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Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care

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Background: Advance directive law may compromise the clinical effectiveness of advance directives.

Purpose: To identify unintended legal consequences of advance directive law that may prevent patients from communicating end-of-life preferences.

Data Sources: Advance directive legal statutes for all 50 U.S. states and the District of Columbia and English-language searches of LexisNexis, Westlaw, and MEDLINE from 1966 to August 2010.

Study Selection: Two independent reviewers selected 51 advance directive statutes and 20 articles. Three independent legal reviewers selected 105 legal proceedings.

Data Extraction: Two reviewers independently assessed data sources and used critical content analysis to determine legal barriers to the clinical effectiveness of advance directives. Disagreements were resolved by consensus.

Data Synthesis: Legal and content-related barriers included poor readability (that is, laws in all states were written above a 12th-grade reading level), health care agent or surrogate restrictions (for example, 40 states did not include same-sex or domestic partners as default surrogates), and execution requirements needed to make forms legally valid (for example, 35 states did not allow oral advance directives, and 48 states required witness signatures, a notary public, or both). Vulnerable populations most likely to be affected by these barriers included patients with limited literacy, limited English proficiency, or both who cannot read or execute advance directives; same-sex or domestic partners who may be without legally valid and trusted surrogates; and unbefriended, institutionalized, or homeless patients who may be without witnesses and suitable surrogates.

Limitation: Only appellate-level legal cases were available, which may have excluded relevant cases.

Conclusion: Unintended negative consequences of advance directive legal restrictions may prevent all patients, and particularly vulnerable patients, from making and communicating their end-of-life wishes and having them honored. These restrictions have rendered advance directives less clinically useful. Recommendations include improving readability, allowing oral advance directives, and eliminating witness or notary requirements.

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Advance directives allow people to designate a health care agent and specify health care preferences for future medical situations (1). Advance directive laws were created in response to high-profile "right-to-die" legal cases, such as those of Nancy Cruzan and Karen Ann Quinlan, to protect patients' rights of self-determination to decline life-sustaining treatments (1, 2). However, a fundamental tension exists between advance directive law and clinical practice.

In the clinical setting, advance directives often are used in conjunction with other forms of verbal or written communication of patients' wishes. In contrast, advance directive law takes a strict, legal-transactional approach to advance care planning that is akin to signing a will. This approach has resulted in many legal requirements and restrictions to execute an advance directive. Moreover, each U.S. state and the District of Columbia has adopted its own statutes that govern advance directives, living wills, and durable powers of attorney for health care, resulting in profound variability (3).

The attempt to safeguard a patient's right of self-determination through a legally driven process may have unintended consequences for patients (4). Although advance directives may stimulate discussions and reduce the stress of surrogate decision making (5–8), well-documented controversy exists over their clinical effectiveness, including their inability to affect clinicians' and families' understanding of patients' preferences and the type of care received (9). Without a health care agent, the absence of an advance directive may result in undertreatment or overtreatment, yet advance directives often are not completed, especially among minority and disenfranchised populations (10). Advance directive legal requirements may actively impede people from engaging in advance care planning (11). Because of ongoing efforts at both state and federal levels to improve advance directive law (12–15), the unintended consequences of the current law on the clinical effectiveness of advance directives must be considered.

We describe unintended consequences of advance directive law that may prevent patients from making or communicating their end-of-life care preferences or having

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their preferences honored. We also discuss vulnerable patient subgroups who may be most affected by unintended consequences of specific laws, explain the effect of advance directive law on clinicians, and suggest changes to current law to improve the clinical effectiveness of advance directives.

Methods

Data Sources and Searches

Our primary data sources included state statutes dedicated to advance directives, living wills, and durable power of attorney for health care in all 50 U.S. states and the District of Columbia (**Appendix Table 1**, available at www.annals.org) and legislative summaries from the American Bar Association through August 2010. We also searched LexisNexis and Westlaw for state and federal legal cases by using the search terms *advance directives, living wills, durable power of attorney for healthcare, surrogate decision maker,* and *physician immunity* from 1966 to August 2010. Finally, we systematically searched MEDLINE and LexisNexis for English-language articles by using the search terms *advance directives, durable power of attorney for healthcare, advance care planning, barriers, health disparities, physician immunity,* and *state advance directive law* and related terms from 1966 to August 2010.

Data Selection and Extraction

Two investigators independently identified eligible state legislative statutes among all U.S. state statutes. Using the aforementioned search terms, we also independently identified 128 articles and selected a subset of 20 that specifically addressed advance directive law. All disagreements were resolved by consensus.

Three lawyers independently selected 105 federal and state legal proceedings by using the aforementioned search terms. All disagreements were resolved by consensus. We excluded references to court-appointed guardians, agents' authority for pregnant patients, and psychiatric directives.

Data Synthesis and Analysis

We analyzed advance directive statutes and related materials for their potential to prevent patients from making or communicating end-of-life preferences. Three lawyers (including one of the authors) and 2 of the investigators also independently analyzed federal and state case law for how courts have interpreted and applied advance directive and physician immunity statutes.

Using content analysis, 2 of the investigators independently grouped legal and advance directive content-related barriers into overarching categories (16). The coding schema was revised by rereading the statutes and recoding until reviewers reached more than 95% agreement. A third investigator helped to resolve discrepancies.

Because advance directives have been shown to be written above a 12th-grade reading level, we hypothesized a priori that poor readability would be a barrier (17, 18). We then assessed how poor readability and other identified legal barriers may specifically affect disenfranchised populations. We focused a priori on socially isolated or institutionalized older persons and patients with limited literacy, limited English proficiency, or both because these groups report difficulty with medical forms and decision making (19–24). We also focused on patients with physical and intellectual disabilities, minority populations, homeless, and migratory patients because these groups perceive a high degree of discrimination (25–28).

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Results

Barriers

We identified 5 overarching legal and content-related barriers: poor readability; health care agent restrictions; execution requirements (steps needed to make forms legally valid); inadequate reciprocity (acceptance of advance directives between states); and religious, cultural, and social inadequacies. **Appendix Table 1** summarizes these barriers, related case law or statute examples, and vulnerable populations particularly affected by these barriers. **Appendix Table 2** (available at www.annals.org) describes individual barriers for all 50 U.S. states and the District of Columbia. We also identified physician immunity statutes that may profoundly affect patients and their families.

