to treat me.* This section addresses desires to have others present, being touched and talked to, being cared for with kindness and cheerfulness, among other matters.

*Wish 5: My wish for what I want my loved ones to know.* This section includes a number of messages of love, forgiveness, acceptance of death, holding of good memories, and prompts for funeral wishes or memorials, disposition of remains, and organ donation if desired.

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13. The author served as a consultant to Aging with Dignity in the revision of its form for purposes of national distribution and continues to do so as needed. *Five Wishes* is available through the web site of Aging with Dignity: <<http://www.agingwithdignity.org>>.

14. Jean Sherman Chatzky, The Today Show, *Starting a Living Will* <<http://msnbc.msn.com/id/3226896>> (December 12, 2003); Christopher J. Gearon, AARP Bulletin Online, *A Matter of Life and Death: Schiavo Case Spurs More Americans to Weigh Living Wills* <<http://www.aarp.org/bulletin/yourhealth/Articles/a2003-12-09-livingwill.html>> (December 2003); Glenn Ruffenach, The Wall Street Journal on line, *Living Wills: Reader Tips* <<http://www.agingwithdignity.org/news.html>> (July 11, 2004).

The signature statement asks that “my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health care Agent (if I have one and he or she is available), or as otherwise expressed in this form.” It goes on to direct that:

This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.<sup>15</sup>

The witness statement and signature lines call for two witnesses over 18 years of age who do not fall within any of several disqualifying categories. A notarization clause is also provided, but the form notes that this is only required for residents of Missouri, North Carolina, Tennessee, and West Virginia. A boxed segment of text gives notice that residents of institutions in California, Connecticut, Delaware, Georgia, New York, and North Dakota must follow special witnessing rules and should contact a social worker or patient advocate at one’s institution for more information.

Finally the form ends with instructions on what to do with the form after completing it, and an optional wallet card that may be completed, cut out, and kept on one’s person. Not to be overlooked is the legal disclaimer, which states:

*Five Wishes* is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.<sup>16</sup>

### III. BARRIERS TO A NATIONAL FORM

The barriers *Five Wishes* faces as a potentially national form arise from the wide variety of sometimes-conflicting legal requirements imposed by state laws. In comparing *Five Wishes* to state law nationally, the following requirements posed the most significant challenges:

1. Differing proxy or agent requirements – states vary in who may serve as one’s health care agent;
2. Differing execution requirements—witnessing, attestation, notarization, and qualifications for who can be a witness;
3. Differing ranges of conditions (and their definitions) that may be addressed or that may be pre-conditions for implementation of the directive, e.g., terminal condition, permanent vegetative state, end-stage condition;
4. Differing state procedural requirements, such as certification of incapacity, certification of the patient’s condition, or revocation procedures;

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15. Aging with Dignity, *Five Wishes* 10 (2001) [hereinafter *Five Wishes*].

16. *Id.*, at 11.

5. State specific “magic words” – i.e., prescribed phrases or mandatory language requirements, e.g., where an agent’s authority or the individual’s instruction must be worded in a particular way;
6. Mandatory disclosures or notices;
7. Mandatory form requirements – as will be elaborated below, this is the most significant barrier in several states;
8. Special institutional protocols for execution, e.g., requiring an ombudsman or patient advocate to witness.

One possible option for any advance directive publisher is to ignore state statutory variations and, instead, provide an advance planning form that presumably will appeal to some target audience with the disclaimer that the form does not claim to be statutorily valid everywhere. Such a form will still provide critical evidence of one’s wishes.

That was the approach taken by the advance directive booklet and form first published jointly in 1995 by the American Bar Association, American Association of Retired Persons, and the American Medical Association.<sup>17</sup> This approach gives up the legal safe harbor that statutory forms provide – including provider immunity for compliance – and instead relies on constitutional principles of liberty, affirmed by the U.S. Supreme Court,<sup>18</sup> and common law doctrines of self-determination<sup>20</sup> and informed consent.<sup>19</sup> These principles buttress the proposition that providers should comply with *any* authentic communication regarding the wishes of a patient, unless compliance with those wishes would violate generally accepted medical standards applicable to the provider.<sup>20</sup>

The perceived need for a statutory safe harbor for health care providers who comply with advance directives is itself a curious phenomenon, rooted in large part in the culture of medicine in the 1970’s when the novel idea of a living will was introduced. So foreign was the notion that individuals might prefer to die than be tethered indefinitely to the latest medical technology that legislators responded to the public cry with a characteristically lawyerly solution – a standard form that health care providers would find easy to identify (called a living will) bolstered by the enticement of a legal carrot – namely, the assurance that health care providers would not be disciplined, sued, or prosecuted for complying with the official form or with the

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17. American Bar Association, *Shape Your Health Care Future with Health Care Advance Directives* <<http://www.abanet.org/ftp/pub/aging/adb.doc>> (accessed Dec. 26, 2004). Only the ABA still distributes this booklet and form.

18. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 110 S.Ct. 2841 (1990), affirming *Cruzan v. Harmon*, 60 S.W.2d 408 (Mo. 1988). See also, Barry R. Furrow, *et al.*, *Health Law* §17-2 (1995).

19. *Id.*

20. Regardless of whether a statutory or non-statutory form is used, a larger issue is whether advance directives really have an effect on decision-making, which is largely driven by the health care institutions and providers who reflect the culture of those institutions. See *e.g.*, A. Fagerlin and C. Schneider, *supra* n. 2. See also, Joan M. Teno *et al.*, *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 J. Am. Geriatric Soc. 500 (April 1997).

authorized direction of a health care proxy. The “stick” backing up the carrot, however, was small – for non-compliance by providers was hardly penalized. Every state permitted providers to refuse to comply based on conscience or for other reasons, with merely an attendant obligation to make some level of effort to transfer the patient to a provider who would comply. States vary in the level of effort mandated.<sup>21</sup>

Today, mainstream medicine in most, though not all, institutions accepts the notion of stopping treatment that merely prolongs the dying process in accordance with the wishes of the patient or authorized surrogate.<sup>22</sup> Yet, there remains a risk adverse bias that tends to favor statutory advance directives over non-statutory forms. For providers, the bias may be partly explained by the carrot of statutory immunity, but more likely by the ease of recognition and familiarity with the statutory form. And for lawyers and other advisors who counsel patients about advance directives, the rationale goes something like this: “Another form may be valid, but the only really safe course of action is to use the statutory form.” This reasoning ignores a core boiler-plate qualifier that exists in most state advance directive statutes that expressly clarifies that the statute does not replace any existing constitutional or common law principles regarding health care decision making. Rather, the statute is cumulative; in effect providing one brightly lit pathway, but not the only pathway, for directing health care decisions in advance.<sup>23</sup>

Aging with Dignity chose not to rely on the bigger picture of health decisions law and rather to achieve the perceived gold standard of statutory advance directive status in as many states as possible. Even if that gold standard was itself a product of a misguided narrow reading of the law, the organization’s aim was to give the public the highest level of confidence in the validity of *Five Wishes* without going so far as to make its form hopelessly complex or legalistic. A primary concurrent goal was to retain its user friendliness.

The sections of the article below examine *Five Wishes*’ success in surmounting the eight barriers to a national form enumerated above. As will be apparent, some barriers were overcome by adding provisions or requirements to *Five Wishes* in order to meet the aggregate restrictions across the several states. These self-imposed “super-restrictions” cover primarily proxy selection and witness selection. Other barriers are not so easy to overcome.

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21. See, Patrick Webster, *Comments: Enforcement Problems Arising From Conflicting Views of Living Wills In The Legal, Medical and Patient Communities*, 62 U. Pitt. L. Rev. 793 (2001); S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment*, 33 Wake Forest L. Rev. 1035 (Winter 1998).

22. See e.g., George E. Dickinson et al., *Twenty Years Beyond Medical School: Physicians' Attitudes Toward Death and Terminally Ill Patients*, 159 Arch. Intern. Med. 1741 (1999).

23. The following is an example of a typical provision: “Nothing in this act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this act are cumulative.” Kan. Stat. Ann. §§ 65-28,108(d) (2003).



### 1. Differing proxy or agent requirements

*Five Wishes* instructs users to name a health care agent who is at least 18 years or older (or at least 21 years old in Colorado) and not one of the following:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee of your health care provider.
- Someone serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.<sup>24</sup>

These restrictions appear to meet all variations found in state statutes, summarized in Column G of the Appendix. The obvious negative effect of this approach is that compliance with these instructions is more burdensome on the user than compliance with the laws of any one state. Many states have no proxy exclusions, and most that do are not as restrictive as *Five Wishes*. For example, many states that exclude health care providers from serving as proxy do not apply the exclusion if the provider is a close relative of the patient.<sup>25</sup>

### 2. Differing execution requirements

In most states, two adult witnesses are sufficient for execution of a directive, although witness qualifications vary significantly, as summarized in Column H of the Appendix. Three states also include a notarization requirement – Missouri, North Carolina, and West Virginia.<sup>26</sup> Several states provide for additional flexibility by permitting notarization to be used as an alternative to witnessing.<sup>27</sup>

The *Five Wishes* witness statement and signature lines call for two witnesses over 18 years of age who do not fall within any of the following disqualifications.

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, or by operation of law.<sup>28</sup>

As with proxies, this approach succeeds in meeting virtually every state's witness qualifications, but with the same negative consequences on user friendliness. The

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24. *Five Wishes*, *supra* note 15, at 10.

