Interstate and International Recognition of Health Care Advance Directives

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State laws providing for health care advance directives vary widely, and the issue of interstate recognition of these documents has yet to be addressed definitively. What happens when an advance directive is presented in a jurisdiction other than the one in which it was executed?

By Russell E. Carlisle

Our mobile society provides unusual and tantalizing opportunities. Many of these involve movement from place to place, jurisdiction to jurisdiction, for various periods of time. Many of us travel for either business or pleasure. We live in different places during different parts of the year and may spend substantial periods of time in places other than our usual residence.

Problems in the recognition and implementation of health care advance directives can arise in any of these situations when the advance directive is presented in a jurisdiction other than the one in which it was executed. Because advance directives are creatures of state law, the variations among state requirements create potential conflict.

Advance directives are recognized by federal law in the Patient Self Determination Act. In addition, statutes providing for health care advance directives have been adopted in all 50 states. These state statutes vary significantly, however, in their scope, execution requirements, definitions, notice requirements, language of specific or substantial forms, and coordination of statutes dealing with different kinds of documents such as living wills, health care powers of attorney or surrogate designations, family consent provisions, and do not resuscitate (DNR) orders. Organ donation instructions may also be included in this list.

As a result, the issue of interjurisdictional recognition of health care advance directives, or portability, has been and is being addressed in various forums for various reasons. International recognition is being addressed in the pending Hague Convention on Incapacitated Adults. This proposed treaty applies to power of representation for property matters as well as health care decision making.

In August 1994, the American Bar Association addressed this issue at the insistence of its Standing Committee on Legal Assistance for Military Personnel in the form of a resolution adopted by its House of Delegates: “BE IT RESOLVED, that the American Bar Association supports the enactment of federal legislation to provide that advance medical directives prepared for members of the Armed Forces, their spouses and other persons eligible for legal assistance be recognized and given full legal effect notwithstanding state and territorial law.”
Currently pending in the U.S. Congress is the Advance Planning and Compassionate Care Act. This legislation would amend the Patient Self Determination Act of 1990 to provide as follows: “An advance directive validly executed outside of the state in which such advance directive is presented to a health care provider or 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 was presented would be given effect.”

Most state laws dealing with advance directives provide for the recognition of advance directives executed in another state. For example, Florida Statutes provide that: “[a]n advance directive executed in another state in compliance with the law of that state or of this state is validly executed for the purposes of this chapter.”

Since the definition of “advance directive” in the Florida Statutes also includes orders not to resuscitate, the Florida definition covers all four health care advance directive areas: living wills, health care surrogates, family consent, and orders not to resuscitate. However, the most telling analysis of the problem of varying statutes and requirements from state to state came about when the American Bar Association Commission on Legal Problems of the Elderly was asked to evaluate the legality of the “Five Wishes Will” that was being circulated among senior organizations and individuals by Aging with Dignity, Inc., a private nonprofit organization based in Tallahassee, Florida. The “Five Wishes Will” combined the living will and health care power of attorney in one document using lay language and covering other areas besides the withholding or termination of life-prolonging procedures. Charles Sabatino, assistant director of the ABA Commission on Legal Problems of the Elderly, undertook this task and opined that the “Five Wishes Will,” properly executed and witnessed, was valid as a living will and health care power of attorney in 33 states. Its validity in other jurisdictions was questionable for a variety of reasons.

It follows that an advance directive executed in one state might be questioned as to recognition or implementation when presented in another state. Sabatino identified the following problem areas.

Multiple advance directive laws. Some state advance directive laws are in multiple parts, with separate statutes for living wills, health care pow-

ers of attorney, family consent laws, and DNR orders. Many state laws provide forms for specific health care advance directives, particularly living wills. Some states, such as Indiana, make these forms mandatory. Yet other states, such as Texas, Vermont, and West Virginia, have no mandatory form for living wills but require mandatory forms for health care powers of attorney.

Mandatory notices. Eighteen states require some sort of warning. Seven states, including California, New Hampshire, Ohio, Texas, and Vermont, have required a specific form of notice that must be executed along with the health care advance directive. In New Hampshire this applies only to the health care power of attorney, but nevertheless prevents the use of the “Five Wishes Will” because of the burden of including the mandatory notice in the document and the fact that “Five Wishes” is a living will as well as a health care power of attorney.