Poor Readability

Legal, precise language has been used in an attempt to minimize ambiguity. For example, some states, such as Ohio, require mandatory language to describe life-sustaining treatment and a 1700-word disclosure statement with warnings to patients (3). Other states, such as Oregon and Wisconsin, require the entire advance directive form to adhere to mandated legal language (3) (**Appendix Tables 1** and **2**).

Although the Institute of Medicine recommends that health-related materials be written at or below a 6th-grade reading level (19), most advance directives are written above a 12th-grade level (17, 18) and are unavailable in many patients' native languages (26). Furthermore, many directives contain ambiguous language, such as forgoing treatment if a condition is considered terminal or irreversible. Physicians, much less patients and their families, have been shown to have difficulty deciphering the meaning of these terms (29).

Approximately 40% of the U.S. population reads at or below an 8th-grade level, and the mean reading level of older persons is a 5th-grade level (19). Being unable to read or understand advance directive forms threatens patients'

ability to understand their health care choices and may limit their ability to communicate their preferences. In fact, limited health literacy explains some of the racial or ethnic variability demonstrated in end-of-life preferences (30).

Health Care Agent or Default Surrogate Restrictions

In an attempt to prevent coercion, many states restrict who may serve as a health care agent (**Appendix Tables 1** and **2**), including primary clinicians, caseworkers, and persons working for the patient's clinician or the care facility in which the patient resides. These restrictions occur in 37 states and the District of Columbia, but most states allow exceptions for immediate relatives.

Furthermore, if a durable power of attorney for health care is not executed, most states also restrict who may serve as a default surrogate. Many states typically authorize next of kin in the following order of priority: spouse; adult children; parents; siblings; sometimes, the nearest living relative; and last, in about 20 states, a "close friend" (**Appendix Tables 1** and **2**).

The decision-making status of a patient's domestic or same-sex partner is more complicated. Only 8 states (Arizona, Maine, Maryland, New York, New Mexico, Nevada, Oregon, Wisconsin, and the District of Columbia) recognize domestic partners in their health decisions law (31). However, same-sex partners may be recognized as valid default surrogates through marriage (in California, Connecticut, Iowa, Massachusetts, New Hampshire, Vermont, and the District of Columbia) or explicit authorization in state statutes (in Arizona, Maryland, and New York). In other states, a domestic or same-sex partner may be considered a "close friend" at the end of the default priority list.

In most states, designated or default surrogates also have limited authority to consent to withdrawal or withhold life-sustaining treatments unless the patient is deemed to be in a terminal or persistent vegetative state (32). A few states, such as Oklahoma, have additional restrictions on withdrawal of artificial nutrition or hydration (**Appendix Tables 1** and **2**).

Restrictions on who may serve as a health care agent have unintended consequences for the estimated 20% of homeless and uninsured persons (28, 33–35) and the 3% to 4% of older nursing home residents who cannot or do not wish to name a surrogate decision maker (24, 36). Homeless, institutionalized, socially isolated, disabled, or migratory patients often lack legally appropriate health care agents and frequently prefer to name their trusted case managers, social service providers, or physicians as surrogates (28, 35, 37). Health care agent restrictions may leave many isolated patients without advocates and potentially in the hands of court-appointed conservators who do not know these patients and may request treatment that is not in the patients' best interests.

In addition, not recognizing same-sex or domestic partners in states' health care decisions laws has unintended consequences for the 6 million Americans within these partnerships (38, 39). If these patients require medical care outside of the states that grant same-sex unions or recognize domestic partnerships, their partner may not be allowed to make medical decisions on their behalf. Because a patient's same-sex or domestic partner often has greater knowledge of the patient's values than statutorily recognized decision makers, such as estranged family (40, 41), presuming that the partner will "act in the patient's best interest" (40) is reasonable. In this regard, having a patient's same-sex or domestic partner act as his or her surrogate is morally and ethically justifiable and disregarding the partner's input is unethical (40, 42).

Furthermore, restrictions on the types of decisions that agents or surrogates can make also may prevent patients from having their wishes honored. Some states require documentation of the exact decisions that an agent can make, which may affect patients who prefer not to write attestations of their wishes in advance, such as racial or ethnic minority populations and people with limited literacy (43–45).

Execution Requirements

Patients must navigate many execution requirements, such as attainment of signatures and witnessing, for advance directives to be considered legally valid. Only 16 states recognize oral advance directives (**Appendix Tables 1** and **2**), and many of these states have additional execution requirements, such as witnessing. Furthermore, several states (for example, Missouri) have separate statutes governing living wills and durable powers of attorney for health care, resulting in separate forms and requirements and potential conflicts (**Appendix Table 1**). In addition, nearly all states require 2 witnesses to make advance directives legally valid, with 18 states permitting notarization as an alternative. However, North Carolina and West Virginia require both 2 witnesses and notarization. Furthermore, most states prohibit a patient's appointed agent, spouse, relative, health care provider, or an employee of the provider from being able to act as a witness. Some states even exclude anyone considered to be an heir from acting as a witness (**Appendix Tables 1** and **2**).

Improperly executed advance directives have caused patients' documented wishes to be invalidated (**Appendix Table 1**). Even if physicians document a patient's verbally expressed wishes, those wishes may not be honored because oral advance directives are not universally accepted. However, substantiated oral declarations are considered to be clear expressions of patients' wishes and may provide the best evidence of their health care preferences (46). Ignoring such declarations may be legally justifiable but ethically problematic (40, 41).

Execution barriers may most affect patients from culturally and socially diverse backgrounds or patients with limited literacy or English proficiency. These populations often prefer not to or cannot document their treatment preferences and may be unable to navigate all required paperwork (33).

Witness restrictions may particularly affect socially isolated, unbefriended older adults, as well as patients who are homeless, institutionalized, or migratory and who often lack appropriate witnesses. Many disenfranchised patients also may not understand what a notary public is; know how to find one; or be able to pay for such services, which cost $0.50 in Wisconsin (47) and $10 in California (48).

In addition, a form of identification is required to use the services of a notary, which prevents patients without proper documentation from executing an advance directive. Finally, although some hospitals provide notary services, these are often unavailable during outpatient visits, potentially resulting in the completion of advance directives without a clinician's input (11).