25. *See e.g.*, Conn. Gen. Stat. §19a-576(d) (West 2004).

26. Mo. Ann. Stat. §404.705(3) and §404.810 (West 2004); N.C. Gen. Stat. §32A-16(3) (2004); W. VA. Code Ann. §16-30-4(a) (West 2004).

27. *See e.g.*, Ariz. Rev. Stat. Ann. §36-3221(A)(3) (West 2004).

28. *Five Wishes*, *supra* note 15, at 10.

notarization clause expressly instructs residents of Missouri, North Carolina, Tennessee, and West Virginia to have the form both witnessed *and* notarized since they require both.<sup>29</sup>

Apart from witness qualifications, another potential barrier arises in three states whose laws prescribe witness attestation clauses and/or notary clauses that must be substantially followed.

- California’s Act requires witnesses “to make the following declaration in substance....”<sup>30</sup>
- Minnesota’s living will act (but not its separate more comprehensive advance directive act) requires that witness “shall substantially make the following declaration on the document....”<sup>31</sup>
- North Carolina’s living will statute (but not health care power of attorney statute) requires a “notary public who certifies substantially as set out in [the statutory form].”<sup>32</sup>

These witness or notary clauses can be quite lengthy and so are not reproduced here. However, their content essentially provides a restatement or confirmation of the execution requirements: the witness qualifications; their presence at signing; and the principal’s identity, soundness of mind, and knowing and voluntary signature. Since the witness and notary statements in *Five Wishes* address those very same issues – as most boilerplate witness attestation clauses and notary statements do – they are not considered a barrier to *Five Wishes* for purposes of this analysis.

### 3. Differing ranges of conditions that may be addressed under state laws

*Wish 2 of Five Wishes* addresses “life-support treatment” and addresses whether one wants it or does not want it under four circumstances that are described in the form: close to death; in a coma and not expected to wake up or recover; permanent and severe brain damage and not expected to recover; and in another condition under which the individual does not wish to be kept alive.<sup>33</sup> The instructions for the last category include “end-stage condition” as an example.

State living will laws are most relevant to this component of *Five Wishes*, yet they offer very little consistency in terminology and definitions. For example, *Five Wishes* defines “close to death” as follows:

[M]y doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death.<sup>34</sup>

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29. The *Five Wishes* form reviewed for this study did not yet reflect changes to Tennessee law in 2004, which eliminated the notarization requirement. See Tennessee 2004 Pub. Acts, c. 862 (eff. July 1, 2004).

30. Cal. Probate Code §4674(d) (West 2004).

31. Minn. Stat. Ann. §145B.03. Subd. 2 (West 2004).

32. N.C. Gen. Stat. §90-32(c)(4) (2004).

33. *Five Wishes*, *supra* note 15, at 7.

34. *Id.*

In state law jargon, this is usually referred to as “terminal condition” or “terminally ill.” But the breadth of definitions of these terms can vary widely. For example, Alabama defines terminal condition restrictively as:

A patient whose death is imminent or whose condition, to a reasonable degree of medical certainty, is hopeless unless he or she is artificially supported through the use of life-sustaining procedures and which condition is confirmed by a physician who is qualified and experienced in making such a diagnosis.<sup>35</sup>

Minnesota is more flexible:

“Terminal condition” means an incurable or irreversible condition for which the administration of medical treatment will serve only to prolong the dying process.<sup>36</sup>

Some states, such as New York and New Mexico, do not use the term at all. Similar variability exists for terms such as “persistent vegetative state” or “permanent unconsciousness,” “life-sustaining medical treatment,” and so on. Clearly, it would be impossible to track the language and definitions of each state. Yet, under the living will statutes in many states, these conditions may be required preconditions to the effectiveness of the instruction, at least where no appointed agent is available.

In light of the tumult in nomenclature and meaning, the only option for a national advance directive form is to settle upon its own terminology and define its terms clearly. In many, if not most instances, the approach should not invalidate the *Five Wishes* form, but instead, merely pose a need for closer attention to the document’s terms by providers to ensure that they understand the maker’s wishes.

In other instances, a statement, term, or instruction in *Five Wishes* may exceed perceived limits of flexibility permissible under state law. Then compliance with the wish in question may become a problem, but that fact should not invalidate the whole form. The form itself contains a severability clause just before the signature lines (“If any part of this form cannot be legally followed, I ask that all other parts of this form be followed.”)<sup>37</sup> Some state advance directive laws expressly recognize the severability of advance directive provisions,<sup>38</sup> and in contracts and other legal documents, severability is the norm whenever practicable.<sup>39</sup> Thus, we conclude that *Five Wishes* overcomes this barrier, albeit imperfectly.

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35. Alabama Stat. § 22-8A-3(14) (West 2004).

36. Minn. Stat. Ann. §145B.02, Subd. 8 (West 2004).

37. *Five Wishes*, *supra* note 15, at 10.

38. *See, e.g.*, Ala. Code 1975 § 22-8A-4(h) (2003): “Should any specific directions be held to be invalid, the invalidity shall not affect other directions of the advance directive for health care which can be given effect without the invalid direction, and to this end the directions in the advance directive for health care are severable.”

39. *See*, 67 Am. Jur. 2d Sales § 244; 13 Am. Jur. 2d Building and Construction Contracts § 14; 16 Am. Jur. 2d Constitutional Law § 118; 17A Am. Jur. 2d Contracts § 558.

#### 4. Differing procedural requirements

Another area of great variability in state law are the requirements for certifying the patient's incapacity or verifying the patient's terminal or other condition, including who is eligible to do the certification and how it must be documented. Revocation of an advance directive may also have to conform to certain criteria or be documented according to certain procedures. These variations are not tracked in the Appendix, because as explained below, they are not considered directly relevant to the underlying validity of the *Five Wishes* form.

As noted with respect to terminology, there is no feasible way for a "national" form to track the procedures required in every state. Accordingly, *Five Wishes* prescribes its own simple procedure for determining the patient's capacity to make decisions ("My attending or treating doctor finds I am no longer able to make health care choices, and another health care professional agrees that this is true.")<sup>40</sup> and determination of medical condition ("If my doctor and another health care professional both decide...").<sup>41</sup>

Where state laws prescribe a certification procedure for either incapacity or medical condition, the most typical approach is to require agreement by the attending physician and one other.<sup>42</sup> Does *Five Wishes*' variation from this norm create a problem, since *Five Wishes* requires only "another health care professional"?

The answer should be in the negative, for the nature of these certifications or verifications in state law is fundamentally distinct from the requisites for validity of the underlying advance directive form. Certification of the patient's condition is a procedural obligation of health care providers, dictated by statute, that does indeed affect how and when the advance directive will be implemented; however, those procedures are not requisites of validity of the underlying form. Legal face validity is dictated by whatever elements the statute prescribes for creation of the directive—usually consisting of a writing, a signature, date, and appropriate witnessing.

Thus, if the statute prescribes a process for certifying the patient's condition that varies from the *Five Wishes* instruction, providers will likely follow, and indeed may be obligated to follow, the statutory process rather than the *Five Wishes* instruction. The *Five Wishes* form in its preamble to *Wish 1* expressly acknowledges, with respect to determining incapacity, that state law may prescribe a different way for determining the patient's incapacity, in which case, "my state's way should be followed."<sup>43</sup>

Another procedural matter that arises in three states – Michigan, North Dakota, and Oregon – concerns a requirement that health care agents sign an acceptance form

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40. *Five Wishes*, *supra* note 15, at 4.

41. *Id.*, at 7.

42. This Wisconsin living will statute provision is common: "'Qualified patient' means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by 2 physicians, one of whom is the attending physician, who have personally examined the declarant." Wisc. Stat. Ann. § 154.02(3) (West 2004).

43. *Five Wishes*, *supra* note 15, at 4.

before their authority becomes effective.<sup>44</sup> Again, this type of requirement serves a procedural precondition to the effectiveness of the advance directive, but should not affect the validity of the underlying advance directive.

##### 5. State specific “magic words” – i.e., prescribed phrases

A few states require that certain matters be addressed with great specificity in either the living will or health care power of attorney, or both. These requirements relate primarily to instructions regarding life-sustaining treatments or to artificial nutrition and hydration in particular. In addition, a few of the health care power laws require specific durability language. Column F of the Appendix summarizes state law provisions in this regard, identifying nine states with mandatory phraseology.

In evaluating *Five Wishes* against these prescribed language requirements, a substantial equivalency approach was used. In other words, if the language used in *Five Wishes* was substantially equivalent in meaning to the language required by statute, then the *Five Wishes* version was deemed acceptable. This necessitates some judgment, but one that is appropriate from a policy perspective, for to insist on absolute compliance with “magic words” furthers neither respect for patient’s wishes nor ethically sound decision-making by providers.

With respect to the intent to permit withdrawal or withholding of life-sustaining treatment, including nutrition and hydration, *Five Wishes* authorizes the agent under *Wish 1*: “to make health care decisions for me.”<sup>45</sup> It goes on to elaborate the authority with eleven short bulleted paragraphs that can be changed, added to, or limited in space provided as desired. One of the bullets authorizes the agent to: “Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.”<sup>46</sup>

In addition, *Wish 2* includes a major paragraph “What ‘Life-Support Treatment’ Means to Me.” It defines life-support treatment as “any medical procedure, device or medication to keep me alive” and then gives the following examples: “medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.”<sup>47</sup>

As described earlier, *Wish 2* goes on to address one’s wishes when “Close to death”; when “In a coma and not expected to wake up or recover”; when suffering “Permanent and severe brain damage and not expected to recover”; or when in another condition that the individual describes in space provided as being one in which he or she does not wish to be kept alive.<sup>48</sup>

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44. Mich. Comp. Laws Ann. §700.5507(3) and (4) (West 2004); N.D. Cent. Code §23-06.5-06 (2004); Or. Rev. Stat. §127.525 (2004).

