

ABA Commission on Legal Problems of the Elderly

10 Legal Myths About Advance Medical Directives

by Charles P. Sabatino, J.D.

Myth 1:

Everyone should have a Living Will.

Living Will, without more, is not the document most people need. As a threshold goal, most people should have a Health Care Power of Attorney (or Health Care Proxy) that names a trusted person as agent or proxy. A still better alternative is to execute both documents or a single, combined "Advance Directive" that names a proxy and provides guidance about one's wishes. Unfortunately, because of statutory restrictions or inconsistencies within state law, many practicing attorneys advise clients to execute separate rather than combined documents. State advance directive laws are slowly moving toward acceptance of flexible, combined advance directives, but the states differ significantly in this regard.

The reason for the primary importance of the proxy appointment is simple. Most standardized living will forms are quite limited in what they can accomplish and what conditions they cover. For example, most provide instructions that apply only if the individual is in a terminal condition or permanently unconscious, yet the majority of health care decisions that need to be made for patients lacking capacity concern questions about day-to-day care, placement options, and treatment options short of "pulling the plug."

Moreover, most boilerplate instructions express fairly general sentiments about not wanting treatments that serve only prolong the dying process. Relatively few people disagree with this sentiment. However, applying it to a particular set of facts is more difficult than at first meets the eye. Virtually no interventions only prolong the dying process. Any intervention can produce multiple consequences, some predictable, some not so predictable. If an aggressive and possibly painful course of treatment will give the patient a 1 in 3 chance of recovering to the point of being able to converse again with loved ones for a least a few more months, is that hope enough to treat aggressively? What if the odds were 1 in 25?

Living will instructions always need interpretation, even when the terminal nature of an illness is clear. An agent or proxy under a health care power of attorney can do precisely that. The proxy, who should know the patient's values intimately, can respond to the actual facts and variables known when an actual health care decision needs to be made. Short of possessing a crystal ball, no one can anticipate the specific and often complicated circumstances fate will place them in. The proxy acts not only as legal decisionmaker, but also as spokesperson, analyzer, interpreter, and advocate.

One caveat: if there is no one close to the individual whom he or she trusts to act as health proxy, then the health care power of attorney should not be used. In this circumstance, the Living Will is safer, despite its limitations.

Myth 2:

Written Advance Directives Are Not Legal in Every State.

False. Every state recognizes both the proxy and living will type advance directives, although the laws of each state vary considerably in terminology, the scope of decisionmaking addressed, restrictions, and the formalities required for making an advance directive.

A more frequently raised question is whether an advance directive written in one state will be recognized in other states. In other words, is the directive portable across state lines. Many states expressly recognize out-of-state advance directives if the directive meets either the legal requirements of the state where executed or the state where the treatment decision arises. Several states are silent on this question. If there is doubt, the rules of the state where treatment takes place, not the state where the advance directive was signed, will normally control. However, even if an advance directive fails to meet technicalities of state law, health providers still should value the directive as important, if not controlling, evidence of the patient's wishes.

The threshold problem with most state provisions addressing portability is that they presumably require providers to be fully knowledgeable of the other state's law. Most use language derived from the Uniform Probate Code and similar to the following provision included in the now defunct Uniform Rights of the Terminally Ill Act:

A declaration executed in another state in compliance with the law of that state or of this State is validly executed for purposes of this [Act].

Colorado and Utah offer a more user-friendly approach to recognizing out-of state directives:

Unless otherwise provided therein, any medical power of attorney or similar instrument executed in another state shall be presumed to comply with the provisions of this [Act] and may, in good faith, be relied upon by a health care provider or health care facility in this state.

Thus, in these, states providers may assume that the out-of-state directive is valid unless they have actual knowledge to the contrary.

Myth 3:

Just telling my doctor what I want is no longer legally effective.

False. While it is better to have a written Advance Directive, oral statements remain important both on their own and as supplements to written directives.