Inadequate Reciprocity

Reciprocity refers to whether an advance directive executed in one state will be accepted in another. Excluding Kentucky, Michigan, and Wyoming, 47 states and the District of Columbia have reciprocity laws. However, reciprocity laws ensure only that out-of-state directives be considered validly executed but do not ensure that the advance directive will be interpreted exactly the same way because of varying mandatory language, restrictions, and differences in how state statutes are interpreted (3). For example, a durable power of attorney for health care designated under Massachusetts law (49) includes the authority to withdraw life support (including artificial nutrition or hydration) and to consent to long-term care placement; whereas Wisconsin law requires that this authority be expressly documented (**Appendix Tables 1** and **2**).

Lack of reciprocity between states may most affect frail elderly people who live with various caregivers in different states, migrant and transient homeless patients, and persons who have the financial means to travel. Although court cases have shown that out-of-state advance directives may be enforceable as a clear expression of patients' wishes, the acceptance of these directives is clinician-dependent and may require the financial, educational, and social means to retain legal counsel (**Appendix Tables 1** and **2**).

Religious, Cultural, and Social Inadequacies

Although the importance of providing culturally competent care is well recognized (50), standardized advance directive forms do not permit the expression of alternative religious, cultural, or social preferences. For example, almost all durable power of attorney for health care statutes anticipate the appointment of a single agent rather than a family unit, and most statutes require completion of a written directive instead of an oral one. In addition, cultural, religious, or social preferences, such as death rituals or religious health care beliefs, have not been in the purview of advance directive statutes and therefore are not incorporated in most advance directive forms. Lack of inclusion of alternative religious, cultural, or social preferences represents a Western, autonomy-oriented, educated cultural bias.

The U.S. population is becoming increasingly diverse (39), yet differing views on autonomy and shared decision making among religious and cultural groups are often not considered (50–52). Most advance directives ignore cultural differences regarding autonomy (such as the concept of family decision making) and individual preferences (such as whether patients want to be aware of their prognoses) (51, 53). Western cultures generally view autonomy as self-empowering, whereas members of other cultures, such as Latinos, Native Americans, and Asians, may view it as a burden, resulting in loss of hope (50, 52, 54). Cultural or religious rituals about body preparation after death also differ. Yet, advance directive forms do not include such choices, which are as important to patients as treatment preferences (55). Decisions based on culture, religion, or spirituality often reflect a patient's inherent values and should be elicited and honored (40).

Advance directive forms also discourage documentation of alternative preferences, such as the desire of isolated older and homeless persons to document their willingness to go to a nursing home or an institution and to discuss the ethical disposal of their body after they die (24, 56). Furthermore, homeless patients often wish to document personal characteristics (for example, tattoos) that may aid health care providers in body identification, preventing an anonymous death (35). In addition, patients with physical disabilities often prefer to document what constitutes good quality of life and their concerns about premature withdrawal of life-sustaining treatment (27, 57).

Because advance directive statues do not include cultural, religious, or social preferences, we identified few legal cases addressing these issues. The most prevalent cases involved adult Jehovah's Witnesses whose wishes to refuse blood transfusions were not honored, even with legally executed directives (**Appendix Table 1**).

Legal Protection for Clinicians

In addition to legal and content-related barriers of advance directive law, legal protection for clinicians may substantially affect patients and their families. Many states have provisions that enable physicians to presume the validity of an advance directive in the absence of actual knowledge that the directive is invalid (**Appendix Table 3,** available at www.annals.org). Most states also have cumulative clauses that consider advance directives as only 1 method to express patients' preferences and may allow for other expressions, such as oral directives. Furthermore, all

states have immunity statutes that protect physicians from criminal or civil liability or disciplinary action if they are acting on information in an advance directive in "good faith."

However, nearly all states grant clinicians the right of refusal based on conscience or other objections (**Appendix Table 3**). The criteria for refusal vary considerably. Nineteen states and the District of Columbia have entirely open-ended criteria that permit providers to decline to comply with patients' wishes for any reason. Most states acknowledge that providers are not required to act contrary to the standard of care, whereas other states variously permit noncompliance on the basis of one's conscience and personal, moral, religious, and philosophical beliefs (58). If a provider invokes a conscience objection, states require the provider or institution to notify the patient and permit his or her transfer to another provider. Obligations range from merely refraining from impeding a transfer (Kentucky) (59) to requiring clinicians or institutions to transfer the patient or comply with his or her wishes within a specified interval (Florida) (60).

Immunity and conscience objection provisions may serve patients if surrogates are abusing their authority but also may give clinicians license to ignore patients' wishes. Even if they receive advance notice of a clinician's conscience objections, patients (especially those who are disenfranchised or live in rural areas) may have limited options. Thus, advance directive statutes meant to protect patients' right of self-determination may instead better protect physicians from punitive action. Indeed, we identified only a few cases in which a physician faced punitive action. Our findings may reflect the inability of most disenfranchised patient populations to procure legal counsel, leaving many individuals without a voice.

Discussion

Empirical evidence suggests that changing the focus of advance care planning from a legal-transactional approach to a relationship- and communication-based one would result in care consistent with patients' goals (4, 7, 35, 61). In this paradigm of advance care planning, written advance directives are considered only 1 piece of information to be evaluated when a decision must be made (61).

Therefore, for advance directives to be clinically useful, advance directive laws must allow flexibility. Patients have differing needs, learning styles, and preferences for information when engaging in advance care planning. Patients also exist within a complex web of culture, religion, relationships, and experiences and have dynamic clinical courses that may change from moment to moment. Therefore, a one-size-fits-all legal-transactional model is not clinically effective.

Some experts suggest that merely designating a surrogate or adopting a universal advance directive form can remedy unintended consequences of advance directive law. However, these approaches do not address the legal restrictions on who may serve as a surrogate or witness; acknowledge that many patients may not have a surrogate (24, 36); or improve the readability, cultural inadequacies, or myriad execution requirements of advance directive forms. Others suggest using the Physician Orders for Life-Sustaining Treatment paradigm for patients with advanced progressive illness (15). However, these orders do not encourage discussions about the patient's wishes before he or she develops an acute or terminal illness or address cultural, religious, or values-based preferences.