45. *Five Wishes*, *supra* note 15, at 5.

46. *Id.*

47. *Id.*, at 6.

48. *Id.*, at 7.

The “magic words” provisions found in the statutory review are extracted in Table 1 below with a judgment as to whether the *Five Wishes* language is substantially compliant. On these criteria, *Five Wishes* falls short in compatibility in Indiana and Ohio. In the other seven states listed, it was either clearly compatible or probably compatible.

TABLE 1

## MANDATORY PHRASEOLOGY AND FIVE WISHES COMPATIBILITY

Statutory Language (key terms highlighted)	Five Wishes compatibility?
Alabama Stat. § 22-8A-4(a) and (b) LW and HCPA: Artificially provided nutrition and hydration shall not be withdrawn or withheld... unless <i>specifically authorized therein</i> .	Yes
Alaska Stat. § 13.52.04 HCPA: Life-sustaining procedures may be withheld or withdrawn from a patient with a qualifying condition when there is (1) a durable power of attorney for health care or other writing that <i>clearly expresses</i> the patient’s intent that the procedures be withheld or withdrawn	Yes
Ind. Code Ann. § 30-5-5-17 and § 16-36-1-14 HCPA: To empower the attorney in fact to act under this section, the <i>following language must be included...in substantially the same form set forth below:</i> (a two-paragraph authorization and instruction follows)	No
Mich. Comp. Laws Ann. § 700.5507(4) HCPA: A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has <i>expressed in a clear and convincing manner</i> that the patient advocate is authorized to make such a decision, and that the <i>patient acknowledges that such a decision could or would allow the patient’s death</i> .	Probably Yes
N.C. Gen. Stat. § 90-321 LW: The attending physician may rely upon a [LW]: (1) Which <i>expresses a desire</i> of the declarant that extraordinary means or artificial nutrition or hydration not be used to prolong his life if his condition is determined to be terminal and incurable, or if the declarant is diagnosed as being in a persistent vegetative state; and (2) Which states that <i>the declarant is aware that the declaration authorizes a physician to withhold or discontinue</i> the extraordinary means or artificial nutrition or hydration	Probably Yes

Statutory Language (key terms highlighted)	Five Wishes compatibility?
<p>Ohio Rev. Code § 2133.02 (A)(2) &amp; (3) and § 1337.13(E)</p> <p>LW: the declarant's <i>declaration shall use either or both of the terms "terminal condition" and "permanently unconscious state"</i> and shall define or otherwise explain those terms in a manner that is substantially consistent with the provisions of [code section].</p> <p>Declarant's wishes must be communicated by:</p> <p>(i) <i>Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the declarant's attending physician may withhold or withdraw nutrition and hydration if the declarant is in a permanently unconscious state and if the declarant's attending physician and at least one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to the declarant or alleviate the declarant's pain, or checking or otherwise marking a box or line that is adjacent to a similar statement on a printed form of a declaration;</i></p> <p>(ii) <i>Placing the declarant's initials or signature underneath or adjacent to the statement, check, or other mark described in division (A)(3)(a)(i) of this section</i></p> <p>HCPA: (Similar provision)</p>	No
<p>Pa. Stat. Ann. tit. 20, § 5403</p> <p>LW: Life-sustaining treatment shall include nutrition and hydration administered by gastric tube or intravenously or any other artificial or invasive means <i>if the declaration of the qualified patient so specifically provides.</i></p>	Yes
<p>S.C. Code § 44-77-20(2) and § 62-5-504(6)</p> <p>LW: The declarant <i>shall indicate in the declaration whether the provision of nutrition and hydration through medically or surgically implanted tubes is to be treated as a life-sustaining procedure...</i></p> <p>HCPA: The <i>principal shall indicate in the health care power of attorney whether the provision of nutrition and hydration through medically or surgically implanted tubes is desired.</i></p>	Probably Yes

Statutory Language (key terms highlighted)	Five Wishes compatibility?
<p>Wis. Stat. Ann. § 155.20(2)(c)2 and § 155.20(4)</p> <p>HCPA: A health care agent may <i>consent to the admission</i> of a principal to the following facilities, under the following conditions:</p> <p>c. <i>To a nursing home or a community-based residential facility...</i> if the power of attorney for health care instrument <i>specifically so authorizes</i> and if the principal is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.</p> <p>A health care agent may consent to the withholding or withdrawal of a feeding tube for the principal if the power of attorney for health care <i>instrument so authorizes</i>.</p>	<p>Probably Yes (although FW does not expressly address “community-based residential facilities”)</p>

## 6. Mandatory Disclosures or Notices

Eight states – Nevada, New Hampshire, Ohio, Oregon, South Carolina, Texas, Vermont, and Wisconsin – require specific disclosures or notice to persons executing health care power of attorneys.<sup>49</sup> The requirement in six of these states is part of a broader mandatory form requirement, discussed in the next section. The mandatory disclosures, shown in Column E of the Appendix, deserve separate analysis because they are conceptually different from mandatory advance directive forms and could be used in conjunction with non-mandatory advance directive forms. Indeed, Ohio and Wisconsin mandate these disclosures without mandating the advance directive form itself. The Ohio and Wisconsin mandates apply only with respect pre-printed forms sold or otherwise distributed in the state, and thus, apply to *Five Wishes*.<sup>50</sup>

One state – Wyoming – requires a specific disclosure for living wills but not health care powers of attorney.<sup>51</sup> In all nine of these states, *Five Wishes* fails to satisfy the statutory notice requirement.<sup>52</sup> Doing so would require incorporating the unique disclosure for each of these states, a step that would be clearly impractical. However, whether *Five Wishes* could be used in Wyoming where it “works” under one law but not the other, is considered below.

These disclosure provisions represent a kind of “Miranda warning” for persons considering completing an advance directive. Since the information to be disclosed is

49. Nev. Rev. Stat. §449.830 (2004); N.H. Rev. Stat. Ann. §137-J:3 (2004); Ohio Rev. Code §1337.17 (West 2004); Or. Rev. Stat. §127.531 (2004); S.C. Code §62-5-504(D) (2004); Tex. [Health and Safety] Code Ann. §166.163 (Vernon 2004); Vt. Stat. Ann. tit. 18, §5276 (2004); Wis. Stat. Ann. §155.30(1) (West 2004).

50. Ohio Rev. Code §1337.17 (West 2004); Wis. Stat. Ann. §155.30(1) (West 2004).

51. Wyo. Stat. §§ 35-22-102(e) (2004).

52. North Dakota requires a special notice only for health care powers of attorney signed by institutionalized persons. N.D. Cent. Code § 23-06.5-10 (2003). Requirements for advance directives signed by institutional patients are discussed elsewhere.



unique to each state, they impede the use of universal advance directive models, because of the impracticality of including all these unique notices or warnings in a single form. This is especially true because of their length, with most exceeding a page in length. The longest – Ohio’s – exceeds 1600 words in length.<sup>53</sup>

Policy makers may justify the disclosures as a way to ensure that the signor understands the advance directive and to prevent abuse. However, there is little if any evidence that standard disclosures are very effective in educating the users of advance directives. Standard notices – especially long ones as Ohio requires – may exacerbate the perception by many that advance directives are excessively legalistic and cumbersome.

The inconsistency between requirements for living wills versus health care powers of attorney presents an important issue: if *Five Wishes* can meet the requirements for one but not the other, what consequence does that have on its statutory validity? This is a problem in those states with separate living will and health care power of attorney statutes. In this analysis, we take the view that if *Five Wishes* meets the requirements of at least the health care power of attorney statute, then that is sufficient to treat *Five Wishes* as compliant, even if it does not meet the living will statutory requirements. Thus, in the case of Wyoming, which requires a specific disclosure for living wills but not health care powers of attorney, *Five Wishes* will still be a viable statutory advance directive under the health care power of attorney law, as long as no other barriers arise in this analysis. The rationale for this position rests upon the fact that health care power of attorney statutes cover a far broader scope of health-care decision making than do living will laws. In addition, they permit the inclusion of any guidance the principal wishes to provide. As a practical matter, they can substitute for the living will and eliminate the need to rely on the separate living will statute as a basis for validity of the document.

### 7. Mandatory Advance Directive Forms

More onerous than mandatory disclosures are mandatory forms for either the living will or health care power of attorney. For example, Oregon clearly states that its comprehensive advance directive form “must be the same as the form set forth in this section to be valid.”<sup>54</sup> Other states use somewhat ambiguous language, mandating directives to be “substantially” in the form set forth in their act. The mandatory form requirements are noted in Column C of the Appendix.

The meaning of “substantially” in the context of advance directive laws is far from clear, and no state has clarified its meaning through litigation, regulation, or advisory opinion. Under the most restrictive interpretation, it may be read to preclude any variation of the form language, although the option of adding additional language may be permitted. Under a more flexible interpretation, substantial compliance should mean equivalent in substance, rather than in vocabulary, grammar, or style. Thus, as long as a directive has the essential elements of a statutory form – i.e., a writing,

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53. Ohio Rev. Code §1337.17 (West 2004).

