

Health Care Decision-making

Report Urges Laws and Practices To Address Problems of Elderly Patients Incapable of Making Health Care Decisions

By Naomi Karp

After ten years in a nursing home, an 89-year-old Alzheimer's patient with no living relatives is admitted to the hospital with a high fever. Doctors find him to be suffering from severe bedsores and a systemic infection. With no authorized decision-maker, how can hospital workers determine whether to treat him aggressively or provide palliative care?

A new ABA Commission on Law and Aging study analyzes cases like this and finds that only 13 states have enacted laws that specifically address the problems confronting isolated elderly patients who lack the capacity to make their own health care decisions. These findings, and 12 recommendations on improving the fate of these isolated patients, are outlined in a new report entitled *Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly*.

"Decisionally incapable patients—elderly persons who have no living relative or friend who can be involved in the decision-making process—are the most vulnerable patients because no one cares deeply if they live or die," states the chief bioethicist at a major New York City medical center and a former ABA Commission member. "We owe it to them to help them live better or to die in comfort and not alone."

Meet the New Commissioners (see page 3)

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Naomi Karp is an associate director of the ABA Commission on Law and Aging.

Health Care Decision-making

De-Balkanizing State Advance Directive Law

By Charles P. Sabatino

After more than 25 years of legislating health care advance directive laws in the states and territories, how close have we come to uniformity and simplicity in our collective advance directive laws? The simple answer is: not nearly as close as we should be, even with the help of a Uniform Rights of the Terminally Ill Act, adopted in 1985, and replaced by a Uniform Health-Care Decision-making Act in 1993.¹

A practical test of uniformity and simplicity is whether one can construct one advance directive form that would unquestionably meet the statutory requirements in all states. One organization has tried to do this—Aging with Dignity, the creator and distributor of the Five Wishes Advance Directive.² As of 2002, the best they could accomplish, according to their own analysis, was to comply with statutory requirements in 35 states (including the District of Columbia).³ The reason for this partial success stems from the balkanization of state advance directive law. Requirements vary to such an extent that no single comprehensive advance directive form can confidently be distributed and used nationally as a valid advance directive form under state statute. Any attempt to include, in one form, all the variations in language and elements required in all the states would create a paper monster, looking something like an elephant with an ostrich's head, tiger fangs, bunny feet, fish fins, and wings.

Non-statutory forms—advance directives that do not conform to statutory requirements—are another matter. A

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Charles P. Sabatino is the assistant director of the ABA Commission on Law and Aging.

Patients Incapable of Making Health Care Decisions

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The report, authored by Naomi Karp and Erica Wood, associate staff directors at the ABA Commission, defines “the unbefriended elderly” patient as follows:

- ◆ The patient does not have decisional capacity to give informed consent to the treatment at hand;
- ◆ The patient has not executed an advance directive that addresses the treatment at hand and has no capacity to do so; and
- ◆ The patient has no legally authorized surrogate, and no family or friends to assist in the decision-making process.

The authors found that the few state laws addressing the needs of unbefriended elderly patients generally fall into three categories: (1) health care consent statutes specifying who can consent to treatment, often listing attending physicians; (2) creation of volunteer committees to make decisions, usually for mentally retarded or mentally ill

individuals; and (3) court processes authorizing limited consent to treatment. Some states also have public guardianship programs, but they are often overburdened and under-funded. The report concludes that all of these mechanisms have drawbacks but move in the right direction.

In addition, the report notes that some hospitals and nursing homes are beginning to develop innovative and patient-centered systems to address the needs of unbefriended patients. Often, however, when state laws fail to authorize clear and ethical mechanisms to deliver or discontinue care for patients who are alone, practitioners and institutions have to “fly below the radar screen.”

The report includes the recommendations of a groundbreaking interdisciplinary symposium bringing together physicians, lawyers, bioethicists, hospital staff, advocates, and representatives of guardianship programs, among others. The consensus statement includes the following important areas:

- ◆ Using preventive and “pre-crisis” approaches, such as educating at-risk individuals about advance directives and developing de facto surrogacy relationships through “buddy systems”;
- ◆ Designing thoughtful mechanisms for decision-making that may be internal to a facility (*e.g.*, interdisciplinary ethics committees) or external surrogate decision-making committees;
- ◆ Incorporating key patient-centered characteristics into a well-designed system; and
- ◆ Utilizing judicial remedies as a last resort.