As advance care planning continues to evolve toward a flexible, relationship- and communication-based model, any advance directive tool or discussion could help to guide clinical care. The American Bar Association already has advocated a flexible approach to advance care planning through the Uniform Health-Care Decision Act (UHCDA), which was drafted in 1994 but only adopted by a few states (62). The UHCDA attempted to simplify state legislation by combining living will and durable power of attorney for health care statutes, allowing oral directives, and decreasing execution requirements. Building on the UHCDA, specific changes to advance directive law may help mitigate its unin-

Table. **Recommended Modifications to Advance Directive Laws to Improve Clinical Effectiveness***

Barrier	Recommendation
Poor readability	Allow wide acceptance of diverse advance care planning tools and oral directives Eliminate mandatory legal language Mandate that forms be written in plain language at a 5th-grade reading level, and consider using pictures Mandate translation of forms into patients' native languages, and pilot-test these forms in target populations
Durable power of attorney for health care restrictions	Allow isolated patients the option of choosing a care provider as a surrogate Allow same-sex and domestic partners to act as default decision makers Eliminate restrictions on the authority of surrogates
Execution requirements	Universally accept oral advance directives Eliminate witness and notary requirements
Lack of reciprocity	Adopt nonrestrictive reciprocity laws
Religious, cultural, and social inadequacies	Include language concerning shared or group decision making and cultural, religious, and social options in statutes

* Many of these provisions are included in the Uniform Health-Care Decisions Act.

tended consequences on clinical care, particularly for vulnerable patient populations (**Table**).

To address readability barriers, we recommend eradicating mandatory legal language; writing advance directives at a 5th-grade reading level, which is the mean reading level of older persons in the United States; and, when possible, offering advance directives in patients' native languages (19, 63). To address the problem of health care agent restrictions, clinicians should encourage socially isolated patients to discuss or document their health care wishes (28).

For patients who are unable or unwilling to do this and would prefer to designate a health care agent, clinicians should direct extensive effort toward helping patients to connect with social networks, distant family, or religious leaders. If a health care agent cannot be identified, we suggest that vulnerable patients with no other options be allowed to designate a professional who is not directly responsible for administering medical care, such as a social worker or case worker.

We also recommend eliminating health care agent or surrogate authority limitations, such as not allowing withdrawal from artificial nutrition and hydration. Clear documentation that the patient made these choices using his or her own judgment can prevent potential abuse (64). Internal ethics reviews also may be considered in such cases.

To address execution barriers, we recommend the universal acceptance of oral advance directives and the eradication of witness requirements. We also recommend that all states adopt nonrestrictive reciprocity laws, regardless of the location or type of advance care planning tools used. To address cultural and social insensitivity, we recommend allowing and encouraging patients to document their values, cultural traditions, and other socially or culturally important information and to consider group or shared decision making. By allowing flexibility to include religious, cultural, and social beliefs, clinicians and surrogates may determine a clearer course of action when deciding on the best treatment for an incapacitated patient.

At the bedside, many clinicians choose to use all available information from patients and their families to help provide the best possible clinical care (61). Many, but not all, states seem to accept such flexibility, given the immunity and cumulative clauses. A flexible rather than a legal-transactional approach to advance care planning may help to ensure that patients' voices are heard even at the end of their lives.

This review has several limitations. First, advance directive laws are dynamic, and this assessment may not reflect the most up-to-date statutes. Second, most available case law information is found at the appellate level, which means that the cases have gone to trial and been appealed to a higher court. Because most disenfranchised populations lack the means to appeal, there may be many more cases that we were not able to ascertain. To elucidate the full scope of advance directive legal barriers, further studies should attempt to identify cases that have progressed only to an ethics review board or lower state courts. Finally, future advance care planning interventions should focus on eliciting individualized patient preferences and promoting discussions rather than solely encouraging advance directive completion.

In conclusion, unintended negative consequences of legal restrictions and requirements related to poor readability of advance directives; health care agent restrictions; execution requirements; insufficient reciprocity; and lack of attention to religious, cultural, and social issues may prevent all patients, and particularly vulnerable patients, from making and communicating their end-of-life wishes and having them honored. In an attempt to safeguard patient autonomy, legal restrictions have rendered advance directives less clinically useful. In addition, advance directive laws seem to protect physicians more than patients.

We recommend improving the readability of advance directives; eliminating surrogate restrictions; accepting oral and out-of-state advance directives; eradicating witness and notary requirements; and encouraging documentation of religious, cultural, and social beliefs. These changes could help to restore the clinical effectiveness of advance directives and ensure that all patients' wishes are heard and honored.

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Appendix Table 1. **Advance Directive Legal and Content-Related Barriers**

Barrier (Number of States)	Statutory and/or Case Illustrations	Vulnerable Populations Most Affected
Poor readability*		
Statutory form required (2)	Excerpt from Wisconsin Living Will: "I, . . . , being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment. . . ."	All individuals, especially those with limited literacy, limited English proficiency, and limited cognition
Writing must be substantially similar to statutory sample form (16)	Excerpt from Colorado statutory form: "I, (name of declarant), being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that . . . in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration. . . ."	
Mandatory disclosure statement required (3)	Ohio requires a 1700-word disclosure statement written at a grade-20 (postgraduate) reading level. At least 50% of the U.S. population would comprehend <10% of this statement (65).	
Health care agent restrictions		
Persons prohibited from being a health care agent		
Health care provider (28)	In Missouri, the health care agent cannot be a clinician or employee of the clinician, owner/operator of a health care facility/facility provider, licensee of department of mental health services or social services (exceptions for relatives or members of the same religious community).	Elderly or isolated patients; homeless persons; or individuals who prefer to name a clinician, social worker, or hospital employee as trusted agent
Employee of health care provider (19)		
Employee of facility provider (18)	Refer to **Appendix Table 2** for individual state examples.	
Agent serving as DPAHC for ≥10 individuals (2); conservator (1); administrator/employee of government agency financially responsible for health care (1); operator/employee of funeral home, crematory, or cemetery (1); or licensee of the department of mental health services or social services (1)		
Default surrogate restrictions		
Same-sex or domestic partner not considered equivalent to spouse (41)	Order of priority for who may act as a default surrogate in Mississippi (Miss. Code Ann. § 41-41-211): 1) The spouse, unless legally separated; 2) an adult child; 3) a parent; or 4) an adult brother or sister; 5) if none of the individuals eligible to act as surrogate under subsection (2) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as a surrogate.	Same-sex or domestic partners
Restrictions on surrogate authority		
Restrictions on withdrawal of care (5)	In Oklahoma, ANH may not be withdrawn except where 1) the physician knows the patient gave informed consent to forgo ANH; 2) a court finds clear and convincing evidence that the patient gave informed consent; 3) the patient has an advance directive authorizing forgoing ANH; 4) the use of ANH will cause pain or is not medically possible; or 5) the patient's condition is considered imminently terminal (66). *Borenstein v. Simonson,* 797 N.Y.S.2d 818 (New York 2009): Family conflict developed over the DPAHC's decision to withdraw ANH in New York. The court held that the nursing home could not withdraw the treatment because the patient had not documented authorization of the removal of such treatment nor given the DPAHC the power to make this decision.	All individuals, especially those with limited literacy, limited English proficiency, and cognitive impairment
Execution restrictions		
Does not allow oral advance directives		
Oral advance directives not allowed (35)	*In the Matter of Gordy*, 658 A. 2d 613 (Delaware 1994): An elderly patient in a long-term care hospital repeatedly stated to her physicians that she did not wish to receive a feeding tube. She had a living will that was effective only in the event that she had a terminal illness as diagnosed by 2 physicians. When incapacitated, her son requested that her physicians withhold the feeding tube; however, the hospital recommended that it be administered. After a legal battle, the court determined that her wishes were clear and no feeding tube was administered. Although this case demonstrates that an oral directive may be enforceable, it requires the patient or family to have the means to procure legal counsel.	Patients with limited literacy, limited English proficiency, cognitive impairment, or diverse cultural backgrounds who are unable or unwilling to document a written advance directive