Notarization requirements. Hawaii, Missouri, and North Carolina require notarization of advance directives. This is not insurmountable for the “Five Wishes Will,” but it raises the question of the validity of an advance directive from another state that lacks notarization. Can such an instrument be acknowledged after the fact upon presentation in a jurisdiction requiring notarization?

“Substantially in the following form. . . .” Fifteen states use this kind of language in their statutes. Again, some have such language in the living will statute and some in the health care power of attorney statute. The question that may arise is how closely one must follow the form. Obviously, the forms vary and the “Five Wishes Will” striving for plain language eliminates the legalese. Charles Sabatino is of the opinion that one cannot safely conclude that the “Five Wishes Will” would meet the statutory test in states requiring “substantially in the following form. . . .” By the same token, would an advance directive from another state be recognized and implemented if it were in different form from that required by the state where it is presented?

Mr. Sabatino also analyzed the do-not-resuscitate statutes in force in 40 states in the Spring 1998 issue of Bifocal, the quarterly newsletter of the American Bar Association Commission on legal problems of the elderly.

On April 30, 1999, Florida’s legislature adopted an End of Life Care Act. This act has been
signed by the governor. It is effective October 1, 1999. It enlarges the application of DNR orders, extending them to hospital emergency rooms, nursing homes, home health care agencies, and hospice settings. Further, the act coordinates the organ donation program, which has a much longer history in Florida than health care advance directive legislation and allows health care surrogates and statutory health care proxies to make organ donations in the absence of a written directive by the patient.

Perhaps more significant from the recognition and implementation standpoint, this act also redefines terminal illness and adopts the concepts of “persistent vegetative state” and “end-stage condition” as situations in which life-prolonging procedures could be commenced or terminated as included in the advance directive. Most state health care advance directives have provisions for health care decision making based on terminal illness or terminal condition as certified by physicians. A significantly lesser number recognize “persistent vegetative state,” and only a few recognize “end-stage condition.” Ohio recognizes and defines “state of permanent unconsciousness.” Will the health care advance directive from a state recognizing “persistent vegetative state” or “end-stage condition” and providing for the withholding or cessation of life-prolonging procedures under those circumstances be recognized and implemented in a state that does not have those concepts in its laws regarding health care advance directives?

There are several possible solutions to the problem of interstate recognition and implementation of health care advance directives:

1. Persons may execute a health care advance directive in more than one jurisdiction when there is a likelihood that it may be needed.
2. Congress could enact the portability provision of the Advance Planning and Compassionate Care Act currently pending.
3. The Commissioners on Uniform State Laws could adopt a model law in one or more of the advance directive areas: living wills, health care powers of attorney, DNR orders, and family consent. Better still, we could try for a uniform law combining these into a single model advance directive, as the “Five Wishes Will” nobly attempted.
4. A federal statute superseding state law could provide for a federal form for health care advance directives. This could be limited by classes, such as military personnel and spouses, or limited in application to cases in which advance directives under state law are not recognized where presented or are otherwise ineffective.
5. An interested national organization such as the American Bar Association or the National Academy of Elder Law Attorneys could seek conforming amendments to state laws or at least recognition and implementation statutes for health care advance directives from other jurisdictions.

There is certainly a case for the harmonization of organ donation statutes with health care advance directive statutes and their implementation, including organ donations authorized by health care surrogates and family consent, as was recently adopted in Florida.

Any of these suggested solutions will take considerable time and effort. The prudent course for practitioners and concerned individuals in the interim is to execute a health care advance directive in accordance with the statutes of the state in which it is expected to be used. If an individual is present in more than one jurisdiction on a regular basis and might need a health care advance directive in a second or even a third jurisdiction, that person should execute one in compliance with the laws of the alternate jurisdiction(s). If an individual does execute multiple health care advance directives, they should be cross-referenced and available in the jurisdiction where they are expected to be needed.

Endnotes
4. Id.

6. See id.