In addition to the Symposium Consensus Statement, the authors include 12 additional policy recommendations. They seek to ensure that solitary patients with no advocate and no track record of values and life history are the focus of a deliberative process of both medical and ethical scrutiny. They include:

- (1) Research should analyze federal data on long-term care residents to shed light on the unbefriended population.
- (2) Long-term care staff should play a greater role in investigating and conveying resident values and preferences.
- (3) Health care professionals should improve techniques for assessing and enhancing patient decisional capacity.
- (4) Facilities should develop and/or strengthen internal decision-making mechanisms; and states and communities should develop external bodies to make health care decisions for patients lacking surrogates.
- (5) Facilities should develop, and funders should support, demonstration projects involving ethics committee decision-making on behalf of unbefriended patients.

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New Commissioners for 2003-04

The ABA Commission on Law and Aging is composed of fifteen members who are appointed on an annual basis by the president of the ABA. As a multi-disciplinary group, the commissioners represent aging experts from a broad spectrum of professions, including law, health care, social work, gerontology, advocacy, and public service. The fundamental diversity of the group ensures a stimulating forum for discussion of the law-related issues facing older Americans. Cooperative efforts between the commissioners and the commission staff have produced numerous publications, as well as research and demonstration projects of considerable value to the public at large. To provide our readers with an abbreviated view into the strengths and expertise of our commission, each Fall issue of BIFOCAL will feature brief profiles of the most recent distinguished appointees.

MICHELLE GRANT ERVIN, M.D., is presently Assistant Professor of Medicine at Howard University College of Medicine in Washington. She was formerly the chairperson of the Department of Emergency Medicine at Howard University Hospital from 1993 to 2003. Dr. Ervins is a graduate of Abraham Lincoln School of Medicine at the University of Illinois in Chicago in 1981 and completed her residency in internal medicine at Cook County Hospital in 1984. Dr. Ervin served a National Health Scholarship commitment from 1984 to 1986. She is board



certified in Internal Medicine (1985) and Emergency Medicine (1989 and 2000); completed a Masters degree in Health Professions Education (1995) from the Department of Medical Education at the University of Illinois; and completed an Ethics Fellowship at the MacLean Center for Healthcare Ethics at the University of Chicago (1996-1997). Dr. Ervin was selected as a faculty scholar for the Project on Death in America funded by the Open Society Institute from 1999 to 2001.

SCOTT MIYAKE GERON is Associate Professor and Director and Principal Investigator at the Institute of Geriatric Social Work at the Boston University School of Social Work. He is an applied policy researcher whose general research interests include long-term care policy and financing, home care, case management and managed care for the elderly and other high-risk and medically complex populations, and quality assurance and assessment. He is currently conducting research on the consumer-based client satisfaction measures of home care services, the assessment of quality in long-term care, and the role of ethnicity and culture in health care utilization.

JORGE J. LAMBRINOS is the Executive Director of the Edward R. Roybal Institute for Applied Gerontology at California State University, Los Angeles. He was chief of staff to Congressman Edward R. Roybal and staff director of the House Select Committee on Aging. He also served as special assistant to U.S. Commissioner on Aging Arthur S. Flemming and director of the Executive Secretariat at the Administration on Aging. Mr. Lambrinos was appointed by former Gov. Gray Davis to the California Commission on Aging and serves as its vice chair. He was appointed to the California Executive Council of AARP as its community service representative and also serves on the board of the National Council on Aging. In 1989, Mr. Lambrinos was named as one of the "Top 100 Most Influential Hispanics in the U.S." by *Hispanic Business Magazine*. He is a decorated (Bronze Star) veteran of the 1991 Gulf War. Mr. Lambrinos received his B.A. from the University of Michigan, an M.A. from Georgetown University, and is pursuing a Ph.D. in public policy from Claremont Graduate University.



