A Comparison of State Advance Directive Documents

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Purpose: Advance directive (AD) documents are based on state-specific statutes and vary in terms of content. These differences can create confusion and inconsistencies resulting in a possible failure to honor the health care wishes of people who execute health care documents for one state and receive health care in another state. The purpose of this study was to compare similarities and differences in the content of state AD documents. Design and Methods: AD documents for 50 states and the District of Columbia posted on the Partnership for Caring website were reviewed. States and regions of the country were compared for type or types of documents used and issues included in AD documents. Results: Three states had statutory living will documents only; however, these states did allow for appointment of a health care agent for limited end-of-life decisions. Three states had statutory durable power of attorney for health care documents only, and 13 had statutory forms which combine both types of directive in one document (advance health care directives). Of 8 identified key issues, those addressed by at least 90% of states were designation of a proxy, personal instructions for care, general life-sustaining measures, and terminal illness. When document types were compared, advance health care directive documents included more of the key issues than did living will or durable power of attorney for health care documents (p < .001). Implications: This variability suggests a need for national dialogue to standardize some provisions of AD documents.

Key Words: End-of-life treatment decisions, Advance decision making, Medical ethics

Advance directives (ADs) allow adults who have the ability to decide and communicate health care wishes (i.e., capacity) to give directions for future care in the event of incapacity. ADs have been recognized in some form by every state and the District of Columbia. The Patient Self-Determination Act of 1990 provided congressional recognition of the right of self-determination for patients in health care decision making (Rich, 1998). This law requires hospitals, health maintenance and managed care organizations, nursing facilities, hospice programs, and home health providers that participate in Medicare and/or Medicaid to advise patients of their rights to make health care decisions with ADs (Haynor, 1998).

The two most common types of ADs are the living will and the durable power of attorney for health care. The living will is an instructional directive that allows instructions for medical treatment in the event of incapacity at the end of life (typically because of terminal illness or persistent vegetative state). The durable power of attorney for health care is a health care document that allows a person with capacity to name a trusted person to act as a health care agent in the event of incapacity. Although the statutes vary from jurisdiction to jurisdiction, typically the agent has broad powers for decision making when acting in this surrogate role and is not limited to decision making at the end of life.

Legislation in the United States regarding refusal of life-sustaining medical treatment began in 1976 with the passage of the California Natural Death Act. Other states followed with their own legislation for living wills (Fade, 1994). In general, statutes for durable power of attorney for health care were enacted later. Some states provide for only a living will or durable power of attorney for health care, whereas other states allow for both.

In 1993, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Health Care Decisions Act (Uniform Law Commissioners, 1994). This model Act recommended uniformity in ADs across states and replacement of existing fragmented legislation with a single statute in each state that would provide for one comprehensive AD document. In accordance with this Act, some states adopted a third type of AD, typically called an “advance health care directive.” This type of document allows appointment of an agent to make health care decisions and also includes a “living will directive.”
or other health care instructions section. The person completing the document is usually provided the option of crossing out a section that he or she prefers not to complete.

Each state has its own statutes and/or regulations regarding ADs. Variations in state laws and types of ADs may result in a plethora of differences in AD documents, some of which can have important implications for the honoring of patients’ wishes. States may differ not only in the type of document that is explicitly authorized by state law, but also in the extent to which a document mentions specific end-of-life issues. Many state laws address the issue of reciprocity and will honor an out-of-state directive; however, provisions in out-of-state documents are honored only to the extent that they conform to the laws of the state where treatment is provided.

As our society becomes more mobile, it becomes more important to understand state differences in AD documents. More people now travel from state to state, and it is not uncommon for people to maintain residences in two states. Many people live in one state and receive their health care in another state. The purpose of this study is to evaluate, in terms of structure and content, similarities and differences in AD documents across the United States.

