Barriers to Universal Advance Directives

Charles P. Sabatino, J.D.

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Every person considering completing a health care advance directive has to think about the legal requirements for a valid advance directive in his or her state. It can be confusing because these laws can be complex and vary from state to state. Countless books, guides, and pamphlets have been written about completing advance directives but, in the end, they are forced to provide forms for only one or a few states, or they advise readers to consult the legal rules in their own state.

National forms of various stripes would be a valuable boost to advance care planning. For the public, it would provide nationally available options with differing philosophical, religious, value-oriented, or condition-based approaches that would engage individuals in advance care planning in a more flexible, person-centered landscape. Planning for incapacity and dying is a difficult task. Individuals approach it, or avoid it, in their own personal way. The National Academy of Medicine in its seminal 2015 report, Dying in America, recognized that. “The many and varied requirements embedded in state laws covering advance directives also discourage their completion.” Legal rules and language are commonly not understood, and most do not have access to a lawyer. Advance directive form and language requirements have, in effect, created a Procrustean bed that individuals feel they must fit into in order to engage in advance care planning.

For health care providers, universal national forms would eventually become just as recognizable and acceptable as their state specific form and provide clinicians with a greater variety of tools for engaging patients in advance care planning. While we have no truly national forms now, the question addressed by this review is, how close are we to enabling national or universal advance directives, and what barriers need to be overcome to make a single advance directive form legally valid in any state?

In answering this question, this article aims to accomplish three things. First, from a consumer perspective, it will provide a rough measure of how far we have come in creating user-friendly state advance directive laws by identifying the range of prerequisites imposed by state laws for a valid advance directive. Second, for policy makers, it will identify barriers to user-friendly, flexible advance directive policy and argue for simplification of state law in the direction of uniform, uncomplicated requirements. Finally, for lawyers who draft advance directives in their practice, it will identify strategies lawyers can use to craft forms that are multi-jurisdictional on their face, rather than relying on reciprocity provisions in state law that allow recognition of out-of-state forms under certain conditions. Reciprocity will be addressed more fully below.

As used in this article, a health care power of attorney (hereinafter “HCPA) is a document in which an individual (referred to as the principal) appoints a health care agent or agents (also called proxy, surrogate, representative), authorized to make health care decisions for the
individual in the event of incapacity. This kind of document is commonly distinguished from documents providing health care instructions or guidance, commonly called living wills, although both kinds of documents are commonly combined into one. Whether separate or combined, these documents are generically referred to as advance directives.

The documents themselves today fit within a much broader advance care planning process that is now seen as a life-time process of reflection and communication rather than a document creation task. Nevertheless, preparing a written advance directive remains a major part of the task, albeit hindered by an outdated legalistic model. Some have gone as far as to propose eliminating the legal model entirely and reframing advance directives only as clinical documents.

Since their inception in the 1970s, state advance directive laws have always imposed multiple, varying legal formalities necessary for the creation of a legally valid advance directives. This makes it difficult to provide the public with user-friendly, multi-state tools for advance care planning. Some 40 states have in their advance directive law provisions recognizing the validity of out-of-state HCPA’s and/or living wills. Typically referred to as “reciprocity provisions,” they sometimes include vague limitations such as Iowa’s law, recognizing the validity and enforceability of the document only “to the extent the declaration or similar document is consistent with the laws of this state;” or Oklahoma’s law which recognizes the authority to withhold artificially administered nutrition and hydration only if the out-of-state directive comports with unique formalities in the Oklahoma law. More importantly, reciprocity provisions do not address the underlying goal of recognizing national advance directives – the freedom to select from a variety of written vehicles for expressing one’s wishes no matter where one lives. If John Doe lives in a state that does not consider a national directive such as Five Wishes valid, then one less planning tool is available to him.