Continued on following page

Appendix Table 1—Continued

Barrier (Number of States)	Statutory and/or Case Illustrations	Vulnerable Populations Most Affected
Oral directives allowed but have additional requirements (15)	Delaware, Florida, Louisiana, Maryland, Texas, Utah, and Virginia require the documented presence of witnesses. Louisiana and Virginia allow for oral instruction only after the diagnosis of a "terminal condition."	
Conflicting statutes/forms for DPAHC, living wills, and advance directives		
DPAHC statute only (4)	Refer to **Appendix Table 2** for individual state examples.	Patients with limited literacy, limited English proficiency, or cognitive impairment
Living will statute only (1)	Refer to **Appendix Table 2** for individual state examples.	
Separate living will and DPAHC statutes (20)	In Missouri, the state advance directive forms do not provide information about the need for a separate DPAHC designation or the restrictions on surrogate decision makers. This is important because Missouri does not allow legally designated or default surrogates the power to make decisions regarding withdrawal of ANH unless the patient specifies this in the separate DPAHC form.	
Additional signatures required		
2 witnesses required (47)	*McCroskey v. University of Tennessee*, No. 03A01-9409-CV-00356, 1995 WL 329133 (Tennessee 1995): A patient with emphysema gave his physician a handwritten, signed, notarized document stating that he did not want to receive life support. At the time, Tennessee required that a living will be signed by 2 witnesses. The patient's condition worsened and he was placed on life support for 18 days until the family convinced the medical center to withdraw care. The patient's wife brought suit for medical malpractice and battery. However, the court held that because the advance directive was not signed by 2 witnesses, it was invalid and the physician could not be held liable for not recognizing it.	Frail and isolated elderly persons, people with limited economic resources to pay for a notary
Notary public signature required (4)	Refer to **Appendix Table 2** for individual state examples	
Ombudsman or other government appointee presence required if the patient is in a long-term care facility (6)	California and the District of Columbia require the presence of an ombudsman when a patient is a resident of a long-term care facility, and Oregon requires the presence of an additional witness with qualifications specified by the Oregon Department of Human Services (67).	
Persons prohibited from being a witness		
Relative or spouse (27) Heir or beneficiary (30) Appointed agent (31) Health care or facility provider (30) Person responsible for health care costs (9) Proxy signer (5) Insurance provider (2) Patient advocate (1) Other patients at facility (1)	In Kentucky, the relative, heir, person responsible for health care costs, clinician, or facility provider cannot be a witness. In South Carolina, witnesses cannot be an heir or other beneficiary of the patient's estate, any creditor, any life insurance beneficiary, or any person responsible for the care costs of the patient (68).	Elderly or isolated individuals lacking legally valid witnesses
Reciprocity barriers		
Lack of reciprocity between states or conflicting legal language		
No reciprocity statute or provision (3)	*Saunders v. State of New York*, 492 N.Y.S.2d 510 (New York 1985): An elderly woman with emphysema and lung cancer executed a living will in Pennsylvania. She then moved to her daughter's home in New York, where she received treatment. Because she feared that her living will would not be honored in New York, which does not have a living will statute, she sought a court judgment declaring that her living will be valid in New York. The court found that her living will was valid. This case demonstrates that an out-of-state advance directive may be enforced without a reciprocity statute; however, the patient or patient's family must have the means to procure legal counsel.	Frail elderly persons living with multiple caregivers, migrant workers, and/or transient homeless patients
Reciprocity provisions for DPAHC only (6)		
Reciprocity for living wills only (3)		
Religious, cultural, and social barriers		
Religious, cultural, and social insensitivity		
Statutes lack language about respecting alternative beliefs*	*In re Duran*, 47, 769 A.2d 497 (Pennsylvania 2001): A devout Jehovah's Witness who needed a liver transplantation traveled to a medical center known for respecting the beliefs of Jehovah's Witnesses. She designated her friend as her health care agent instead of her husband. She also amended her advance directive with the statement "I absolutely, unequivocally and resolutely refuse homologous blood and stored autologous blood under any and all circumstances . . . " (50). She also discussed her wishes with her physicians. After her procedure, her hemoglobin level became life-threateningly low and she became comatose. Without contacting the designated health care agent, the patient's husband petitioned the court and was granted to be his wife's temporary guardian in order to permit a blood transfusion. Despite the transfusion, she died a few weeks later. After a subsequent court case, no punitive action was brought against the medical center.	Any individual with wishes deviating from standard care (especially individuals with cultural values deviating from those of the United States)

ANH = artificial nutrition and hydration; DPAHC = durable power of attorney for health care.
* All states.