JACK SCHWARTZ is an Assistant Attorney General and Director of Health Policy Development in the Maryland Attorney General's Office. Prior to joining the Attorney General's Office in 1982, he held a series of senior staff positions at the Federal Trade Commission in Washington. Mr. Schwartz is an adjunct professor at the University of Maryland School of Law and has been a guest lecturer at



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the Johns Hopkins University School of Public Health, the Kennedy Institute of Ethics at Georgetown University, and the University of Virginia. He was a senior consultant to the National Bioethics Advisory Commission and has served on a national advisory committee for the Robert Wood Johnson Foundation. He is currently a member of an institutional review board at the National Cancer Institute and the advisory board of the Maryland Healthcare Ethics Committee Network. Mr. Schwartz has written and lectured extensively on legal, policy, and ethical issues in health care, especially concerning advance care planning, pain management, and biomedical research. He has received several awards for promoting patient rights and pro bono service, including a President's Award from the National Association of Attorneys General for outstanding leadership on end-of-life health care issues. Mr. Schwartz earned a B.A. from the University of Maryland in 1972 and a J.D. from Yale Law School in 1975.

ANNA WILLIAMS SHAVERS is a Professor of Law at the University of Nebraska College of Law in Lincoln, Nebraska. She is a member of the



Council of the American Bar Association Section of Administrative Law and Regulatory Practice, where she also serves as chair of the Immigration and Naturalization Committee. She is a former member of the American Bar Association Coordinating Committee on Immigration Law and a former chair of the American Association of Law School's Immigration Section. She has written extensively and made presentations in numerous international settings on immigration and gender issues. Professor Shavers earned a B.S. from Central State University of Ohio in 1967, an M.S. from the University of Wisconsin-Madison in 1973, and a J.D. from the University of Minnesota in 1979.

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- (6) States with existing surrogate decision-making systems should test their use for the unbefriended elderly population.
- (7) States and localities should develop temporary medical treatment guardianship programs.
- (8) States should support public guardianship programs that are adequately funded and staffed; and research should explore key questions about the quality of care and decision-making in public guardianship programs.
- (9) State health care consent laws and their practical application to the unbefriended population merit further study.
- (10) Further study should include a focus on cultural diversity and health care decision-making.

The Commission's research was funded by New York-based Fan Fox and Leslie R. Samuels Foundation and performed in collaboration with Hunter College's Samuel Sadin Institute on Law of the Brookdale Center on Aging. The report is available for \$25 (*see order form on next page*). For further information on the study, contact via email Naomi Karp at nkarp@staff.abanet.org or Erica Wood at ericawood@staff.abanet.org.

Michigan Poverty Law Attorney Receives National Aging and Law Award

Alison E. Hirschel, staff attorney with the Michigan Poverty Law Program, is the recipient of the 2003 National Aging and Law Award. Ms. Hirschel received her award at the National Aging and Law Conference, held in October in Arlington, Virginia.

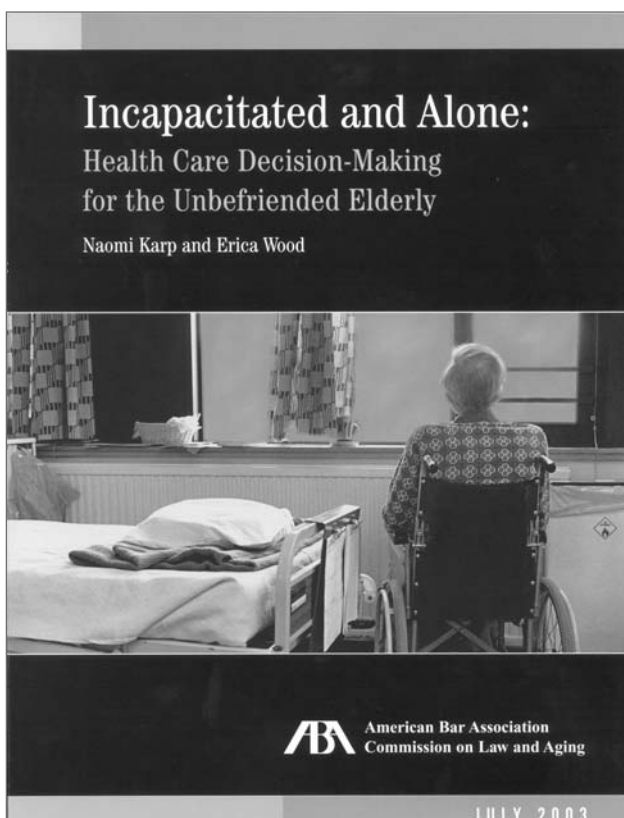
Ms. Hirschel is considered a preeminent legal advocate for the nation's low income and frail elders and a leading expert in legal matters pertaining to nursing home residents. As staff attorney for the Michigan Poverty Law Program, she represents low-income elders through litigation, legislation, and administrative advocacy. She is currently co-counsel on a major lawsuit challenging the state of Michigan in its failure to adequately fund the Medicaid Home and Community Based Waiver program (*Eager v. Engler*), which is nearing final settlement and will result in expansion of waiver slots and important systemic changes within the program. Ms. Hirschel is also the legal counsel and statewide coordinator of the Michigan Campaign for Quality Care, which has mobilized family members in advocating for better care, better quality of life, and better choices for Michigan's long-term care consumers.