In 2005, this author examined the feasibility of a universal advance directive in the face of those varying state laws. That article used as a convenient measuring tool, a popular form already distributed in most states, known as Five Wishes, because it was drafted to meet the cumulative statutory requirements of as many states as possible. That 2005 review concluded that Five Wishes was compatible with the legal requirements in 36 states and the District of Columbia, although to meet the requirements of that many states, it became somewhat more complex in its instructions for completion and execution. In the more than dozen years since that study, state law has continued to evolve, albeit slowly. Both the public and professionals have become more familiar with advance directives and advance care planning in general. Consequently, a repeat of that review should serve as a measure of the extent to which the state of state law has changed at all to become more consumer-friendly to multi-state or universal advance directive models. Other guides with advance directive forms that aspire to national applicability have also been published during this period, and could also be used as measuring tools, but for the sake of comparing change over time, Five Wishes provides a stable measure.

Technology is another field that has changed far more dramatically than the law since the last review. Computers now have the ability to take complex data from many sources and make it accessible and customizable with ease, so that the program user sees only the information and the steps relevant to him or her. The potential exists right now to offer personalized, state-specific advance directives through a single software platform. However, that approach is merely an end-
run around complexity and variation. It does not address the underlying policy problem and goal of this article to assess how far states have come in achieving uniform, consumer-friendly advance directive laws and to push states further in that direction. To answer that, we ask: to what extent can a single, printed document be crafted to work in all or most states, and more importantly, what are the barriers?

**Methodology**

The research consisted of a review by the author of the HCPA laws of the 50 states and the District of Columbia in effect as of January 1, 2018. In most states, HCPAs and living wills are merged into one set of provisions. But, 18 states have entirely separate statutes for the two functions, sometimes with differing formal requirements, creating a risk of confusion in requirements. This review ignored the separate living will statute in these states as an unnecessary vestige, because a validly executed health care power of attorney that also provides instructions or guidance serves as a comprehensive advance directive on its own.

The findings and analysis are based on interpretation of black letter state law in a way that is consistent and reasoned, but cannot and should not be read as equivalent to a legal opinion about the use of *Five Wishes* or any other multi-state health care power of attorney form under the law of any particular state. As part of this research, a comparative chart of all state advance directive laws was created and is posted online.\(^\text{13}\)

**Results**

The review identified six elements of state law requirements in health care power of attorney statutes that pose barriers of varying difficulty to universal validity under state laws. Three of these elements or barriers were substantially surmountable, although they increase the complexity of drafting: (1) proxy/agent qualifications; (2) witness qualifications, and (3) the timing of commencement of the agent’s authority. A 4th barrier – mandates for prescribed, decision-specific language for termination of certain life support – was surmountable for some but not all states. The last two barriers found in some states – mandatory forms and mandatory notices – are insurmountable and directly undercut the possibility of a universally valid advance directive.

A. **The Surmountable Barriers**

1. **Differing proxy or agent requirements** – All states require the health care agent to be an adult,\(^\text{14}\) and ten states had no other limitations on who may serve as agent and were thus the most flexible.\(^\text{15}\) The other 40 states and the District of Columbia impose a variety of disqualifiers as a prophylactic to avoid certain conflicts of interest, such as serving as both decision-maker and health care provider. Specific terminology varies, but the most common categories of disqualifiers can be described as follows:

- Individual health care providers caring for the principal and their employees, agents, and relatives
- Owners or operators, and their employees, agents and relatives, of health or long-term care facilities caring for the principal
The majority of states provide an exemption from these disqualifications if the person appointed is a relative, as defined by the law. Four states include an exemption for individuals who are members of the same religious or fraternal organizations as the principal.16

Less common were the following disqualifiers:

- Any agent representing 10 or more individuals (e.g., NY17);
- The conservator of the principal unless certain circumstances are met (e.g., CA18);
- An administrator or employee of a government agency financially responsible for care of the principal (e.g., CT19);
- An individual appointed to make the determination of the principal’s capacity (e.g., MN20);
- Any person whose license as a fiduciary has been revoked or suspended (e.g., AZ21);
- Any person whom the principal has disqualified in writing from making health care decisions for the principal (e.g., OR22);
- A person subject to a protective order for which the principal is the subject protected (e.g., MD23);