**Methods**

We conducted a content analysis of statutory-based AD documents of all 50 states and Washington, DC. For this purpose, we obtained all AD documents posted on the Partnership for Caring (PFC; formerly known as Choice in Dying) website (Partnership for Caring, 2000) as of October 2000. PFC provides state-specific ADs and updates them continually as state statutes and/or documents change.

We included all AD documents from the PFC website that were based specifically on state statutes. Appendix A provides a listing of citations for state statutes as a matter of reference. For six states that had statutes but no suggested forms, PFC drafted documents with the counsel of local attorneys in accordance with the statutes. These states were: Massachusetts (durable power of attorney for health care), Michigan (durable power of attorney for health care), Indiana (durable power of attorney for health care), New Jersey (living will and durable power of attorney for health care), South Dakota (durable power of attorney for health care), and Tennessee (durable power of attorney for health care). For New York, Massachusetts, and Michigan, PFC provided a living will document that has been recognized by case law rather than by statute. These three living will documents were not included in analysis. For three states (Pennsylvania, Louisiana, and Montana), statutes provide for living will only. However, two of these states (Pennsylvania and Louisiana) have durable power of attorney for finances statutes that include a check-off section for health care. In fact, lawyers in all three of these states may draft power of attorney for health care documents providing for broad decision-making authority. For this analysis, these three states were counted as living will only.

Gail Gunter-Hunt, who is a social worker, and two social work graduate students reviewed each document to categorize the type of document and summarize issues addressed in the document. From this, eight topics were defined as key issues in decision-making: (a) naming of any proxy, even when limited to situations of terminal illness or persistent vegetative state; (b) personal instructions for care; (c) general life-sustaining measures; (d) terminal illness; (e) artificial sustenance; (f) persistent vegetative state; (g) admission to a long-term care facility; and (h) advanced illness/dementia. Documents were then reviewed twice more by Gail Gunter-Hunt to determine document type and inclusion of the eight key issues. Document type was defined as living will, durable power of attorney for health care, or advance health care directive. Appendix B provides definitions and equivalent terms for the three document types. Appendix C provides definitions and equivalent language for the eight key issues. An issue was considered as included in a document if the document had wording (first column of Appendix C), a definition (essence of definition in second column of Appendix C) or equivalent language (third column of Appendix C) for that issue. A specific issue was considered as mentioned in the document if some wording was used that indicated the issue was addressed. More specifically, an issue could be automatically included in a document, included only by a check mark of some kind, included unless excluded by a check mark of some kind, or automatically excluded. None of our eight key issues were automatically excluded. When questions arose regarding type or content of a document, decisions were made by consensus between Gail Gunter-Hunt and Jane E. Mahoney, who is a geriatrician.

States and regions of the country were compared for type or types of documents used and issues included in state documents. The 1990 census map identifying four major regions of the country (Northeast, South, Midwest, and West) was used to divide the fifty states plus Washington, DC, into these regions (U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1992). Comparison was made also for frequency of issue inclusion by type of document (living will, durable power of attorney for health care, advance health care directive). Pearson chi-square test was used to determine significance of differences among groups for more than two groups, and Fisher exact test was used for two groups. To determine the significance of differences in mean number of issues across groups, we used one-way analysis of variance (ANOVA) for more than two groups and two-sample t test for two groups. Significance level was set at $p \leq .05$.

**Results**

*Types of Documents Used by States*

All 50 states and the District of Columbia had at least one statute-based AD document. Three states had a liv-
ing will only (with limited proxy) and lacked the durable power of attorney for health care (Pennsylvania, Louisiana, and Montana; 6%). Three states had durable power of attorney for health care only (Massachusetts, New York, and Michigan; 6%). Thirty-two (31 states plus Washington, DC) had both living will and durable power of attorney for health care (63%), and 13 states had the combination document, advance health care directive (25%). Figure 1 shows types of documents officially sanctioned by states and Washington, DC. Although not statistically significant, the South had a larger percentage of states with advance health care directives (41%), compared with 11% of Northeastern states, 8% of Midwestern states, and 31% of Western states ($p = .156$ for comparison across regions).