Appendix Table 2. **Individual Barriers, by State**

State	Probate Code	Readability: Mandatory Language Requirements	DPAHC Restrictions		
			Persons Restricted From Being a DPAHC	Domestic Partners Not Equal to Spouses as Default Surrogates	Restrictions on Surrogate Authority
Alabama	Ala. Code § 22-8A-2 to -14, § 26-1-21975 (1975)	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, employee of clinician*	Yes	
Alaska	Alaska Stat. § 13.52.010 to .395		Owner/operator of health care facility/facility provider	Yes	
Arizona	Ariz. Rev. Stat. § 36-3201 to § 36-3262				
Arkansas	Ark. Code Ann. § 20-13-104, § 20-17-20-218			Yes	
California	Cal. Prob. Code § 4600–4948 806; oral directive: 4623		Clinician, conservator, owner/operator of health care facility/facility provider*		
Colorado	Colorado Rev. Stat. Ann. § 15-14-503-509, § 15-14-501-502, § 15-14-601-611, § 15-18-10-113	Writing must be substantially similar to the writing in the AD statute/state AD form		Yes	
Connecticut	Conn. Gen. Stat. § 19a-570 to § 19a-580d; oral directive: 19a-578	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, employee of clinician/facility provider, owner/operator of health care facility, person responsible for health care costs*		
Delaware	Del. Code Ann. tit., 16, § 2501 to § 2518; oral directive: 2507(b)(1)		Owner/operator of health care facility/facility provider*	Yes	
District of Columbia	D.C. Code § 21-2201 to -2213, § 7-621 to -630	Writing must be substantially similar to the writing in the AD statute/state AD form for living wills	Clinician, owner/operator of health care facility/facility provider		
Florida	Fla. Stat. Ann. § 765.101 to .404; oral directive: 765.101(1)			Yes	
Georgia	Ga. Code Ann. § 31-36A-1 to -13, § 31-32-1-12		Clinician	Yes	
Hawaii	Haw. Rev. Stat. § 327E-1 to -16, § 551D-2.5; oral directive: 327E-3 to 327E-5		Employee of clinician, owner/operator of health care facility/facility provider*	Yes	
Idaho	Idaho Code § 39-4501 to -4509	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, owner/operator of health care facility/facility provider, employee of clinician/facility provider*	Yes	
Illinois	755 Ill. Comp. Stat. 45/4-1 to 4-12; 755 Ill. Comp. Stat. 35/1 to 35/10	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician	Yes	
Indiana	Ind. Code Ann. § 30-5-1-1 to 30-5-5-19, § 16-36-1-1-19, § 16-36-4-1-21	Writing must be substantially similar to the writing in the AD statute/state AD form		Yes	
Iowa	Iowa Code Ann. § 144B.1 to .12, § 144A.1 to .12		Clinician, employee of clinician*		
Kansas	Kan. Stat. Ann. § 58-625 to -632, § 65-28,101 to 28,109	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, employee of clinician†	Yes	
Kentucky	Ky. Rev. Stat. § 311.621 to .643	Writing must be substantially similar to the writing in the AD statute/state AD form	Owner/operator of health care facility/facility provider, employee of facility provider†	Yes	
Louisiana	La. Rev. Stat. § 1299.58.1, § 1299.58.10; oral directive: 40:1299.58.2-3			Yes	
Maine	Me. Rev. Stat. Ann. tit., 18, § 5-801 to § 5-817; oral directive: 18-A-5-802		Owner/operator of health care facility/facility provider, employee of facility provider*	Yes	

Appendix Table 2—**Continued**

Execution Requirements				Reciprocity: Lack of Reciprocity
Oral Directives Not Recognized or Additional Restrictions	**Conflicting Statutes/Forms**	**Witness or Notary Signatures Required**	**Persons Restricted From Being a Witness**	
		2 witnesses personally known	Relative, heir, agent, person responsible for health care costs	
Yes		2 witnesses or a notary	Relative (1 witness), heir (1 witness), agent, clinician, facility provider	
Yes		1 witness or a notary	Relative/heir (1 witness), appointed agent, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	2 witnesses		
		2 witnesses or a notary; an ombudsman if in a skilled nursing facility	Relative (1 witness), heir (1 witness), agent, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	2 witnesses	Heir, clinician, facility provider, other patients at facility	Reciprocity for DPAHC only
Physicians must record any oral statements in the patient's chart		2 witnesses; a notary for DPAHC	Appointed agent, clinician, facility provider (if residing at a facility)	
Patients can orally designate DPAHCs, but witnesses are required, and this designation must be written in the patient's medical record		2 witnesses; an ombudsman if in a long-term care facility	Relative, spouse, heir, person responsible for health care costs, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	2 witnesses; a living will requires an ombudsman or patient advocate if in a long-term care facility (replaces 1 witness)	Relative (1 witness), heir (1 witness), person responsible for health care costs, clinician, facility provider, proxy signer	Reciprocity for DPAHC only
Requires witnesses		2 witnesses	Relative (1 witness), appointed agent	
Yes		2 witnesses	Heir, appointed agent, clinician/facility provider (if directly involved in health care)	
		2 witnesses or a notary	Relative, heir (1 witness), appointed agent, clinician, facility provider	
Yes		2 witness or a notary		
Yes	Separate living will and DPAHC statutes	2 witnesses for living will only	Heir	Reciprocity for living will only
Yes	Separate living will and DPAHC statutes	1 witness	Appointed agent	
Yes	Separate living will and DPAHC statutes	2 witnesses or a notary	Relative (1 witness), appointed agent, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	2 witnesses or a notary	Relative, heir, appointed agent, person responsible for health care costs	Reciprocity for DPAHC only
Yes		2 witnesses or a notary	Relative, heir, person responsible for health care costs, clinician, facility provider	No reciprocity statute/provision
Requires witnesses, and the patient must be diagnosed with a terminal condition	Separate living will and DPAHC statutes	2 witnesses		Reciprocity for living will only
Oral instruction only valid if stated to a clinician or the DPAHC		2 witnesses		