Incapacitated and Alone:

Health Care Decision-Making for the Unbefriended Elderly

By Naomi Karp and Erica Wood

American Bar Association Commission on Law and Aging, July 2003



Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly presents the findings of a ground-breaking study aimed at improving medical decision-making on behalf of older patients incapable of making their own decisions and lacking surrogate decision-makers.

Conducted by the American Bar Association Commission on Law and Aging, in collaboration with The Samuel Sadin Institute on Law, Brookdale Center on Aging of Hunter College, this innovative study and report informs health care professionals, administrators, attorneys, regulators, advocates, legislators, and other policy-makers about existing law and practice, barriers to optimal decision-making, and cutting-edge solutions and options for the future. Specifically, the report assesses the current state of the law and practice and lays out policy recommendations on the best mechanisms for health care decision-making for this population.

Through these efforts, the report seeks to enhance medical decision-making on behalf of isolated adults, reduce over-treatment and under-treatment, and improve the quality of care delivered in acute care, long-term care, and the community.

Please send me _____ copy/copies of : **Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly** (PC #H443/ABA PC# 4280022)

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De-Balkanizing State Advance Directive Law

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threshold premise of advance directive law is that advance directive statutes provide only one pathway for making one's wishes known, not the only way. The advantage offered by statutory advance directive forms is merely the statutory immunity granted to providers and agents and the practical advantage of familiarity and presumptive acceptance by providers. Constitutional principles of liberty, affirmed by the Supreme Court in the Nancy Cruzan case,⁴ and common law doctrines of self-determination and informed consent 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.

Do non-statutory forms receive such deference? Data are lacking, but anecdote suggests that they do not. Indeed, it is not surprising that attorneys for health providers, as well as attorneys doing advance directives for individuals, advise their clients that the only "safe" thing to do is to use the statutory form.

The advice is understandable, but unfortunate, for it overly constricts the expression of individual wishes and reinforces a misplaced deference given to statutory forms. The correct question counsel to health care providers should ask is whether anything in the state's law says they cannot recognize the patient's form of communication, rather than whether state law expressly authorizes it.

Nevertheless, given the sometimes exclusive deference given to statutory advance directives, the variations and inconsistencies among these laws creates a serious barrier to the availability of national models of advance directives. The solution to the balkanization of state law is legislative simplification to eliminate some of the unnecessary hurdles to individual expression of health care wishes. This article describes four prominent elements of many state advance directive laws that perpetuate the balkanization of the law in this area, and the elimination of which would accomplish the goal of simplification and broad inclusion of advance directive variations. Many states have already eliminated one or more of these barriers, but until every state acts, restriction and exclusion will remain barriers to the use of truly national advance directive models.

The analysis below will ignore one superficial source of variation—that of nomenclature. The discussion will use the term "living will" to refer to any instructional document,

whether it be called a "medical directive," "declaration," "directive to physicians," or other term. Similarly, the term durable power of attorney for health care, or DPAHC, will refer to any document designating a health care agent or proxy, regardless of the term used in a particular state's law.

Barrier 1: Multiple Advance Directive Laws

Multiple advance directive laws within a single state increase the likelihood of inconsistency and confusion within the state's own laws. Most state law regarding health care decision-making has evolved incrementally with the passage of multiple statutes. For example, most states enacted living will laws during the mid-1970s to the mid-1980s, followed by the enactment of laws creating DPAHC from the early 1980s to the 1990s.