**Issues Included in State Documents**

We evaluated the extent to which eight identified key issues were covered by state documents. All states allowed naming of a proxy in at least one document. In three states (Pennsylvania, Louisiana, and Montana), the proxy was limited to circumstances of terminal illness and/or persistent vegetative state. In the other 47 states and the District of Columbia, a broad proxy could be named. For the other issues, the extent to which issues were mentioned in state documents varied depending on the issue. As shown in Figure 2, almost all states addressed personal instructions for care, general life-sustaining measures, and terminal illness. Most states addressed artificial sustenance and persistent vegetative state. In contrast, admission to a long-term care facility and advanced illness/dementia were specifically mentioned by less than one fourth of the states.

**Issue Inclusion by Type of Document**

As shown in Table 1, there were substantial differences in issue inclusion according to type of document. Thirty-five states had living wills based on statutes. By definition, the living will included issues related to general life-sustaining measures and terminal illness 100% of the time. However, one third of living will directives made no specific mention of persistent vegetative state or artificial sustenance. A little more than one fourth of living will documents allowed for naming a proxy (limited to end-of-life care); fewer mentioned admission to a long-term care facility or advanced illness/dementia.

Thirty-five states had durable power of attorney for health care documents. By definition, this type of document always appointed a broad proxy (i.e., not limited to terminal illness or persistent vegetative state). Regarding specific mention of other key issues, in general, these documents did less well than either the living will or the advance health care directive.

The 13 advance health care directive documents were the most comprehensive documents, including...
each of the eight issues more frequently or at least as frequently as either of the other document types. A broad proxy could be named in 100% of documents. Personal instructions, general life-sustaining measures, terminal illness, and artificial sustenance each were mentioned in 100% of documents, with persistent vegetative state mentioned in more than 90% of documents. Advance health care directive documents were significantly more likely to mention admission to a long-term care facility than were living will documents. Overall, the advance health care directive included a significantly greater number of the eight key issues, with a mean of 6.3 (SD = 0.6) issues per advance health care directive, compared with 3.5 (SD = 1.6) per durable power of attorney for health care and 4.7 (SD = 1.0) per living will (p < .001, ANOVA).

### Issue Inclusion Comparing States With Advance Health Care Directives Versus States With Other Documents

We compared states that used the advance health care directive document (n = 13) with states that used other types of documents (n = 38). Table 2 shows frequency of inclusion of issues in states with advance health care directive documents versus states without this document. The only significant difference was for artificial sustenance. All states with advance health care directive documents included artificial sustenance in their documents, compared with 74% of states without. Overall, states with advance health care directives included a greater number of the eight issues, with a mean of 6.3 (SD = 0.6) issues included in these state documents, compared with 5.6 (SD = 1.3) issues included in the other state documents (p = .019, two-sample t test).

### Regional Differences

Table 3 shows the frequency of inclusion of key issues in state documents according to region of the country. There were significant differences across regions regarding the inclusion of general life-sustaining measures and admission to a long-term care facility. Northeastern states mentioned general life-sustaining measures significantly less often than did states in other regions (p = .021). Regarding admission to a long-term care facility, no Northeastern or Western states mentioned the issue in their documents; in contrast, 42% of Midwestern and 35% of Southern states included it (p = .013). The average number of issues included in state documents did not differ by region (M = 5.3, SD = 1.7 issues included per state for Northeastern states; M = 6.2, SD = 1.0 for Southern states; M = 5.6, SD = 1.4 for Midwestern states; and M = 5.8, SD = 0.8 for Western states; p = .349, ANOVA).

### Discussion

A recent study (Steinhauser et al., 2000) found in a survey of seriously ill patients, recently bereaved family members, physicians, and other care providers that there was strong agreement in all four groups regarding the importance of having treatment preferences in writing and naming someone to make decisions in the event of incapacity. Despite the perception of importance among the public and health care professionals, the published literature contains limited data examining the type and content of AD documents used by each of the 50 states and the District of Columbia. We found substantial variability across the country both in the types of documents used by states and in the content of documents.