A multi-state advance directive such as Five Wishes succeeds in addressing these variations by instructing users to avoid selecting an agent that meets any of the disqualifiers in a cumulative list of all state disqualifying conditions. This necessitates using more generic language for the categories of disqualified persons to approximate in substance the terminology variations in state laws. Any multi-state HCPA can use a similar strategy, although the consequence, even when written in plain language, is greater complexity of proxy instructions in the form. The preferable solution would be for states to adopt a basic, universal disqualifier such as that recommended in the Uniform Health Care Decisions Act which states: “Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long term health care institution] at which the principal is receiving care.”24

2. Differing execution requirements

In all states, a written HCPA must specify the principal and agent; be signed and dated; specify the authority being given to the agent; and be witnessed.25 Many states expressly recognize the signature of someone who is directed to sign on behalf of the principal in the presence of witnesses. Beyond that, witnessing requirements vary significantly. Forty-two states and DC require two adult witnesses, although 19 of those permit notarization as an alternative to witnessing. Four states mandate two witnesses and notarization, thus posing the most onerous procedure upon individuals (MO, NC, SC, WV).26

Witness disqualifications vary more than any other aspect of advance directive requirements. Only seven states chose the simplest option by imposing no disqualifications (IN, ME, MO, MT, NM, SD, and VA). In the other states, the most common witness disqualifiers are:

- A relative of the principal (parent, sibling, spouse, or descendent by blood, marriage or adoption (e.g., VT27);
- The named agent (e.g., IL28);
- The owner, operator or employee of facility caring for the principal (e.g., CA29);
• An individual provider or employee of the provider caring for the principal (e.g., CA\textsuperscript{30});
• An heir or beneficiary of the estate (e.g., CA\textsuperscript{31} and KS\textsuperscript{32}).

Several states specify that the above disqualifications apply to just one of the witnesses, thus exempting the second witness. Other disqualifiers that exist in one or more states include:

• A creditor of the principal (e.g., DE\textsuperscript{33});
• Person responsible for the health care costs of the principal (e.g., ND\textsuperscript{34});
• The principal’s life or health insurer or an employee of the insurer (e.g., MI\textsuperscript{35});
• The beneficiary of the principal’s life insurance policy (e.g., UT\textsuperscript{36});
• A person signing the instrument on behalf of the principal (e.g., PA\textsuperscript{37});
• A home care or adult home provider of the principal (e.g., WA\textsuperscript{38}).

As with agent disqualifications, \textit{Five Wishes} instructs users to avoid using anyone on a cumulative list of disqualified individuals as witnesses. And, it uses more generic language for the categories of disqualified persons in order approximate in substance the terminology variations in state laws. The trade-off again is less simplicity and brevity. \textit{Five Wishes} further provides for notarization in the four states that require both two witnesses and notarization. This approach would be viable in any multi-state form. As with agent disqualifications, a preferable solution would be for states to agree upon a simple, uniform set of witness disqualifiers.

One major caveat to using a cumulative list of witness disqualifications concerns institutional witnessing protocols. Seven states impose special witnessing requirements when the HCPA is signed in certain institutional settings such as a hospital or residential care facility.\textsuperscript{39} For example, an ombudsman or patient advocate\textsuperscript{40} or psychologist\textsuperscript{41} may be a required witness. No two of these special rules are precisely alike in their definitions of targeted facilities or procedures mandated. Including this level of detail and variability in a single, printed form goes beyond workability. Any multi-state form would have to be limited to use in community settings as a practical matter in these seven states, unless the drafters chose to describe the differing requirements in the seven states, including the specialized witness attestations; but this would likely push the complexity of the form beyond what the average person is willing to read. \textit{Five Wishes} concedes this limitation by clearly identifying the seven states with special institutional requirements and merely advises users to “contact a social worker or patient advocate at your institution.”\textsuperscript{42}