54. Or. Rev. Stat. §127.531 (2004).

signature, date, and proper witnessing – it meets the test of substantial compliance. Unfortunately, the existence of doubt about the meaning of substantial compliance often leads health care institutions and lawyers to advise their patients or clients that the only “safe” thing to do is to recognize and use the statutory form nearly verbatim. This practice, of course, perpetuates the most restrictive interpretation of the law.

For purpose of this analysis, a conservative measure is used. Any language requiring advance directive forms to be “substantially” in the form set forth in statute is deemed to create a mandatory form obligation. A substantial equivalency test, as was used in evaluating prescribed phraseology above in Section 5, was not deemed feasible in the case of evaluating mandatory forms, because the forms are far more extensive and complex in their make-up. Substantial equivalency judgments become increasingly subjective the more extensive and complex the document.

Using this measure:

- Seven states require *any* advance directives to be substantially in the form contained in the statute: Alabama, Kansas, Kentucky, Oklahoma, Oregon, South Carolina, and Utah.<sup>55</sup>
- Four more states apply the requirement only to health care powers of attorney: Nevada, New Hampshire, Ohio, and Texas.<sup>56</sup>
- Three more jurisdictions apply the requirement only to living wills: District of Columbia, Indiana, and Minnesota.<sup>57</sup>

Using this analysis, twelve of the above states would not deem *Five Wishes* compatible with their laws. The District of Columbia, Indiana, and Minnesota could still be viewed as *Five Wishes* compatible if no other barriers presented themselves, because their mandatory form applies only to living wills and not health care powers of attorney. Among these three states, only Indiana presented other barriers in the form of mandatory language requirements, discussed previously.

### 8. *Special Institutional Protocols*

Seven states impose special witnessing requirements where the maker of the advance directive is in an institutional setting: California, Connecticut, Delaware, Georgia, New York, North Dakota, and Vermont.<sup>58</sup> Two other jurisdictions apply special witnessing requirements only for living wills signed in institutions, but not for

55. Alabama Stat. § 22-8A-4(h) (West 2004); Kan. Stat. Ann. §58-632 (2003); Ky. Rev. Stat. §311.625(1) (Baldwin 2004); Okla. Stat. Ann. tit. 63, §3101.4(B) (West 2004); Or. Rev. Stat. §127.531 (2004); S.C. Code §62-5-504(C)(1)(a) and (D) (2004); Utah Code Ann. §75-2-1104(4) (2004).

56. Nev. Rev. Stat. §449.830 (2004); N.H. Rev. Stat. Ann. §137-J:3 (2004); Ohio Rev. Code §1337.17 (West 2004); Tex. [Health and Safety] Code Ann. §166.163 (Vernon 2004).

57. D.C. Code Ann. §7-622(c) (2004); Ind. Code Ann. §16-36-4-9 (West 2004); Minn. Stat. Ann. §145B.04 (West 2004).

58. Cal. Probate Code §4675(a) (West 2004); Conn. Gen. Stat. §19a-576(b) and (c) (West 2004); Del. Code Ann. tit. 16, §2511(b) (2004); Ga. Code Ann. §31-36-5(a) (West 2004); N.Y. Pub. Health Law §2981(2)(b) and (c) (McKinney 2004); N.D. Cent. Code §23-06.4-03, §23.06.5-10(2) and (3) (2004); Vt. Stat. Ann. tit. 18, §5271(b) and (c) (2004).

health care power of attorneys: District of Columbia and South Carolina.<sup>59</sup> Institutional protocols are noted in Column H of the Appendix.

Following the reasoning described in the previous section of giving living will restrictions less weight than health care power of attorney limitations, we conclude that the institutional protocol barrier makes *Five Wishes* incompatible only in those states that apply it to all advance directives or to health care powers of attorney. Thus, only in the first seven states listed is *Five Wishes* not usable in institutional settings in its current form.

The protocols in the group of seven states vary in detail as well as to the range of institutional settings to which they apply. For example, the California requirement is limited to nursing homes:

If an individual is a patient in a skilled nursing facility when a written advance health care directive is executed, the advance directive is not effective unless a patient advocate or ombudsman, as may be designated by the Department of Aging for this purpose pursuant to any other applicable provision of law, signs the advance directive as a witness, either as one of two witnesses or in addition to notarization. The patient advocate or ombudsman shall declare that he or she is serving as a witness as required by this subdivision.<sup>60</sup>

Georgia's law applies to hospitals and nursing homes and requires the involvement of an attending physician:

[I] at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested and subscribed in the presence of the principal by the principal's attending physician.<sup>61</sup>

Connecticut's applies only to facilities for the mentally ill and mentally retarded:

For persons who reside in facilities operated or licensed by the Department of Mental Health and Addiction Services, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist with specialized training in treating mental illness.

For persons who reside in facilities operated or licensed by the department of mental retardation, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist with specialized training in developmental disabilities.<sup>62</sup>

Because of the variability, the *Five Wishes* form provides only a general notice to "residents of institutions" in six of the seven states (California, Connecticut, Delaware, Georgia, New York, and North Dakota). Vermont originally was not included because *Five Wishes* was not compatible with Vermont law prior to July 1, 2004, for other reasons. But Vermont can now be added to the compatible list. The *Five Wishes* states that where special witnessing requirements apply, institutionalized individuals should

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59. D.C. Code Ann. §6-2423; S. C. Code §44-77-40(3) (2004).

60. Cal. Probate Code *supra* n. 58.

61. Ga. Code Ann. *supra* n. 58.

62. Conn. Gen Stat. *supra* n. 58.

“contact a social worker or patient advocate at your institution” for more information.<sup>63</sup> These six states are retained as *Five Wishes*-friendly under this analysis, since the bulk of *Five Wishes* usage is likely to be in community settings. However, the institutional witnessing requirements constitute a major limitation.

#### IV. FINAL TALLY

Reviewing all the barriers identified above in the aggregate, *Five Wishes* encounters the following impediments to statutory compliance with state advance directive laws (listed in order of frequency):

- Eleven states are “mandatory form” states, requiring health care powers of attorney or other advance directives to be substantially in the form contained in the statute: Alabama, Kansas, Kentucky, Nevada, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, Texas, and Utah.
- Eight states require specific notices or warnings to persons executing any health care power of attorney: Nevada, New Hampshire, Ohio, Oregon, South Carolina, Texas, Vermont, and Wisconsin. However, all but two of these states are already eliminated because they require mandatory forms. Only Vermont and Wisconsin are new additions to the list of problem states.
- Two states prescribe specific phraseology for certain instructions – Indiana and Ohio. Indiana is new to the problem list. Wisconsin is a potential phraseology state because *Five Wishes* does not address admission to a “community-based residential facility” as defined in Wisconsin. However, Wisconsin is already on the problem list for other reasons.

In total, fourteen states pose one or more clear barriers to the use of *Five Wishes* as a statutory advance directive in those states. The remaining thirty-six states and the District of Columbia achieve the status of “*Five Wishes* compatible” under this analysis. The state-specific conclusion of *Five Wishes* compatibility is noted in Column J of the Appendix. The one additional caveat is that the conclusion ignores those states with special institutional signing protocols. *Five Wishes*, as published, will not work as a statutory form in one or more institutional settings in six states that are otherwise *Five Wishes*-friendly.<sup>64</sup>

#### V. PUSHING THE ENVELOPE

The final tally provides a ready list of the top three priorities for state advance directives law reform that would permit nationally usable advance directives: (1) eliminate mandatory forms, (2) eliminate mandatory disclosures, and (3) eliminate mandatory phraseology for specific wishes or powers. Since the first two of these are often packaged together, they are best confronted together.

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63. *Five Wishes*, *supra* n. 15, at 11.

64. California, Connecticut, Delaware, Georgia, New York, and North Dakota.

It is important to recall that the conservative criteria used to categorize statutory forms as mandatory have the effect of discounting the use of *Five Wishes* in several states, even where some legal and medical authorities might find *Five Wishes* perfectly acceptable. The more flexible view is definitely worthy of encouragement, because the reality is that squeezing everyone into a single statutory Procrustean form serves to accomplish little, other than routinizing the use of advance directives in the most superficial way possible. However, the health care field needs some specific precedents of authority to bolster a more flexible view. Of course, a state legislature can simply repeal the substantial compliance language and that would remove the barrier. However, legislation is not necessarily needed, nor is litigation. An interpretive opinion from a state's attorney general would provide a powerful lever to change the view. Even though non-binding, such opinions carry tremendous weight.<sup>65</sup> Alternatively, consensus statements of state medical societies or state bar associations likewise provide significant persuasive authority.

The most user-friendly legislative model for states is the Uniform Health-Care Decisions Act, which provides a form prefaced with this assurance: "The following form may, but need not, be used to create an advance health-care directive" and with the further assurance: "You are free to use a different form."<sup>66</sup> Moreover, the Act requires little more than a writing and signature as the necessary elements of a valid advance directive. Witnessing or notarization is not required, so it would be hard to find any form that would not qualify as a statutory directive under the Uniform Act.