Oral instructions may take many forms. A person physically unable to execute an advance directive may provide oral instructions that are reduced to writing by the doctor or another person, acting for the patient. Several states treat such statements as formal Advance Directives if witnessed properly. Less formal instructions in the nature of conversations with family, friends, or physicians will not have the same legal status of a written Advance Directive.

Nevertheless, informal oral statements have two important attributes. First, good health care decisionmaking requires good communication among all interested parties, and oral communication is our most natural and, indeed, primary mode of communication. Ideally, a

formal advance directive serves to aid this kind of communication, not to replace it. Second, oral statements constitute important evidence of one's wishes and help expand upon, clarify, and reinforce individual preferences. The contents of the written Advance Directive should reflect a continuing conversation among the individual, physician, family, and close friends.

Myth 4:

An Advance Directive means "Don't treat."

False. While it is true that most people use Advance Directives to avoid being kept alive against their wishes when death is near, it is a mistake to assume that the existence of an advance directive means, "Don't treat." Advance directives are also used to say that the individual wants all possible treatments within the range of generally accepted medical standards. What is said depends upon one's particular wishes and values. Moreover, even when an advance directive eschews all life-sustaining treatments, one should always assume (and insist upon) continuing pain control, comfort care and respect for one's dignity.

Myth 5:

When I name a proxy in my Advance Directive, I give up some control and flexibility.

False. An individual gives up no authority or choice by doing an Advance Directive. As long as the person remains able to make decisions, his or her consent must be obtained for medical treatment. Health care providers cannot legally ignore the patient in favor of one's agent or written instruction. Indeed, in most states, health care advance directives are "springing." That is, they have no legal effect unless and until the patient lacks the capacity to make a health care decision. In a minority of states, immediately effective directives are permissible, but the maker always retains a right to override the proxy or revoke the directive.

There are situations in which a competent patient abdicates decisionmaking by saying, for example, "Do whatever my daughter thinks is best." However, this form of delegation of decisionmaking is effective only from moment to moment and needs to be rechecked at every significant decision point. Neither the proxy nor a written instruction can override one's currently expressed choice.

Myth 6:

I must use a prescribed Advance Directive form for my state.

Usually false. In most states, you do not have to use a specific form. About 37 state statutes include forms for appointing proxies or for creating comprehensive advance directives. In the majority of these, the forms are optional. In about 18 states, the forms must be "substantially followed" or certain information disclosure language must be included in the form. Even with these requirements, changes and additions to standard language are permissible. Indeed, any form can and should be personalized to reflect the individual's particular values, priorities, and wishes. If you do not agree with language contained in an approved form, change the language. If changing the language creates any doubt about the validity of the form, then further legal consultation is in order. Above all, it is a mistake to pick up an "official" form and just sign it unchanged, without first being sure that it truly reflects one's specific wishes.

Myth 7:

I need a lawyer to do an Advance Directive.

No, a lawyer is not needed. Yes, a lawyer is a helpful resource, but not the only resource, nor necessarily the best resource for all persons. Advance directives are not difficult to complete, but they require a few steps to do well. Try these steps for yourself, even if you already have an advance directive.

First, obtain an "official" or generally accepted form for your state, plus at least one or two additional advance directive forms from other sources. See the attached resource list for forms. This helps you see the variations in topics different advance directives cover and the alternative instructions they provide. The form-publishing business may be burgeoning, but most are inadequate in one respect or another. Even with the best drafting, there is no perfect form for everyone. People are different.

Second, discuss the contents of the forms with your physician, close family, and the person you may name as proxy. Most people find these discussions difficult to initiate, but they are extremely important. Gather information about your current medical condition and its implications for future medical problems; clarify your own values and wishes; and ask your physician, close family, and proxy if they are willing to support you in the way you want.

Third, complete the form you choose, being sure to add or modify language to reflect your wishes more accurately. Be sure to follow the witnessing instructions for your state exactly. Most, but not all states, require two completely disinterested witnesses. If you have a potential family conflict, special legal concern, or unusual request, additional legal drafting help may be needed. These circumstances call for consultation with a lawyer experienced in personal planning.