3. Differing requirements for commencement of the agent’s authority.

Twenty states and the District of Columbia condition the effectiveness of the agent’s power upon a finding that the principal lacks capacity to make medical decisions. These are commonly called “springing” powers of attorney. Twenty-nine states permit the option of immediately effective powers of attorney if the principal chooses.\textsuperscript{43} If the principal does not specify, the default is usually a springing power.\textsuperscript{44}

Given this split, the practical solution is to make the agent’s authority springing, since that option is acceptable in all states. \textit{Five Wishes} takes this approach. An alternative could be to provide an option for immediate effectiveness and list the 29 states in which it is recognized by statute. But, the cumbersomeness of doing this eclipses any benefit.
When a finding of incapacity is required, states apply varying clinical procedures and documentation requirements. These may be mandatory or merely applicable as defaults. The procedural differences are directed to health care providers, not to the principal, and therefore should not affect the validity of the HCPA, even where the document happens to specify a procedure differing from the mandated procedure. In such a case, providers will have to follow the required state procedure, but the substance of the advance directive, i.e., the naming of a proxy and health care instructions, should not be affected.

*Five Wishes* does specify a procedure for determining incapacity but adds: “If my state has a different way of finding that I am not able to make health care choices, then my state’s way should be followed.” A similar approach could work for any multi-state HCPA.

Another procedural matter that arises in three states (MI, ND, and OR) concerns a requirement that health care agents sign an acceptance form before their authority becomes effective. This serves a procedural precondition to the commencement of the agent’s authority but is unrelated to the validity of the underlying advance directive. States impose other post-execution requirements directed at matters such as provider documentation obligations and procedures for revoking the HCPA. Such state procedures should apply regardless of any contrary directions in the document. To avoid raising concerns about such discrepancies, a multi-state HCPA could include a provision known as a severability clause which states that the powers delegated or instructions provided under the document are severable, so that the invalidity of one or more of them shall not affect any others.

### B. Insurmountable Barriers

#### 1. Mandatory Forms

Thirty states plus the District of Columbia provide an optional, statutory form for their HCPA. However, in six states, the form must be “substantially” followed: Alabama, Kansas, Kentucky, New Hampshire, Oregon, and Texas. While substantial compliance issues have been litigated in many areas of law, such as public works contracts law, there are no cases construing substantial compliance with an advance directive form. Oregon has a useful savings clause in its statute that states that an advance directive not in compliance with the statutory form “shall constitute evidence of the patient’s desires and interests.” This eliminates the legal barrier to using other forms, but it leaves some uncertainty about how compliant health care providers will be with a non-statutory form in practice.

If substantially following the state form means merely including its essential elements (signature, date, statement of authority delegated, and proper witnessing), then the mandate in these six states poses a minimal barrier. If it means following the form substantially verbatim, then the mandate precludes compliance by multi-state forms with the exception of Oregon. Since state law is not clear, then absent new legislation, only litigation or possibly a state attorney general’s opinion will clarify which interpretation is correct. The conservative conclusion must be that a multi-state HCPA will not meet the statutory requirements in these six mandatory form states.
2. Mandatory Notices

Mandatory notices or disclosures are not common, but where they exist, they are intended to ensure that the signor understands the advance directive and prevent mistake and abuse. Four states prescribe specific mandatory disclosure to be included with any pre-printed HCPA—New Hampshire, Ohio, Texas, and Wisconsin. As an example, see the Wisconsin notice in FIGURE 1. The Wisconsin notice is required to be printed in not less than 10-point boldface type.