Interestingly, this analysis suggests that, while variations in state witnessing requirements create a problem for national forms, it is in most cases a surmountable problem. Simplification of witnessing qualifications clearly would enhance the user-friendliness of *Five Wishes*, but there is not a strong case to be made for eliminating witnessing requirements entirely for purposes of national forms. Rather, elimination of mandatory form requirements stands as the single most significant change needed to assure the recognition of a wide variety of advance directives nationwide.

An alternative policy direction is to abandon statutory advance directives, or at least the living will type instructional directive, entirely. A recent critique by Fagerlin and Schneider proposes exactly that direction, citing ample research on the ineffectiveness of living wills.<sup>67</sup> They continue to support the use of health care powers of attorney as an essential decision-making tool, arguing that the presence of a

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65. Attorney General opinions have helped clarify aspects of health care decision-making law in several states. For example, a 1997 Attorney General Opinion in North Carolina clarified the legal authority of emergency medical services personnel to comply with both statutory and common law do-not-resuscitate (NDR) orders. 1997 WL 858260 (N.C.A.G.). A year 2000 Attorney General opinion in Maryland clarified the application of state law to decisions about tube feeding, including the legal standards governing decisions to withhold or withdraw a feeding tube. 85 Opinions of the Attorney General Opinion No. 00-029, November 16, 2000.

66. National Conference of Commissioners on Uniform State Laws, *Uniform Health-Care Decisions Act §4 (1993)* <<http://www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93.htm>> (accessed Dec. 26, 2004).

67. Angela Fagerlin and Carl E. Schneider, *supra* note 2.

legally authorized proxy improves decision making in very practical terms.<sup>68</sup> However, they conclude essentially that instructions are far too speculative, general, and detached from medical facts to be relevant to actual decisions. The reconsideration of thirty years of advance directive policy that Fagerlin and Schneider advocate is a useful exercise. In the mid-1970(s) when the first living will legislation was enacted, the desire to reject the proliferation of medical technology that could prolong life at any cost was novel. Medical institutions, particularly acute care hospitals, had a predominant disposition toward prolonging life.<sup>69</sup> The public felt nearly defenseless in the face of it. Yet, the frequency of experiences in which loved ones died senselessly long, painful deaths, insulated within institutions and intensive care settings, was growing.

From this reality sprang the intended legal solution of advance directives with its carrot of statutory immunity and its hope of providing clear, legally sanctioned pathways for decision-making. Some thirty years later, it may be fair to say that the medical profession grants more deference to the wishes of patients and surrogates and to the use of palliative care in the last stage of life, although hard evidence of this change may be elusive. If there has been any change, the body of research cited by Fagerlin and Schneider would suggest that it has not come about because of the use of living wills.

If standardizing patient's communications in the form of living wills has not been particularly effective, what is the alternative? An alternative that most respects individual, family, and cultural difference is to encourage the greatest variety of tools and avenues for advance planning as possible. To borrow a famous Chinese political expression, "Let a thousand flowers bloom."<sup>70</sup> The goal should be thoughtful, respectful decision-making and better communication. But how one gets there is a very personal matter.

From a health care systems point of view, the rub is that the opportunity for thoughtful and thorough discussions with patients and families is frequently non-existent. Hospitals and other health care institutions largely run on shorthand communications and orders. Individualized advance directives, especially lengthy ones, do not mesh well with the cogs of the medical engine.

Is there any systems solution to the disconnect? One possible glimmer of hope emanates from the convergence of two trends. One trend has been the gradual legislative movement towards simplification of advance directive laws. Some sixteen states now have combined or comprehensive advance directive laws that eliminate some or all of the barriers described in this article.<sup>71</sup> Recent signs that the trend is

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68. *Id.*, at 39.

69. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions* 106-117 (1983).

70. Attributed, with some variations, to Mao Zedong (Mao Tse Tung).

71. See ABA Commission on Law and Aging, Legislative Chart: *Health Care Power Of Attorney And Combined Advance Directive Legislation* <<http://www.abanet.org/aging/HCPA-CHT04.pdf>> (accessed Dec. 26, 2004).

continuing include major revisions to the advance directive laws in Alaska and Tennessee in 2004.<sup>72</sup> One envelope-pushing element of this trend is the statutory recognition of oral directives recorded in the medical record, permissible now in at least nine states.<sup>73</sup> The ultimate policy consequence of this trend is to support the communication of one's wishes in any form the individual prefers.

The second trend is the change of focus from attempting to standardize patient communications regarding end-of-life care to standardizing physician orders and care plans regarding end-of-life care. The harbinger of this trend has been the Oregon POLST form (Physicians Orders for Life Sustaining Treatment), which grew out of a 1991 statewide meeting of ethics committees and developed into a collaborative effort among health care providers and other stakeholders in Oregon.<sup>74</sup> It is worthy of note that the POLST form is not a creature of legislation, but of provider problem solving. The POLST form aims to accomplish at least three important tasks. One, the use of POLST necessitates a discussion between the treating physician and patient or surrogate about a range of end-of-life care treatment options. The precise method of communication is not dictated; the objective is discerning the wishes of the patient in light of his or her current condition. Two, the patient's wishes are incorporated into doctor's orders that are recorded on a unique, visible (bright pink) POLST form that serves as a cover sheet to the medical record and is reviewed periodically. And three, providers have committed to ensuring that the POLST form travels with the patient whenever transfers from one setting to another are made, thus, promoting continuity of care decisions.

Since Oregon's development of the POLST form, Washington and West Virginia have implemented similar protocols, and other states are considering following suit.<sup>75</sup> In many ways, the POLST form represents a sea change in advance planning policy by its change of focus to provider communications rather than solely on patient communications. In effect, it seeks to put patients' wishes into a language that the health care system understands, i.e., doctor's orders. It also focuses much more directly on here-and-now decisions rather than theoretical decisions that could occur in the distant future. It does not eliminate the need for and value of advance planning tools like *Five Wishes*; rather it surmounts the disconnect between them and the functioning of health care systems.

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72. 2004 Alaska Laws Ch. 83 (H.B. 25); Tennessee 2004 Pub.Acts, c. 862.

73. Cal. Probate Code §4711 (West 2004); Conn. Gen. Stat §19a-578 (West 2004); Del. Code Ann. tit. 16 §2507 (2004); Fla. Stat. Ann. §765.101; Hawaii Rev. Stat. §327E-3 and §327E-5 (West 2004); La. Rev. Stat. Ann. 40:1299.58.2; Md. Code Ann. [Health-Gen.] §5-602(d)(1) (2004); Miss. Code Ann. §41-41-205 (West 2004); N.M. Stat. Ann. §24-7A-5 (West 2004); Tenn. Code Ann. §68-11-1803 and -1806; Va. Code §54.1-2982 (West 2004).

74. Susan W. Tolle *et al.*, *A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment*, 46 J. Am. Geriatr. Soc. 1 (1998). Detailed information about the POLST form is available at <<http://www.polst.org>>.

75. *See e.g.*, 2004 Maryland Laws Ch. 506 (H.B. 556) which authorizes the creation of a "Patient Plan of Care" form by the Attorney General that will function in a similar fashion to the POLST form. For more about the W. Va. form, *see* <[http://www.hsc.wvu.edu/chel/ad\\_forms/WVHA\\_POST\\_form\\_disc.htm](http://www.hsc.wvu.edu/chel/ad_forms/WVHA_POST_form_disc.htm)> and <[http://www.hsc.wvu.edu/chel/wvi/faq\\_post.htm](http://www.hsc.wvu.edu/chel/wvi/faq_post.htm)>.

## VI. CONCLUSION

Historical inertia, more than anything else, has caused the fragmentation and conflict among state advance directive laws described in this article. Law evolves incrementally, and when the body of law on a particular subject works “well enough” within a state, the incentive to re-examine it weakens. But, the ever-increasing mobility of society as well as the desires of an aging baby boomer population may fuel an increasing demand for simplicity and flexibility in the legal tools we have created for health care advance planning.

There are no defensible grounds for maintaining the Balkanized conglomeration of widely differing advance directive laws that we currently encounter in the states. This article examined the primary barriers in existing state legislation that inhibit the availability of national models of advance directives. The analysis focused on the *Five Wishes* advance directive, because it comes as close to a national advance directive as any in circulation. However, the analysis is directly applicable to the use of any other advance directive that might aspire to national circulation. Indeed, our central conclusion is that public policy should support and encourage a wide variety of advance planning tools. Such a policy would not only conform more closely to the fundamentally personal nature of advance planning for health care, it would also be more respectful of individual, family, and cultural differences.

Signs of change toward simplification are visible, as are signs of a fundamental shift away from the standardization of patient communications toward the standardizing of provider communications regarding patients’ end-of-life wishes. These are both directions worth pursuing if our ultimate goal is that of collaborative, respectful, and accurate decision-making.