These serial enactments sometimes result in conflicting requirements for living wills versus DPAHC within a state. For example, Texas⁵ and Vermont⁶ impose mandatory forms for their statutory DPAHC, but allow an open field for living will forms. Inversely, Indiana requires a mandatory form for its living will, but not for an appointment of a "representative for health care consent" (their version of a DPAHC). But Indiana also requires two paragraphs of very specific language in order to authorize an agent to have the power to withdraw or withhold health care treatments.⁷ Mandatory forms will be discussed further in "Barrier 3," below. Here, the point is that the profusion of inconsistency and fragmentation within a single state's own laws presents a barrier to inclusiveness both within states and across state lines

Missouri demonstrates another inconsistency. It requires notarization for a DPAHC, but not for a living will. Moreover, the living will statute excludes nutrition and hydration from the definition of "death prolonging procedures" that may be withheld, whereas there is no such limitation for the DPAHC.⁸

Health decisions law encompasses more than just living wills and DPAHC. Other components include default surrogate laws (in the absence of an advance directive), and out-of-hospital do-not-resuscitate (DNR) laws that permit emergency medical services workers to honor DNR orders of patients living in the community. Considering the full range of health-care decision-making, many states have two, three, or more separate laws on the topic, adding to the fragmentation and potential confusion. Until 1999, Texas, for example, had one statute for living wills, one for DPAHC, a separate provision for out-of-hospital DNR orders, and two family consent provisions—one in the living will statute and the other in the out-of-hospital DNR statute.

The legislative remedy to internal state balkanization is the merging of all or most of these separate laws into one

comprehensive statute. Some sixteen states have accomplished this goal over time.⁹ Like Texas, West Virginia is a case in point. Until 2000, West Virginia had four separate laws dealing with substitute decision-making—a Living Will Act, a Medical Power of Attorney Act, a Health Care Surrogate Act (for decision-making when there is no agent or living will), and a DNR Act. In 2000, it merged and simplified its disparate existing laws into a comprehensive Health Care Decisions Act. Similar consolidations in other states will eliminate one of the key barriers to universal advance directives.

Barrier 2: Mandatory Notices or “Warnings”

Nevada, New Hampshire, Texas, and Vermont all require specific notices or warnings to persons executing any DPAHC. Ohio and Wisconsin apply a similar requirement, but only to pre-printed forms sold or otherwise distributed in the state. These laws represent a kind of required “Miranda warning” mandated in these states for persons considering completing an advance directive. Since the “warning” is unique in 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.

The notices are justified as a way to ensure the signer’s understanding of the advance directives and to prevent abuse. Yet, in the 25 and more years of advance directive law, there is very little evidence of abuse, and even less evidence that standard notices are very effective in educating the users of advance directives. Standard notices—especially long ones, as Ohio requires (more than 1,600 words in length)¹⁰—may be perceived as so excessive and cumbersome that they may, in the end, discourage people from using advance directives.

The solution is to eliminate the mandatory notice. This is not to discount the need for education of users of advance directives, but rather to recognize that education is a more complex and shared challenge for those charged with delivering, regulating, or providing counsel regarding health care decision-making. Advance directive forms and materials, such as Five Wishes, include substantial explanatory material that may, indeed, be more understandable than the statutory notices. They should not be precluded from use for lack of the boilerplate warning.

Barrier 3: Mandatory Form States

More onerous than mandatory notices are mandatory forms for either the living will or DPAHC. Thirteen states and the District of Columbia require, or may be interpreted to require, that the statutory forms be followed precisely to

ensure validity. Oregon is clearest in its mandate. Its comprehensive advance directive form “must be the same as the form set forth in this section to be valid.” (§127.531) Other states use somewhat ambiguous language, mandating directives to be “substantially” in the form set forth in their act. For example, among other states with single, unitary advance directive acts, Alabama, Kentucky, and Oklahoma all use the language, “shall be substantially in the following form. . . .”