**Figure 1**
Wisconsin Mandatory Notice

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NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care providers and any other person to whom you have given a copy. If your agent is your spouse or domestic partner and your marriage is annulled or you are divorced or the domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

It is suggested that you keep the original of this document on file with your physician.
New Hampshire additionally requires that its disclosure be signed by the individual before executing an advance directive. Two of these states - New Hampshire and Texas - already fall into the category of barrier states because they dictate mandatory forms, and thus pose double trouble for a multi-state form.

The longest disclosure – Ohio’s – exceeds 1600 words in length. Since the information to be disclosed is unique to the law and advance directive form of each state, the requirement prevents the use of a multi-state advance directive, unless the directive includes the notices for residents of these four states. *Five Wishes* opted to do that as an add-on attachment to its forms distributed in one state, Wisconsin. That strategy may work, since the notice does not have to be integrated into the text of the advance directive, but besides added complexity, it runs a real risk of providing explanations of state terms, options, limitations, and procedures that are not entirely congruent with those described in the multi-state form. And more relevant to this inquiry, it surrenders universality, for including all four of these state notices in one form would be unwieldy. Therefore, mandatory notices are categorized here as an insurmountable obstacle.

### 3. Decision-specific language requirements for agent’s authority.

**Life-sustaining treatments**

HCPA laws are generally free of diagnostic triggers for effectiveness that are universal in living wills (e.g., terminal condition, permanent vegetative state, end-stage condition) although a few states require those triggers be met before anyone, including a health care agent, can withdraw or withhold certain life-sustaining treatments. More problematic is the imposition of certain language and even formatting requirements necessary to confer authority over life-sustaining treatment decisions. Five states recognize a health care agent’s authority to permit the withholding or withdrawal of life-sustaining treatment only if expressly granted in the power of attorney.50 Michigan imposes a slight twist to this requirement in adding that, “the patient acknowledges that such a decision could or would allow the patient’s death.” 51 Indiana is unique and most problematic in requiring the HCPA to include special language verbatim - 169 words in length - if the authority to withhold or withdraw any health care is being granted.52

Thirteen states impose a similar requirement that authority be expressly granted with respect to artificially administered nutrition and/or hydration (ANH). Ohio’s law goes further in requiring that the wording be in capital letters or other conspicuous type, and certain medical and procedural conditions be included.53 Oklahoma is unique in that the authority must be specified in the declarant’s own words or contained in a separately initialed or signed paragraph that deals only with ANH.54

A requirement merely to be explicit in conferring authority over decisions involving life support or ANH poses no big problem in itself, since almost all forms, including *Five Wishes*, include express language to that effect. However, additional mandates to use precisely prescribed language such as required by Indiana and Ohio present more formidable challenges.

*Five Wishes* clearly does not incorporate Indiana’s language nor Ohio’s formatting. Nor does it fully meet Oklahoma’s mandate, because it does not require a separate initialing or personal drafting of the power to withhold. However, a 2006 state attorney general’s advisory opinion
found that, “Absent provisions to the contrary, a person who has properly completed and executed Five Wishes® is also presumed to have given informed consent to the withholding or withdrawal of artificially administered hydration and artificially administered nutrition.” Even without the attorney general’s opinion, the Oklahoma requirement could still be met in any multi-state form by formatting the form to have a separately initialed or signed paragraph that deals only with ANH.

Thus, these language hurdles are partly surmountable in a multistate HCPA, except for Ohio’s and Indiana’s mandates. Their language and formatting requirements are too detailed and too idiosyncratic.

**Other decision-specific authorities that must be expressly stated.**

Most frequently arising (in 23 states) are restrictions on the effectiveness of the agent’s authority if the principal is pregnant, ranging from prohibiting the withholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability, to permitting the principal to specify how she would like her pregnancy, if any, to affect health care decisions made on her behalf. Five Wishes does not address pregnancy, but any multi-state HCPA could do so by introducing an instruction with the qualifier, “To the extent permitted by law, I authorize my agent to….” Even without the qualifier, a single provision in an otherwise valid HCPA would not invalidate the entire directive, especially if a severability clause were part of the form.