## ACKNOWLEDGMENTS

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STATUTORY ADVANCE DIRECTIVE LAW OBSTACLES TO FIVE WISHES  
2004

A. STATE + HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS*	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
1. ALABAMA Alabama Stat. § 22-8A-2 to -13 (West 2004). <i>See also</i> Durable Power of Attorney Act, § 26-1-2	Same	Combined Advance Directive	Unclear. "substantially in the following form"	No	None, but must specifically authorize w/h or w/d of N&H	<ul style="list-style-type: none"> <li>• Indiv. Provider *</li> </ul> * Exception for relatives employed by the provider	2 witnesses must be at least 19 yrs of age	<ul style="list-style-type: none"> <li>• Minor = 18</li> <li>• Agent</li> <li>• Proxy signor</li> <li>• Relative</li> <li>• Heir</li> <li>• Person responsible for care costs</li> </ul>	No
2. ALASKA Alaska Stat. §13.52.010 to .395 (West 2004) * Effective 1/1/05	Same	Combined Advance Directive	No	No	None, but must clearly express intent re life sustaining procedures	<ul style="list-style-type: none"> <li>• Facility provider*</li> </ul> * Exception for relatives	2 witnesses or notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Facility provider</li> <li>• One may not be:</li> <li>• Relative</li> <li>• Heir</li> </ul>	No
3. ARIZONA Ariz. Rev. Stat. Ann. §36:3201 to -3262 (West 2004)	Same	LW HCPA	No	No	No	None specified	1 witnesses or notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Provider</li> </ul> If only one witness, person may not be: <ul style="list-style-type: none"> <li>• Relative</li> <li>• Heir</li> </ul>	No
4. ARKANSAS Ark. Code. Ann. § 20-13-104 (2004)	Ark. Code Ann. §§20-17-201 to -218	LW HCPA	No	No	No	None specified	2 witnesses	None specified	No
5. CALIFORNIA Cal. Probate Code §§4600 to -4948 (West 2004)	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>• Supervising Indiv. Provider</li> <li>• Facility Provider</li> <li>• Conservator – unless conditions are met.</li> </ul>	2 witness or notarized Has a required witness declaration "in substance"	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Indiv. Provider</li> <li>• Facility Provider</li> <li>• One may not be:</li> <li>• Relative</li> <li>• Heir</li> </ul>	Yes
6. COLORADO Colo. Rev. Stat. §§15-14-503 to -509 (West 2004)	Colo. Rev. Stat. §§15-18-101 to -113	LW HCPA (NB. Proxy must be 21)	No	No	No	None specified	None specified Special Institutional Protocols (See end notes)	N/A	No

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<b>7. CONNECTICUT</b> § 19a-570 to -580a (West 2004) Also Conn. Gen. Stat. § 1-43 et seq. (short form DFA)	Same	LW HCPA Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>Facility Provider*</li> <li>Attending physician</li> <li>Administrator or employees of gov't agency financially responsible for care*</li> </ul> * Exception for relatives	2 witnesses  Special Institutional Protocols (See end notes)	<ul style="list-style-type: none"> <li>Agent</li> </ul>	Yes
<b>8. DELAWARE</b> Del. Code Ann. tit. 16, §§2501 to 2518 (2004)	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>Residential LTC Facility Provider*</li> </ul> * Exception for relatives	2 witnesses  Special Institutional Protocols (See end notes)	<ul style="list-style-type: none"> <li>Facility provider</li> <li>Relative</li> <li>Heir</li> <li>Creditor</li> <li>Person responsible for care costs</li> </ul>	Yes
<b>9. DISTRICT OF COLUMBIA</b> D.C. Code Ann. §§21-2201 to -2213 (2004)	D.C. Code Ann. §§7-621 to -630	LW HCPA	Uncertain for LW: "substantially in the following form" HCPA: Not mandatory	No	Durability language must be substantially similar	<ul style="list-style-type: none"> <li>Indiv. Provider</li> <li>Facility Provider</li> </ul>	2 witnesses  Special Institutional Protocols for LW only (See end notes)	<ul style="list-style-type: none"> <li>Principal</li> <li>Individual Provider</li> <li>Facility Provider</li> </ul> One may not be relative or heir	Yes for LW only.
<b>10. FLORIDA</b> Fla. Stat. Ann. §765.101 to -.404 (West 2004)	Same	LW HCPA	No	No	No	None specified	2 witnesses	<ul style="list-style-type: none"> <li>Agent</li> </ul> One may not be spouse or relative	No
<b>11. GEORGIA</b> Ga. Code Ann. §§31-36-1 to -13 (West 2004)	Ga. Code Ann. §§ 31-32-1 to -12	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>Indiv. Provider directly or indirectly involved</li> </ul>	2 witnesses  Special Institutional Protocols (See end notes)	None specified	Yes
<b>12. HAWAII</b> Hawaii Rev. Stat. §§327E-1 to -16 (2004) <i>See also</i> Hawaii Rev. Stat. §351D-2.5 re DFA	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>Facility Provider*</li> </ul> * Exception for relatives	2 witnesses <i>or</i> notarized  Special Institutional Protocols (See end notes)	<ul style="list-style-type: none"> <li>Indiv. provider</li> <li>Facility provider</li> <li>Agent</li> </ul> One may not be Relative	No
<b>13. IDAHO</b> Idaho Code §§39-4-501 to -4509 (West 2004)	Same	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>Indiv. Provider*</li> <li>Community Care Facility Provider*</li> </ul> * Exception for relatives who are employees of.	2 witnesses <i>or</i> notarized	<ul style="list-style-type: none"> <li>Agent</li> <li>Indiv. Provider</li> <li>Community Care Facility</li> </ul> One may not be relative or heir	No

A. STATE HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
14. ILLINOIS 755 ILCS 45/4-1 through 4-12 (West 2004)	755 ILCS 35/1 to 35/10	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Indiv. Provider</li> </ul>	LW; 2 witnesses HCPA: None required	None specified	No
15. INDIANA Ind. Code Ann. §§30-5-1 to 30-5-10 (West 1998), specifically §§30-5-5, 16 and -17. (General DPA with health powers) <i>See also</i> §16-36-1-1 to -14 (Health Care Consent Act)	Ind. Code Ann. §§16-36-4-1 to -15	LW	LW: Unclear "substantially in the form set forth in this chapter"	No	DPA & Appt of HC Representative: Mandatory language for authority re life-sustaining treatment	None specified	LW; 2 witnesses DPA: notarization Appt of HC Rep: 1 witness	HC Consent Act: <ul style="list-style-type: none"> <li>• Agent</li> <li>• Agent</li> </ul>	No
16. IOWA Iowa Code Ann. §§144B.1 to 12 (West 2004)	Iowa Code Ann. §§144A.1 to 12	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> </ul> *Exception for relatives	2 witnesses <i>or</i> notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Indiv. Provider</li> </ul> One may not be relative	No
17. KANSAS Kan. Stat. Ann. §§65-28,101 to 28,109	Kan. Stat. Ann. §§65-28,101 to 28,109	LW HCPA	LW & HCPA Uncertain: "shall be substantially in the following form:"	No	Durability phrase or similar language required	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives & religious community members	2 witness <i>or</i> notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Relative</li> <li>• Heir</li> <li>• Person responsible for care costs</li> </ul>	No
18. KENTUCKY Ky. Rev. Stat. §§311.621 to 643 (Baldwin 2004)	Same	Combined Advance Directive	Uncertain: "shall be substantially in the following form:"	No	No	<ul style="list-style-type: none"> <li>• Facility provider*</li> </ul> * Exception for relatives	2 witness <i>or</i> notarized	<ul style="list-style-type: none"> <li>• Relative</li> <li>• Facility Provider</li> <li>• Attending physician</li> <li>• Heir</li> <li>• Person responsible for care costs</li> </ul>	No
19. LOUISIANA La. Rev. Stat. Ann.40:1299.58,1 to .10 (West 2004)	Same	LW	No	No	No	None specified	2 witnesses	<ul style="list-style-type: none"> <li>• Relative</li> <li>• Heir</li> </ul>	No
20. MAINE Me. Rev. Stat. Ann. tit. 18A, §5-801 to §5-817 (West 2004)	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>• LTC Facility provider*</li> </ul> * Exception for relatives	2 witnesses	None specified	No
21. MARYLAND Md. Code Ann. [Health-Gen.] §5-601 to -608 (2004)	Same	LW Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>• Facility provider*</li> </ul> * Exception for relatives	2 witnesses	<ul style="list-style-type: none"> <li>• Agent</li> </ul> One may not be: Heir or have any other financial interest in person's death	No

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22. MASSACHUSETTS Mass. Gen. Laws Ann. Ch. 201D (West 2004) (HCPA only)	None	None	No	No	No	<ul style="list-style-type: none"> <li>Facility provider*</li> </ul> * Exception for relatives	2 witnesses	<ul style="list-style-type: none"> <li>Agent</li> </ul>	No
23. MICHIGAN Mich. Comp. Laws Ann. §700.5501 to 5513 (West 2004) (HCPA only)	None	None	No	No	Decision re life support requires that patient "has expressed in a clear and convincing manner that the [agent] is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death."	None specified	2 witnesses	<ul style="list-style-type: none"> <li>Agent</li> <li>Relative</li> <li>Heir</li> <li>Indiv. Provider</li> <li>Facility Provider</li> <li>Employee of life/health insurance provider for patient</li> </ul>	No
24. MINNESOTA Minn. Stat. Ann. §145B.01 to .17 (West 2004)	Minn. Stat. Ann. §145B.01 to .17 (West 2004)	LW Combined Advance Directive	LW: Yes (Forms printed for public distribution must be substantially in the form in this section)  Combined Advance Directive. Not mandatory	No	No	<ul style="list-style-type: none"> <li>Indiv. Provider*</li> <li>Facility Provider*</li> </ul> * Exception for relatives	2 Witnesses <i>or</i> notarized LW: requires that witnesses "Shall substantially make the following declaration on the document: "I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will."	<ul style="list-style-type: none"> <li>Agent</li> </ul> One may not be provider	No
25. MISSISSIPPI Miss. Code Ann. §§41-41-201 to -229 (West 2004)	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>LTC Facility</li> </ul> * Exception for relatives	2 Witnesses <i>or</i> notarized	<ul style="list-style-type: none"> <li>Agent</li> <li>Indiv. Provider</li> <li>Facility Provider</li> </ul> One may not be relative or heir	No
26. MISSOURI Mo. Ann. Stat. §§404.700 to 735 And §§800 - 870 (West 1998)	Mo. Ann. Stat. §§459.010 to 459.055 (West 2004)	LW	No	No	Durability phrase or similar language required	<ul style="list-style-type: none"> <li>Attending Physician*</li> <li>Facility Provider*</li> </ul> * Exception for relatives and members of same religious community	LW: 2 witnesses HCPA: Notarized	None specified	No