In states with separate living will and DPAHC acts, inconsistencies between the two acts are common. For example, the DPAHC laws in Alaska, Nevada, New Hampshire, Texas, and Vermont, require the form to comply “substantially” with the statutory form, yet their living will laws clearly describe the living will form as optional. Conversely, the living will forms in the District of Columbia and Indiana laws must be “substantially” complied with, while the DPAHC forms are optional, although there is one caveat to the Indiana optional form. As noted previously, the Indiana DPAHC law requires quite specific statutory language to be used to grant authority to withhold or withdraw treatment. (§30-5-5-17, §16-36-1-14). Finally, three states impose a substantial compliance requirement on both their separate living will and DPAHC provisions—Kansas, South Carolina, and Utah.

The meaning of “substantially” in the context of these laws is far from clear, and in no state has it been clarified in the courts. Under the most restrictive interpretation, it may be interpreted to preclude any variation of the form language, although with the option to include additional language if desired. Under a more flexible interpretation, substantial compliance means equivalent in substance, rather than in vocabulary, grammar, or style. Thus, as long as a directive has the required building blocks of a statutory form—*i.e.*, a writing, 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.

The reality of advance health care planning is that everyone approaches it (or avoids it) differently—based on one’s experience, culture, personality, and inclinations. Accordingly, squeezing everyone into a single statutory Procrustean bed serves to accomplish little, other than routinizing the production and use of advance directives in the most superficial way possible.

The model for states in this regard is the Uniform Health-Care Decisions Act, which provides a form prefaced with this assurance: “The following form may, but need not,

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be used to create an advance health-care directive” and with the further assurance: “You are free to use a different form” (Sec. 4). Moreover, the Act requires little more than a writing and signature as the necessary elements of a valid advance directive, so it would be hard to find any form that would not qualify as a statutory directive under the Act. While we do not propose to eliminate witnessing requirements as the Uniform Act suggests, elimination of mandatory form requirements is unquestionably the single most significant change that states can make to assure the recognition of a wide variety of advance directives nationwide.

Barrier 4: Lack of Explicit Recognition of Out-of-State Directives

A common question individuals ask when thinking about making a health care advance directive is whether the directive made in one state will be recognized in other states.¹¹ This is somewhat of a different issue than recognition of nationally distributed advance directives. National uniformity of the law is not needed in order to ensure that a directive validly executed in one state is recognized in another state. That kind of recognition is a matter of comity or reciprocity—that is, the mutual recognition of legislative, executive, and judicial acts among the states. Comity, however, is a discretionary doctrine, unless state statute expressly requires it. Thus, if a state’s advance directive law is silent on the matter, there is no guarantee that a directive validly executed in another state will be given deference as a statutorily valid advance directive.

The DPAHC data compiled by the ABA Commission on Law and Aging indicates that 12 states lack comity or reciprocity provisions in their DPAHC laws.¹² The legislative change needed in these states is fairly easy to accomplish—add a comity provision. The Virginia statute provides an example of a typical comity or reciprocity provision:

An advance directive executed in another state shall be deemed to be validly executed for the purposes of this article if executed in compliance with the laws of the Commonwealth of Virginia or the laws of the state where executed. Such advance directives shall be construed in accordance with the laws of the Commonwealth of Virginia. (§54.1-2993)¹³

Even with such a provision, another potential impediment to portability across state lines remains—variation in the interpretation of the advance directive. Different states may apply different presumptions or limitations to the meaning of language in directives. For example, granting an agent the authority to make all health care decisions in Illinois presumptively includes decisions about withdrawing or withholding feeding tubes (§45/4-3), but not so in Missouri, unless the directive explicitly states so (§404.820).

Interpretive rules or presumptions cut both ways. They may limit, or expand, the potential meaning of a provision in one’s advance directive, depending upon whose boarder the maker of the directive crosses. This may be an unavoidable risk, since states are unlikely to give up their interpretive authority. Thus, the language in the Virginia provision is probably as far as most states would consider going in establishing reciprocity with other states.

The comity/reciprocity question is one that Congress has also considered in the past but, to date, has not acted upon. The “Advance Planning and Compassionate Care Act,” introduced by Sen. Jay Rockefeller and colleagues in three consecutive sessions of Congress, the last time in August 2002, includes the following language applicable to health care providers who participate in Medicare or Medicaid:

An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider of services, a Medicare+Choice organization, or a prepaid or eligible organization, shall be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

This provision would effectively preempt state law to ensure portability of advance directives across state lines. In the absence of such federal legislation, states can resolve the problem fairly simply by enacting reciprocity provisions on their own.