Other decisions requiring expressly stated authority occur only in a few scattered states:

- Authority to admit the principal to a nursing home or a community-based residential facility for more than three months (WI).
- Authority of the agent to delegate health decision-making authority to another (IN, MI, MO, SD, WA). In some states, delegation by the agent is not permitted at all (e.g., GA);
- Authority to restrict visitation of the patient (VA).

These are all authorities that can be incorporated into a multi-state HCPA without adding too much language complexity. Five Wishes specifies authority to admit the principal to a nursing home but does not address delegation or visitation.

In summary, this review of state health care power of attorney laws identified nine states (shown in TABLE 1) with provisions so detailed and state-specific as to be incompatible with the use of multi-state HCPAs.
Table 1
Fatal State Law Barriers to a Universal Health Care Power of Attorney

<table>
<thead>
<tr>
<th>State</th>
<th>Statutory Form</th>
<th>Mandatory Notice</th>
<th>Prescribed Language to Confer Certain Authority</th>
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* While the Oregon form is mandatory, its law states that non-statutory forms “shall constitute evidence of the patient’s desires and interests.”

Discussion

Of the nine states in TABLE 1, six of them impose a requirement to substantially follow a prescribed form -- Alabama, Kansas, Kentucky, New Hampshire, Oregon, and Texas. This prevents use of a common form. As noted earlier, substantial compliance is a fuzzy requirement. A strong argument can be made that forms such as *Five Wishes* do substantially comply with the statute, but that course requires a leap of faith, testing, and possible litigation to confirm. In addition, two more states, Ohio and Wisconsin, along with two repeat barrier states, New Hampshire and Texas, mandate that unique written disclosure notices be included in any pre-printed HCPA poses a similar barrier. Finally, one state, Indiana, along with a repeat barrier state, Ohio, prescribes unique, mandatory language for conferring certain authority.

If substantial compliance with a statutory form were eliminated as a concern by virtue of legal opinion, decision, or practice consensus, there are still 5 absolute outlier states -- Indiana, New Hampshire, Ohio, Texas, and Wisconsin. The mandates in these states are insurmountable without individualizing the form to each state. Statutory changes needed in these 5 outliers would be relatively simple but may be impeded by entrenched practices and political sensitivity to the topic of end-of-life decision-making.

Other barriers identified in this review involved requirements for expressly stated powers, agent disqualifications, and witnessing requirements. These are all theoretically surmountable by cumulative drafting to encompass all state variations. *Five Wishes* has largely succeeded in accomplishing this without becoming overly complicated and unwieldy, but there is clearly a
trade-off with simplicity. Lawyers drafting these documents can also use similar drafting strategies if multi-state validity is desired on the face of the document, rather than relying on fragmented reciprocity rules.

In sum, carefully drafted multi-state HCPAs are feasible now in 41 States and the District of Columbia. Only nine states prevent their recognition on a truly universal scale. The number of barrier states could be reduced to only 5 states without a change in state law if substantial compliance with state statutory forms were flexibly construed in Alabama, Kansas, Kentucky, and Oregon. The 2005 study found compatibility of Five Wishes with the law of 36 states and the District of Columbia, so progress has been made toward uniformity and consumer-friendly flexibility, but it is limited progress.

The more important lesson from this review is that there is no real rhyme or reason for this unnecessary Balkanization of advance directive law. In total, we found:

- 13 different Categories of Agent Disqualifications
- 8 different Categories of Witness Disqualifications
- 7 different approaches to witnessing
- 7 unique witnessing requirements for institutional residents
- Significant splits on whether states provide a form at all and whether the form is mandatory.
- Six unique mandatory disclosures or mandatory language for certain authority.