A. STATE + HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS <sup>1</sup>	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
27. MONTANA Mont. Code Ann. §§50-9-101 to -206 (2004). Also incorporates by reference §72-5-501 and -502 (regular DPA statute)	Same	LW	No	No	For DPA, durability phrase or similar language required, but not applicable to LW with proxy appointment.	None specified	LW (with proxy appointment); 2 witnesses DPA with health powers: customarily notarized	None specified	No
28. NEBRASKA Neb. Rev. Stat. §§30-3401 to -3432 (2004)	Neb. Rev. Stat. §20-401 to -416 (2004)	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Provider</li> <li>• Facility</li> <li>• Any agent serving 10 or more principals</li> </ul>	2 witnesses <i>or</i> notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Spouse</li> <li>• Relative</li> <li>• Heir</li> <li>• Attending Physician</li> <li>• Insurer</li> </ul> One may not be Facility provider	No
29. NEVADA Nev. Rev. Stat. §§449.800 to .860 (2004)	Nev. Rev. Stat. 449.535 to 690 (2004) (Includes a proxy designation)	LW HCPA	LW: Not mandatory HCPA	LW: No HCPA: Yes	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives	LW: 2 witnesses HCPA: 2 witnesses <i>or</i> notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Indiv. Provider</li> <li>• Facility Provider</li> </ul> One may not be relative or heir	No
30. NEW HAMPSHIRE N.H. Rev. Stat. Ann. §§137-J:1 to -J:16 (2004)	N.H. Rev. Stat. Ann. §§137-H:1 to -H:16 (2004)	LW HCPA	LW: Not mandatory HCPA: Form and disclosure statement "shall be substantially in the form set forth"	LW: No HCPA: Yes	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives who are employees of	2 witnesses Special Institutional Protocols for LW only (See end notes)	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Spouse</li> <li>• Heir</li> </ul> One may not be provider or facility	Yes, LW only
31. NEW JERSEY N.J. Stat. Ann. §26:2H-53 to -81 (West 2004)	Same	None	No	No	No	<ul style="list-style-type: none"> <li>• Attending Physician</li> <li>• Facility Provider</li> </ul> * Exception for relatives	2 witnesses <i>or</i> notarized	• Agent	No
32. NEW MEXICO N.M. Stat. Ann. §§24-7A-1 to - 18 (West 2004)	Same	Combined Advance Directive	No	No	No	<ul style="list-style-type: none"> <li>• LTC Facility Provider</li> </ul> * Exception for relatives	None required, but recommended.	None specified	No
33. NEW YORK N.Y. Pub. Health Law §§2980 to 2994 (McKinney 2004)	None	HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Attending Physician</li> <li>• Facility Provider*</li> <li>• Any agent serving 10 or more principals*</li> </ul> * Exception for relatives	2 witnesses Special Institutional Protocols (See end notes)	• Agent	Yes

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<p><b>34. NORTH CAROLINA</b> N.C. Gen. Stat. §§32A-15 to -26 (2004)</p>	<p>N.C. Gen. Stat. §90-320 to -322 (2004)</p>	<p>LW HCPA</p>	<p>No</p>	<p>No</p>	<p>LW: Must state that "declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means of artificial nutrition or hydration" HCPA: None</p>	<ul style="list-style-type: none"> <li>• Indiv. Provider</li> </ul>	<p>2 witness <i>and</i> notarized LW only: Notary certification must be substantially as set out in the Act</p>	<ul style="list-style-type: none"> <li>• Relative</li> <li>• Heir</li> <li>• Attending Physician</li> <li>• Facility Provider</li> <li>• Creditor</li> </ul>	<p>No</p>
<p><b>35. NORTH DAKOTA</b> N.D. Cent. Code §§2-06.5-01 to -18 (2004)</p>	<p>N.D. Cent. Code §23-06.4-01 to -14 (2004)</p>	<p>LW HCPA</p>	<p>No</p>	<p>LW: No HCPA: Only for institutionalized persons.</p>	<p>No</p>	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> <p>* Exception for relatives who are employees of</p>	<p>2 witness <i>or</i> notarized Special Institutional Protocols for HCPA only (See end notes)</p>	<ul style="list-style-type: none"> <li>• Agent *</li> <li>• Spouse *</li> <li>• Heir *</li> <li>• Relative *</li> <li>• Creditor *</li> <li>• Indiv. Provider</li> <li>• Facility Provider</li> </ul> <p>* Also disqualifies notary</p>	<p>LW: No HCPA: Yes</p>
<p><b>36. OHIO</b> Ohio Rev. Code §§1337.11 to .17 (West 2004)</p>	<p>Ohio Rev. Code §2133.01 to 15 (West 2004)</p>	<p>Only for HCPA mandatory disclosure statement</p>	<p>Only for HCPA mandatory disclosure statement</p>	<p>LW: No HCPA: Yes, if a preprinted form is used</p>	<p>LW: Must use the terms "terminal condition" and "permanently unconscious state" <i>and</i> wishes re nutrition &amp; hydration must be "in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type" <i>and</i> must be initialed.</p>	<ul style="list-style-type: none"> <li>• Attending Physician*</li> <li>• Nursing home administrator*</li> </ul> <p>* Exception for relatives who are employees of</p>	<p>2 witnesses <i>or</i> notarized</p>	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Relative</li> <li>• Attending Physician</li> <li>• Nursing home administrator</li> </ul>	<p>No</p>
<p><b>37. OKLAHOMA</b> Okla. Stat. Ann. tit. 63, §3101.1 to .16 (West 2004)</p>	<p>Same</p>	<p>Combined Advance Directive</p>	<p>Yes "shall be in substantially the following form"</p>	<p>No</p>	<p>No</p>	<p>None specified</p>	<p>2 witnesses</p>	<ul style="list-style-type: none"> <li>• Heir</li> </ul>	<p>No</p>

A. STATE + HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS*	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
38. OREGON Or. Rev. Stat. §127.505 to .660 and 127.995 (2004)	Same	Combined Advance Directive	Yes "must be the same as the form set forth in this section"	Yes included in mandatory form	No	<ul style="list-style-type: none"> <li>• Attending physician*</li> <li>• Facility provider*</li> </ul> * Exception for relatives	2 witnesses  Special Institutional Protocols (See end notes)	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Attending physician</li> </ul> One may not be relative, heir, or facility provider	Yes
39. PENNSYLVANIA Pa. Stat. Ann. tit. 20, §§401 to 5416 (West 2004). <i>See also</i> 20 Pa. Cons. Stat. Ann. §5601 to 5611	Same	Combined Advance Directive	No	No	LW must specifically address nutrition and hydration	None specified	2 witnesses	<ul style="list-style-type: none"> <li>• LW: Person who signs declaration on declarant's behalf</li> <li>• Statutory Form DPA: None specified</li> </ul>	No
40. RHODE ISLAND R.I. Gen. Laws §23-4.10-1 to -12 (2004)	R.I. Gen. Laws §§ 23-4.11-1 to -15 (2004)	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Community Care Facility*</li> </ul> * Exception for relatives who are employees of	2 witnesses	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Indiv. Provider</li> <li>• Community Care Facility</li> </ul> One may not be relative or heir	No
41. SOUTH CAROLINA S.C. Code §62-5-501 to -505 (2004) <i>See also</i> §62-5-501 re durable power.	S. C. Code § 44-77-10 to -160 (2004)	LW HCPA	LW & HCPA Yes "must be substantially in the following form"	LW: No HCPA: Included in mandatory form	LW and HCPA must specifically address nutrition and hydration	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> <li>• Spouse of a Provider*</li> </ul> * Exception for relatives	LW: 2 witnesses and notarized HCPA: 2 witnesses  Special Institutional Protocols for LW only (See end notes)	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Spouse</li> <li>• Relative</li> <li>• Heir</li> <li>• Attending physician</li> <li>• Creditor</li> <li>• Life insurance beneficiary</li> <li>• Person responsible for care costs</li> </ul> One may not be facility provider	LW: Yes HCPA: No
42. SOUTH DAKOTA S.D. Codified Laws § 34-12D-1 to -22 (2004) <i>See also</i> §34-12C-1 to -8 (Health care consent procedures)	S.D. Codified Laws § 34-12D-1 to -22 (2004)	LW	No	No	No	None specified	LW: 2 witnesses (plus notary suggested but not required) HCPA: Not specified (but notarization is typical)	None specified	No
43. TENNESSEE Tenn. Code Ann §68-11-1801 to -1815 (2004)	Same	Combined Advance Directive	No	No	No	None specified	2 witnesses or notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Provider</li> <li>• Facility</li> </ul> One may not be relative or heir.	No