Conclusion

More often than not, historical inertia causes 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, in a new millennia, the ever-increasing mobility of society, as well as the desires of an aging baby boomer population, fuel an increasing demand for simplicity and flexibility in the legal tools we have created for health care

advance planning. This article describes four primary barriers that cause significant balkanization in advance directive law among the states and confusion among the public and professionals. The most direct pathway for states to reach the goal of simplification and broad inclusion of advance directives is by removal of the four barriers by means of fairly simple legislative changes, described herein.

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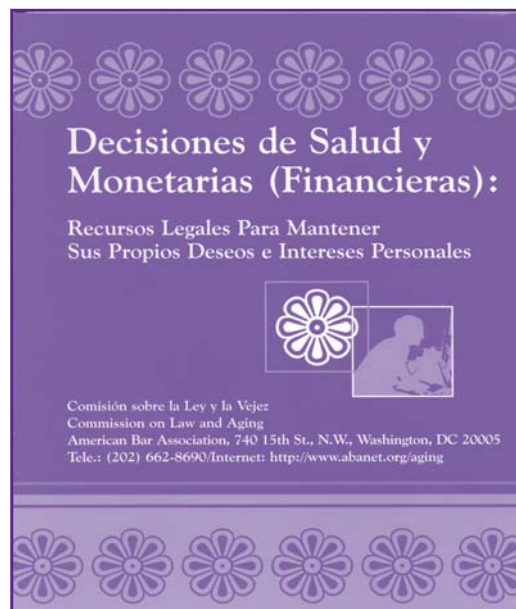
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Uniform Health Care Decisions Act, 9 Uniform Laws Ann., pt. I, 201-222 (1995 Supp).
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Utah Personal Choice and Living Will Act, Utah Code Ann. §75-2-1101 to 75-2-1119 (West 1998).
Vermont Terminal Care Document Act, Vt. Stat. Ann. tit. 18 §§5251 to 5262.
Vermont Durable Power of Attorney for Health Care, Vt. Stat. Ann. tit. 14, §§3451 to 3467 (1989).
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Wisconsin Power of Attorney for Health Care Act, Wis. Stat. Ann. §§155.01 to 155.80 and 11.243.07(6m) (West 2001).

Notes

1. Uniform Health Care Decisions Act, 9 Uniform Laws Ann., pt. I, 201-222 (1995 Supp).
2. Aging with Dignity, creator of *Five Wishes*, available on the Web at <http://www.agingwithdignity.org>.
3. Aging with Dignity, *Five Wishes Advance Directive*, page 3.
4. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 110 S.Ct. 2841 (1990), *aff'g Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988).
5. Texas Advance Directives Act, Tex. Health & Safety Code Ann. §§166.001 to 166-.166 (West 2000).
6. Vermont Durable Power of Attorney for Health Care, Vt. Stat. Ann. tit. 14, §§3451 to 3467 (1989).
7. Ind. Code Ann. §30-5-5-17.
8. Missouri Life Support Declarations Act, Mo. Ann. Stat. §§459.010 to 459.055 (West 1998); Missouri Durable Power of Attorney for Health Care Act, Mo. Ann. Stat. §§404.700 to 404.735, and §§800 to 870 (West 1998).
9. ABA Commission on Law and Aging, *Legislative Updates*, <http://www.abanet.org/aging/update.html>.
10. Ohio Notice Provision Ohio Rev. Code Ann. §1337.17.
11. ABA Commission on Law and Aging, *Ten Legal Myths About Advance Medical Directives*, <http://www.abanet.org/aging/myths.html>.
12. ABA Commission on Law and Aging, "Health Care Power of Attorney and Combined Advance Directive Legislation," available on the Web at <http://www.abanet.org/aging/update.html>.
13. Virginia Health Care Decisions Act, Va. Code §§54.1-2981 to 54.1-2993 (Matthew Bender & Co. 2000).