How can a persuasive policy justification be made for such chaos? Suggestions have been made in the past for a federal advance directive, but that is difficult to promote since health-care decision-making has always been governed by state law. States need to embrace the person-centered, communication model recommended by the National Academy of Medicine:

Elements of good communication in advance care planning include

open, clear, and respectful communication between clinician and patient;

good communication with families and health care agents; and shared decision

making and patient-centered care.63

Advance directives are not eliminated in this model, but the goal must be for the advance directive document to serve meaningful communication, rather than communication being constrained by the veneer of a legally valid document. Simplifying state advance directive laws is a necessary step toward greater access to universal form options that will facilitate a more meaningful communication model of advance care planning.
References


2 *Id.*, at 185-187.


6 Most state advance directive laws expressly recognize directives from another state validly executed under the law of the other state. See D. Anderson, “Review of Advance Health Care Directive Laws in the United States, the Portability of Documents, and the Surrogate Decision Maker When No Document Is Executed,” *NAELA Journal* 8, no. 2 (Fall 2012):183-203. But, that fact does not address the issue examined here, i.e., whether one directive form can be used by anyone in any state and meet the legal formalities of all states.


8 IOWA CODE ANN. §144A.3 (West 2017).


Alabama is unique in specifying that the principal (as well as witnesses) must be age 19 or older, rather than age 18, the normal age of maturity. ALA. CODE § 22-8A-4(c) (2017).

Colorado, Idaho, Indiana, Louisiana, Maine, Missouri, Montana, New Mexico, South Dakota, and Virginia.

KAN. STAT. ANN. § 58-629(d) (West 2017); KY. REV. STAT. ANN. § 311.625(4) (West 2017); MO. REV. STAT. § 404.815 (West 2017); OHIO REV. CODE ANN. § 1337.12 (West 2017).

N.Y PUB. HEALTH LAW § 2981(4) (McKinney 2017).

CAL. PROB. CODE § 4659(c) (West 2017).

CONN. GEN STAT. ANN. § 19a-576(d) (West 2017).

MINN. STAT. ANN. § 145C.03 (West 2017).


OR. REV. STAT. ANN. § 127.520(3) (West 2017).


Colorado, Idaho, and Louisiana do not expressly mandate witness in their statutes, but witnesses are nevertheless used in common practice.

N.C. GEN. STAT. ANN. § 32A-16(3) (West 2017); S.C. CODE ANN. § 62–5–517 (2017); W. VA. CODE ANN. § 16-30-4 (West 2017); MO. ANN. STAT. § 404.810 (West 2017) incorporates by reference §404.705 requiring acknowledgement in the manner prescribed by law for conveyances of real estate (i.e., notarization), but the Missouri Bar instructs that if instructions are also included in the document, it must also be witnessed. See, The Missouri Bar, DPA Frequently Asked Questions, at 7. available at <http://www.mobar.org/pdf/2014-dpa/faqs-instructions.pdf> (last visited February 16, 2018).

VT. STAT. ANN. TIT. 18, § 9703 (West 2107).

755 ILL. COMP. STAT. ANN. § 45/4-5.1 (West 2107). Illinois also appears to be unique in also excluding a relative or spouse of the agent or any successor agent.

CAL. PROB. CODE § 4674 (West 2107).

Id.

Id.

KAN. STAT. ANN. § 58-629(e) (West 2107).

DEL. CODE ANN. TIT. 16, § 2503(b) (West 2017).

N.D. CENT. CODE ANN. § 23-06.5-05(2) (West 2017).

MICH. COMP. LAWS ANN. § 700.5506(4) (West 2017).

UTAH CODE ANN. § 75-2a-107 (West 2017).
Immediate powers are attractive to many because the principal still remains in the driver’s seat for consenting to or refusing treatment until decisional capacity is lost, determinations of incapacity may not need to be as formal as for springing powers, and the agent is given immediate authority to have access to protected health information.


See Aging with Dignity, *supra* note 6, at 4.


63 See Institute of Medicine, *supra* note 1, at 157.