A. STATE + HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS*	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
<b>44. TEXAS</b> Tex. [Health & Safety] Code Ann. §166.001 to -.166 (Vernon 2004)	Same	LW (with proxy designation) HCPA	LW: No HCPA: Yes *must be substantially in the following form'	LW: No HCPA: Yes	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives who are employees of	2 witnesses	One may not be: <ul style="list-style-type: none"> <li>• Agent</li> <li>• Attending Physician</li> <li>• Relative</li> <li>• Facility</li> <li>• Heir</li> <li>• Creditor</li> </ul>	No
<b>45. UTAH</b> Utah Code Ann. §75-2-1101 to -1119 (2004)	Same	LW (2 versions) HCPA	LW & HCPA Yes *shall be substantially in the following form'	No	No	None specified	LW: 2 witnesses HCPA: notarized	None specified	No
<b>46. VERMONT</b> Vt. Stat. Ann. tit. 18, §5251 to §262 (2004)	Same	LW HCPA	No	LW: No HCPA: Yes	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Residential Care Provider*</li> <li>• Funeral/crematory/cemetery representative (if authorized to dispose of remains or donate organs)</li> </ul> * Exception for relatives who are employees of	2 witnesses Special Institutional Protocols (See end notes)	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Indiv. Provider</li> <li>• Residential Care Provider</li> <li>• Spouse</li> <li>• Heir</li> <li>• Creditor</li> <li>• Funeral/crematory/cemetery representative</li> </ul>	Yes
<b>47. VIRGINIA</b> Va. Code §54.1-2981 to -2993 (West 2004)	Same	Combined AD	No	No	No	None specified	2 witnesses	<ul style="list-style-type: none"> <li>• Spouse</li> <li>• Relative</li> </ul>	No
<b>48. WASHINGTON</b> Wash. Rev. Code Ann. Wash. Rev. Code Ann. §11.94.010 to 900 (West 2004)	Same	LW	No	No	For DPA, durability phrase or similar language required	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives	LW: 2 witnesses HCPA: None specified	None specified	No
<b>49. WEST VIRGINIA</b> W. Va. Code Ann. §16-30-1 to -25 (West 2004)	Same	LW HCPA	No	No	No	<ul style="list-style-type: none"> <li>• Indiv. Provider*</li> <li>• Facility Provider*</li> </ul> * Exception for relatives who are employees of	W witnesses <i>and</i> notarized	<ul style="list-style-type: none"> <li>• Agent</li> <li>• Attending Physician</li> <li>• Principal's signatory</li> <li>• Relative</li> <li>• Heir</li> <li>• Person responsible for care costs</li> </ul>	No



A. STATE + HEALTH CARE POWER OF ATTORNEY STATUTE CITATION	B. LIVING WILL STATUTE CITATION	C. FORMS PROVIDED	D. MANDATORY FORM?	E. MANDATORY NOTICE	F. PRESCRIBED PHRASES	G. PROHIBITED AGENTS	H. WITNESSING	I. PROHIBITED WITNESSES (HCPA)	J. SPECIAL INSTITUTIONAL PROTOCOLS (See End Notes)
<b>50. WISCONSIN</b> Wis. Stat. Ann. § 155.01 to .80 (West 2004)	Wis. Stat. Ann. §§ 154.01 to -15 (West 2004)	LW HCPA	No	LW: No HCPA: Yes on printed forms	HCPA must specifically authorize: • w/h or w/d of artificial nutrition & hydration • Admission to nursing home or community-based residential facility	• Indiv. Provider* • Facility Provider* * Exception for relatives	2 witnesses	• Agent • Indiv. Provider • Facility provider* • Relative • Heir • Person responsible for care costs * Exception for chaplains & social workers	No
<b>51. WYOMING</b> Wyo. Stat. §3-5-201 to -213 (2004)	Wyo. Stat §§ 35-22-101 to -109 (2004)	LW	No	LW: Yes HCPA: No	No	• Indiv. Provider • Facility Provider* * Exception for relatives who are employees of	LW: 2 witnesses HCPA: 2 witnesses <i>or</i> notarized	• Agent • Indiv. Provider • Facility Provider One may not be relative or heir	No
<b>UNIFORM HEALTH-CARE DECISIONS ACT</b>	Same	Combined Advance Directive	No	No	No	• LTC Facility Provider	2 witnesses recommended, but not required	None specified	No

**Abbreviations:** LW = Living Will; HCPA = Health Care Power of Attorney; DPA = Durable Power of Attorney; UHCDA = Uniform Health Care Decisions Act

<sup>1</sup> In all states, an agent must be 18 years of age or older, except in Colorado in which the requirement is 21 or older.

**CAUTION:** The descriptions and limitations listed in this chart should be viewed as broad characterizations for comparison purposes and not as precise quotations from legislative language.

**Special Institutional Protocols for Witnessing:**

- CA** Advance Directive: If in "skilled nursing facility," "a patient advocate or ombudsman, as may be designated by the Department of Aging for this purpose" must sign "as a witness, either as one of two witnesses or in addition to notarization. Cal., Probate Code §§4675(a) (West 2004).
- CT** Advance Directive: If in facility operated by Dept. of M.H. and Addiction Svcs, one W must have no affiliation with facility and I must be physician or clinical psychologist w/ specialized training in treating mental illness.  
If in a facility operated or licensed by the Dept. of M.R., one W must have no affiliation with facility and one must be physician or clinical psychologist w/ specialized training in developmental disabilities. Conn. Gen. Stat. § 19a-576(b) and (c) (West 2004).
- DE** Advance Directive: If in a sanatorium, rest home, nursing home, boarding home or related institution, one W must be a person designated as a patient advocate or ombudsman by [state agency Def. Code Ann. tit. 16, §2511(b) (2004)].
- DC** LW only: If resident of an intermediate or skilled care facility, one W must be a patient advocate or ombudsman. D.C. Code Ann. §7-623.

**GA**

LW: If in hospital, must additionally be signed in presence of either (1) the chief of the hospital med staff, (2) any physician on the med staff not participating in the care of the patient, or (3) a person on the hospital staff who is not participating in the care of the patient designated by the chief of staff and the hospital administrator.

If in SNF, must additionally be signed in presence of (1) medical director or (2) any physician on the medical staff not participating in the care of the patient. Ga. Code Ann. § 31-32-4.

HCPA: If in a hospital or skilled nursing facility, must additionally be signed in the presence of the principal by the principal's attending physician. Ga. Code Ann. § 31-36-5(a) (West 2004)

**NH**

LW only: If in hospital, "no more than one witness may be the health care provider or such provider's employee" N.H. Rev. Stat. Ann. 137-Hf:4.

**NY**

Health Care Proxy: If in mental hygiene facility operated or licensed by the office of mental, "at least one witness shall be an individual who is not affiliated with the facility and, if the mental hygiene facility is also a hospital...., at least one witness shall be a qualified psychiatrist.

If in a mental hygiene facility operated or licensed by the office of mental retardation and developmental disabilities, "at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist who either is employed by a school named in section 13.17 of the mental hygiene law or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office of mental retardation and developmental disabilities, or who has been approved by the commissioner of mental retardation and developmental disabilities in accordance with regulations approved by the commissioner. Such regulations shall require that a physician or clinical psychologist possess specialized training or three years experience in treating developmental disabilities. N.Y. Pub. Health Law §§2981 (b) and (c) (McKinney 2004).

**ND**

HCPA only: If in a long-term care facility, either:

(1) A "recognized member of the clergy, an attorney licensed to practice in this state, or a person as may be designated by the department of human services or the district court" ... must sign "a statement affirming that the person has explained the nature and effect of the durable power of attorney for health care to the principal" or

(2) The "principal acknowledges in writing that the principal has read the explanation prefacing the statutory form in section 23-06.5-17 or a similar written explanation of the nature and effect of a durable power of attorney for health care."

If in a hospital, either:

(1) A "person designated by the hospital or an attorney licensed to practice in this state signs a statement that the person has explained the nature and effect of the durable power of attorney for health care to the principal" or

(2) The "principal acknowledges in writing that the principal has read the explanation prefacing the statutory form in section 23-06.5-17 or a similar written explanation of the nature and effect of a durable power of attorney for health care."

**OR**

Advance Directive: If in a long term care facility, "one of the witnesses must be an individual designated by the facility and having any qualifications that may be specified by the Department of Human Services by rule." Or. Rev. Stat. §127.515(4)(e) (2003).

**SC**

HCPA: If in a nursing care facility, must be "witnessed by an ombudsman as designated by the State Ombudsman, Office of the Governor, with the ombudsman acting as one of the two witnesses" S.C. Code §44-77-40(3).

LW: If in a hospital or nursing care facility, must be "witnessed by an ombudsman as designated by the State Ombudsman, Office of the Governor, with the ombudsman acting as one of the two witnesses and having the same qualifications as a witness as provided in this section." S.C. Code §44-77-40(3).

**VT**

HCPA/Combined form: If in a nursing or residential care home, requires that "an ombudsman, recognized member of the clergy, attorney licensed to practice in this state, or other person as may be designated by the probate court for the county in which the facility is located, signs a statement affirming that he or she has explained the nature and effect of the durable power of attorney for health care to the principal" Vt. Stat. Ann. tit. 14, §3-460.

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