Appendix Table 2—**Continued**

State	Probate Code	Readability: Mandatory Language Requirements	DPAHC Restrictions		
			Persons Restricted From Being a DPAHC	Domestic Partners Not Equal to Spouses as Default Surrogates	Restrictions on Surrogate Authority
Maryland	Md. Code § 5-601 to § 5-618; oral directive: 5-602		Owner/operator of health care facility/facility provider, employee of facility provider*		
Massachusetts	Mass. Gen. Laws Ann. ch. 201D		Owner/operator of health care facility/facility provider, employee of facility provider*		
Michigan	Mich. Comp. Laws Ann. § 700.5506 to .5512			Yes	
Minnesota	Minn. Stat. Ann. § 145C.01 to .16, § 145B.01 to .17	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, employee of clinician*	Yes	
Mississippi	Miss. Code Ann. § 41-41-201 to -229; oral directive: 41-41-205		Owner/operator of health care facility/facility provider	Yes	
Missouri	Mo. Ann. Stat.§ 404.800 to .872 and § 404.7000 to .735; living will: § 459.010 to .055		Clinician, employee of clinician, owner/operator of health care facility/facility provider, licensee of the department of mental health services or social services†	Yes	Yes
Montana	Mont. Code Ann. § 50-9-101 to 206			Yes	
Nebraska	Neb. Rev. Stat. § 30-3401 to -3432, § 20-401-416		Clinician, employee of clinician, owner/operator of health care facility/facility provider, employee of facility provider, person serving as a health care agent for ≥10 people*	Yes	Yes
Nevada	Nev. Rev. Stat. § 449.800 to .860, § 449.535 to .690			Yes	
New Hampshire	N.H. Rev. Stat. § 137-J:1 to J:16	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician or owner/operator of health care facility/facility provider, employee of clinician, employee of facility provider*		
New Jersey	N.J. Stat. Ann. § 26:2H-53 to -81		Clinician or owner/operator of health care facility/facility provider*	Yes	
New Mexico	N.M. Stat. Ann. § 24-7A-1 to -18; oral directive: 24-7A-2		Owner/operator of health care facility/facility provider*	Yes	
New York	N.Y. Pub. Bldgs. Health § 2980 to § 2994		Clinician, owner/operator of health care facility/facility provider, agent serving ≥10 people*		Yes
North Carolina	N.C. Gen. Stat. Ann. § 32A-15 to -27, § 90-320 to -323		Clinician if receiving payment for services	Yes	
North Dakota	N.D. Cent. Code § 23-06.5-01 to -18		Clinician, owner/operator of health care facility/facility provider, employee of clinician or employee of facility provider*	Yes	
Ohio	Ohio Rev. Code § 1337.11 to .17, § 2133.01 to .15		Clinician, employee of clinician, employee of facility provider†	Yes	
Oklahoma	Okla. Stat. Ann. § 3101.1 to .16	Writing must be substantially similar to the writing in the AD statute/state AD form		Yes	Yes for artificial nutrition and hydration
Oregon	Or. Rev. Stat. § 127.505 to .660, § 127.995	Statutory form required	Clinician, employee of clinician, owner/operator of health care facility/facility provider, employee of facility provider*	Yes	
Pennsylvania	20 Pa. Cons. Stat. Ann. § 5401 to § 5416 and § 5601 to 5611		Clinician, owner/operator of health care facility/facility provider, employee of facility provider*	Yes	
Rhode Island	R.I. Gen. Laws 1956, § 23-4.10-1 to -12, § 23-4.11-1 to -15 (1956)		Clinician, owner/operator of health care facility/facility provider, employee of clinician, employee of facility provider*	Yes	

Appendix Table 2—**Continued**

Execution Requirements				Reciprocity: Lack of Reciprocity
Oral Directives Not Recognized or Additional Restrictions	**Conflicting Statutes/Forms**	**Witness or Notary Signatures Required**	**Persons Restricted From Being a Witness**	
Requires witnesses, must be signed by the attending physician, and must be part of the patient's medical record		2 witnesses	Heir (1 witness), appointed agent	
Yes	DPAHC statute only	2 witnesses	Appointed agent, patient advocate	Reciprocity for DPAHC only
Yes	DPAHC statute only	2 witnesses	Relative, heir, appointed agent, clinician, facility provider, insurance provider	No reciprocity statute/provision
Yes		2 witnesses or a notary	Appointed agent, clinician, facility provider (1 witness)	
Patients can only orally designate a living will; requires witnesses		2 witnesses or a notary	Relative (1 witness), heir (1 witness), appointed agent, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	1 notary		Reciprocity for DPAHC only
Yes	Separate living will and DPAHC statutes	2 witnesses		
Yes	Separate living will and DPAHC statutes	2 witnesses or a notary	Relative, heir, appointed agent, clinician, facility provider, insurance provider	
Yes	Living will statute only	2 witnesses or a notary		No reciprocity statute/provision
Yes		2 witnesses or a notary	Heir, appointed agent, clinician, facility provider	
Yes		2 witnesses or a notary	Appointed agent	
The oral directive must be made by informing the clinician		2 witnesses recommended but not required		
Yes	DPAHC statute only	2 witnesses	Appointed agent, clinician, facility provider (1 witness)	Reciprocity for DPAHC only
Yes	Separate living will and DPAHC statutes	2 witnesses and a notary	Relative, heir, clinician, facility provider	
Yes	DPAHC statute only	2 witnesses or a notary	Relative, heir, appointed agent, clinician facility provider (1 witness)	
Yes	Separate living will and DPAHC statutes	2 witnesses or a notary	Relative, appointed agent, clinician, facility provider	
Yes		2 witnesses	Heir	
Yes		2 witnesses; an ombudsman if in a long-term care facility	Relative, heir (1 witness), appointed agent, clinician, facility provider	
Yes	Separate living will and DPAHC statutes	2 witnesses	Clinician, facility provider, proxy signer	
Yes	Separate living will and DPAHC statutes	2 witnesses or a notary for DPAHC; 2 witnesses for a living will	Relative, heir (1 witness), appointed agent, clinician, facility provider	