New Brochure and Video Help Spanish-Speaking Seniors Understand Legal Tools for Health and Financial Decision-making

The brochure, entitled *Decisiones de Salud y Monetarias (Financieras): Recursos Legales Para Mantener Sus Propios Deseos e Intereses Personales*, encourages seniors to use legal planning tools such as durable powers of attorney, trusts, health care powers of attorney, and living wills to ensure that their personal, healthcare, and financial wishes are honored in the event they become sick, disabled, or incapacitated. (Continued on back page)



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Funding Opportunities

Partnerships in Law and Aging

The ABA Commission on Law and Aging and the Borchard Foundation Center on Law and Aging are pleased to announce the availability of grants to encourage new, collaborative, community-based projects to enhance the legal awareness of older persons and to improve their access to the legal system.

The Partnerships in Law and Aging Program, with funding from the Borchard Foundation Center on Law and Aging and the Marie Walsh Sharpe Endowment of the ABA Fund for Justice and Education, will award up to ten grants of \$7,500 each to bar associations, legal services providers, elder rights advocates, and other local non-profit organizations.

Now entering its sixth year, the Partnerships Program has supported development of such projects as:

- ❖ outreach and legal services to culturally or linguistically isolated elders;
- ❖ senior attorney and other volunteer legal assistance;
- ❖ mediation handbooks and educational programs for lawyers and non-lawyer professionals;
- ❖ senior telephone hotlines, Web sites, and other technology-based efforts;
- ❖ self-help and community legal education on particular legal issues; and
- ❖ holistic and other innovative delivery systems.

The request for proposals and the application are available on the ABA Commission Web site at www.abanet.org/aging.

Descriptions of previously funded projects are also available on the Web site.

Applications must be postmarked or hand-delivered on or before December 2, 2003, and must include all items to be considered, including application, budget, timeline, outcomes chart, and letters of support.

Awards will be announced in early March 2004. Grants will run from April 1, 2004, through March 31, 2005. For additional information contact Stephanie Edelstein by email at sedelstein@staff.abanet.org or phone at (202) 662-8694.

More information about the Partnerships in Law and Aging Program is available on the ABA Commission's Web site at www.abanet.org/aging.

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Brochure and Video Help Spanish-Speaking Seniors Understand Legal Tools for Health and Financial Decision-making

The ABA Commission on Law and Aging has published a new brochure and video to help Spanish-speaking seniors understand the importance of health and financial decision-making.

The brochure, entitled *Decisiones de Salud y Monetarias (Financieras): Recursos Legales Para Mantener Sus Propios Deseos e Intereses Personales*, is the Spanish translated version of the commission's most-requested consumer brochure, *Health and Financial Decisions: Legal Tools for Preserving Your Personal Autonomy*. It encourages seniors to use legal planning tools such as durable powers of attorney, trusts, health care powers of attorney, and living wills to ensure that their personal, healthcare, and financial wishes are honored in the event they become sick, disabled, or incapacitated.

The Spanish-subtitled version of the commission's video *In Your Hands: The Tools for Preserving Personal Autonomy*, also addresses the legal aspects of planning for incapacity. In a clear and positive way, it utilizes personal vignettes in which seniors talk candidly about their concerns for their future healthcare and financial well-being.

The video is narrated by the late actress Helen Hayes, who died shortly after its filming, and includes a poignant epilogue from her son, James MacArthur. The 19-minute video, available in DVD and VHS formats, is in English

with Spanish subtitles and comes with a program guide that provides sample scripts and discussion points to help present the program.

Copies of the brochure and video may be obtained from the ABA Commission on Law and Aging (*see order form on page 10*). Single copies of the brochure are \$1 each; or \$20 for bulk orders of 50 brochures. The DVD (or video) is \$89 and comes with a copy of the presenters' *Program Guide*.

FREE Brochures and Video or DVD for Legal Services Developers and Elder Law Bar Section/Committee Chairs

Our Older Americans Act National Legal Assistance Support Project funding enables us to offer state legal services developers and state bar elder law section and committee chairs a complementary set of these new products. The packet includes your choice of the DVD or video, a program guide, and one copy each of the Spanish and English versions of the brochure. We encourage you to use them and to share them with advocates in your state who make presentations to Spanish-speaking elders. To receive your complimentary brochures and video or DVD, complete the order form on page 10 in this issue.

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