Myth 8:

Doctors and other health care providers are not legally obligated to follow my Advance Directive.

Legally false, but as in many endeavors, reality muddies the waters. As a matter of law, it is clear that medical providers cannot treat an individual against his or her wishes. Consequently, if a physician acts contrary to a patient's clear instruction directive or contrary to the decision of the patient's authorized proxy, the physician risks the same liability he or she would face if the physician were to ignore a refusal of treatment by a fully competent patient. Treatment would constitute a battery. However, a few factors complicate the situation.

First, the doctor or health facility sometimes do not know about the existence of an advance directive. While federal law requires hospitals, nursing homes, and home health agencies to ask about and to document your Advance Directive, the document often does not make it into the appropriate record. It is up to the patient and those close to the patient you to ensure that everyone who might need a copy of the directive in fact has a copy.

Second, as noted earlier, people often do not express their wishes very clearly or precisely in advance directives. Simply using general language that rejects "heroic measures" or "treatment that only prolongs the dying process" does not give much guidance. Therefore, interpretation

problems may arise. Giving a proxy broad authority to interpret one's wishes will help avoid this problem, except that sometimes proxies themselves are not quite sure what the patient would want done. This fact underscores the importance of discussing one's wishes and values with the intended proxy.

Third, in most states, if a physician or facility objects to an Advance Directive based on reasons of conscience, state law permits the physician or facility to refuse to honor it. However, facilities must notify the patient of their policies regarding advance directives at the time of admission. If a refusal occurs, the physician and facility should provide assistance in transferring the patient to a provider that will comply with the directive.

Fourth, persons who are dying, but living in the community, may face problems in having an advance directive followed if a crisis occurs and emergency medical services (EMS) are called (for example, by calling "911"). EMS personnel are generally required to resuscitate and stabilize patients until they are brought safely to a hospital. States are beginning to address this situation by creating procedures that allow EMS personnel to refrain from resuscitating terminally ill patients who are certified as having a "do not resuscitate order" and who have an approved identifier (such as a special bracelet).

Myth 9:

If I do not have an Advance Directive, I can rely on my family to make my health care decisions when I am unable to make decisions for myself.

This is only partly true. If an individual does not have an advance directive naming a health decisions agent or proxy, several states expressly designate default "surrogates," typically family members in order of kinship, to make some or all health care decisions. Only a few of these statutes authorize a "close friend" to make decisions, and then normally only when family members are unavailable.

Even without such statutes, most doctors and health facilities routinely rely on family involvement in decisionmaking, as long as there are close family members available and there is no disagreement. However, problems can arise because family members may not know what the patient would want in a given situation, or they may disagree about the best course of action. Disagreement can easily undermine family consent. A hospital physician or specialist who does not know you well may become the default decisionmaker.

In these situations, patients risk having decisions made contrary to their wishes or by persons whom they would not choose. Moreover, family members and persons close to patients experience needless agony in being forced to make life and death decisions without the patient's clear guidance. It is far better to make one's wishes known and to appoint a proxy ahead of time through an Advance Directive.

Myth 10:

Advance Directives are a legal tool for old people.

False. Don't think of this as an "old" people's issue. It may be natural to link death and dying issues with old age, but that is a mistake when it comes to advance directives. Consider that

perhaps the most well known landmark court cases those of Nancy Cruzan and Karen Ann Quinlan involved individuals in their 20's. The stakes are actually higher for younger persons in that, if tragedy strikes, they might be kept alive for decades in a condition they would not want. An Advance Directive is an important legal planning tool for all adults.

Commission on Legal Problems of the Elderly
American Bar Association
740 Fifteenth Street, NW
Washington, DC 20005-1022
Telephone: 202-662-8690
Fax: 202-662-8698
Email: abaelderly@abanet.org