Appendix Table 2—**Continued**

State	Probate Code	Readability: Mandatory Language Requirements	DPAHC Restrictions		
			Persons Restricted From Being a DPAHC	Domestic Partners Not Equal to Spouses as Default Surrogates	Restrictions on Surrogate Authority
South Carolina	S.C. Code § 62-5-501 to -505, § 44-77-10 to § 44-77-160 (1976)	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, employee of clinician, owner/operator of health care facility/facility provider, employee of facility provider (excludes spouses)	Yes	Yes
South Dakota	S.D. Codified Laws § 34-12D-1 to -22			Yes	
Tennessee	Tenn. Code Ann. § 68-11-1801 to -1815; oral directive: 68-11-1801(a)	Writing must be substantially similar to the writing in the AD statute/state AD form		Yes	
Texas	Tex. Rev. Cit. Stat. Ann. Health & Safety § 166.001 to .166; oral directive: 166.003, 166.034	Writing must be substantially similar to the writing in the AD statute/state AD form for DPAHCs; disclosure statement required	Clinician, owner/operator of health care facility/facility provider, employee of clinician, employee of facility provider*	Yes	
Utah	Utah Code Ann. § 75-2A-1101 to -1119; oral directive: 75-2a-0107	Writing must be substantially similar to the writing in the AD statute/state AD form	Clinician, owner/operator of health care facility/facility provider*	Yes	
Vermont	Vt. Stat. Ann. tit. 18, § 9713, § 5263 to § 5278		Clinician, operator/employee of funeral home, owner/operator of health care facility/facility provider*		
Virginia	Va. Code Ann. § 54.1-2981-2993; oral directive: 54.1-2982			Yes	
Washington	Wash. Rev. Code Ann. § 11.94.010 to .900, § 70.122.010, § 70.122.920		Clinician, employee of clinician, owner/operator of health care facility/facility provider, employee of facility provider*	Yes	
West Virginia	W. Va. Code § 16-30-1 to -25		Clinician, employee of clinician, owner/operator of health care facility/facility provider, employee of facility provider*	Yes	
Wisconsin	Wis. Stat. Ann. § 155.01 to .80, § 154.01 to .15	Statutory form and disclosure statement required	Clinician, employee of clinician* (excludes spouses of employees)	Yes	Yes
Wyoming	Wyo. Stat. Ann. § 35-22-401 to -416, § 35-22-101 to -109; oral directive: 35-22-430(a)		Owner/operator of health care facility/facility provider, employee of facility provider*	Yes	

AD = advance directive; DPAHC = durable power of attorney for health care.
* Except relatives.
† Except relatives and members of the same religious community.

Appendix Table 2—**Continued**

Execution Requirements				Reciprocity: Lack of Reciprocity
Oral Directives Not Recognized or Additional Restrictions	**Conflicting Statutes/Forms**	**Witness or Notary Signatures Required**	**Persons Restricted From Being a Witness**	
Yes	Separate living will and DPAHC statutes	2 witnesses; a notary (replaces 1 witness); an ombudsman if in long-term care	Relative, heir, appointed agent, person responsible for health care costs, clinician, facility provider (1 witness)	
Yes	Separate living will and DPAHC statutes	2 witnesses		Reciprocity for living will only
Patients can only orally designate a DPAHC		2 witnesses or a notary	Relative, heir (1 witness), appointed agent	
Requires witnesses, and a physician must be present	Separate living will and DPAHC statutes	2 witnesses or a notary for written directive; 2 witnesses and the attending physician for oral directive	Relative, heir, appointed agent, clinician, facility provider (1 witness)	
Requires 1 witness and must state circumstances under which the directive was made		1 witness	Relative, heir, appointed agent, person responsible for health care costs, clinician, facility provider, proxy signer	
Yes		2 witnesses; an ombudsman if in long-term care	Relative, heir, appointed agent	
Witnesses required and can only be made after the patient is diagnosed with a terminal condition		2 witnesses for written directive; 2 witnesses and the attending physician for oral directive		
Yes	Separate living will and DPAHC statutes	2 witnesses		
Yes		2 witnesses and a notary	Relative, heir, appointed agent, person responsible for health care costs, clinician, facility provider, proxy signer	
Yes	Separate living will and DPAHC statutes	2 witnesses	Relative, heir, person responsible for health care costs, clinician, facility provider	
Only a living will can be orally designated		2 witnesses or a notary	Heir, appointed agent, clinician, facility provider	

Appendix Table 3. **Potential Legal Protection for Clinicians**

Statutes	Examples
Presumed validity of advance directive or appointed agent (except DC, FL, GA, KS, ME, NC, NH, NJ, NY, TX)	In Idaho, the statute ID St § 39-4513(1) states, "No emergency medical services personnel, health care provider, facility, or individual employed by, acting as the agent of, or under contract with any such health care provider or facility shall be civilly or criminally liable or subject to discipline for unprofessional conduct for acts or omissions carried out or performed in good faith pursuant to the directives in a facially valid POLST form or living will or by the holder of a facially valid durable power of attorney or directive for health care."
Cumulative clause (except AK, KS, ME, MD, MA, MI, OR, which do not have cumulative and/or oral advance directive statutes)	In *Camp v. White,* 510 So.2d 166 (Alabama 1987), a competent patient orally refused treatment after physicians determined that she should permanently be placed on a ventilator. Her physicians complied with this oral statement, and the patient died soon thereafter. The patient's daughter sued the physicians for (among other things) failing to obtain her mother's wishes in writing, as required by Alabama's Natural Death Act. The Alabama Supreme Court concluded that written directives are not the only means of communicating patient preferences at the end of life and that following the oral directive of the patient in this case was proper. The physician was not held liable.
Immunity statute (relying on advance directive or agent in "good faith"; upheld in all states)	In *Estate of Maxey v. Darden*, 187 P.3d 144 (Nevada 2008), a patient attempted suicide by overdose. In the emergency department, the patient's ex-husband requested comfort care even though Nevada law prohibits ex-spouses from acting as default agents. The medical team believed that the patient's ex-husband was a valid surrogate and removed life-sustaining treatment, and the patient died. The Nevada Supreme Court stated that a physician's "belief" that an individual was a permitted surrogate was not subject to judicial review.
Provider right of refusal (except IN and MI)	In *Duarte v. Chino* (Duarte et al. v. Chino Community Hospital et al., 72 Cal. App. 4th 849, 1999), a patient in California was in a persistent vegetative state after an automobile accident. The patient had not completed an advance directive or designated an agent. Thus, the patient's family was left to make medical decisions. The family asked the patient's physician to withdraw life-sustaining treatment, but the physician refused. The family and hospital negotiated an agreement that would release the physician and hospital from liability if the physician withdrew treatment, but the physician refused to sign the agreement. The family then sued the hospital and physician. The court held that, under California law, the physician could not be held liable for refusing to withdraw treatment as requested by the patient's family. The court noted that, even if the patient had validly appointed a family member to be an agent, the physician would not be required to withdraw treatment if the agent requested this action. Furthermore, even if the patient directly requested to withdraw treatment through an advance directive or POLST, the physician would not be required to withdraw treatment but only to take reasonable steps to transfer the patient to another facility.

POLST = Physician Orders for Life-Sustaining Treatment.