Regarding types of AD documents, most states had statutes providing for both a living will and a

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**Table 1. Frequency of Issue Inclusion by Document Type**

<table>
<thead>
<tr>
<th>Type of document</th>
<th>LW (n = 35)</th>
<th>DPAHC (n = 35)</th>
<th>AHCD (n = 13)</th>
<th>p value of χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any proxy*</td>
<td>10 (29%)</td>
<td>35 (100%)</td>
<td>13 (100%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Personal</td>
<td>35 (100%)</td>
<td>21 (60%)</td>
<td>13 (100%)</td>
<td>.001</td>
</tr>
<tr>
<td>General life-sustaining measures</td>
<td>35 (100%)</td>
<td>26 (74%)</td>
<td>13 (100%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>35 (100%)</td>
<td>5 (14%)</td>
<td>13 (100%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Artificial</td>
<td>23 (66%)</td>
<td>17 (49%)</td>
<td>13 (100%)</td>
<td>.004</td>
</tr>
<tr>
<td>Persistent</td>
<td>23 (66%)</td>
<td>8 (23%)</td>
<td>11 (92%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Long-term care</td>
<td>0 (0%)</td>
<td>8 (23%)</td>
<td>3 (23%)</td>
<td>.010</td>
</tr>
<tr>
<td>Dementia</td>
<td>0 (0%)</td>
<td>8 (23%)</td>
<td>3 (23%)</td>
<td>.010</td>
</tr>
</tbody>
</table>

*Includes District of Columbia.

**Table 2. Frequency of Issue Coverage Comparing States With and Without Advance Health Care Directive (AHCD) Documents**

<table>
<thead>
<tr>
<th>Issue</th>
<th>States With AHCD Documents (n = 13)</th>
<th>States Without AHCD Documents (n = 38)</th>
<th>p value Exact Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any proxy</td>
<td>13 (100%)</td>
<td>38 (100%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Personal instructions</td>
<td>13 (100%)</td>
<td>37 (97%)</td>
<td>.745</td>
</tr>
<tr>
<td>General life-sustaining measures</td>
<td>13 (100%)</td>
<td>36 (95%)</td>
<td>.551</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>13 (100%)</td>
<td>35 (92%)</td>
<td>.405</td>
</tr>
<tr>
<td>Artificial sustenance</td>
<td>13 (100%)</td>
<td>28 (74%)</td>
<td>.037</td>
</tr>
<tr>
<td>Persistent vegetative state</td>
<td>12 (92%)</td>
<td>26 (68%)</td>
<td>.085</td>
</tr>
<tr>
<td>Long-term care facility</td>
<td>3 (23%)</td>
<td>8 (21%)</td>
<td>.579</td>
</tr>
<tr>
<td>Advanced illness/dementia</td>
<td>2 (15%)</td>
<td>6 (16%)</td>
<td>.666</td>
</tr>
</tbody>
</table>

Note: LW = living will; DPAHC = durable power of attorney for health care; AHCD = advance health care directive.
durable power of attorney for health care, but some provided for only one or the other. Only a minority of states had a combination advance health care directive document providing for both types of directives in one document. Besides varying in type of document, states also varied considerably in the extent to which key issues were included in their documents. States with advance health care directive documents included significantly greater numbers of the key issues in their documents compared with states with other types of documents.

In 1989, Emanuel and Emanuel proposed a single “medical directive” that included both treatment preferences and designation of a proxy (Emanuel & Emanuel, 1989). The Uniform Health Care Decisions Act (Uniform Law Commissioners, 1994), which was recommended to all states in 1993 and approved by the American Bar Association in 1994 (Galambo, 1998), called for a single comprehensive directive in each state to replace existing fragmented directives. Despite this, most states continue to maintain separate documents and directives.

We agree with Emanuel and Emanuel (1989) and the Uniform Law Commissioners (1994) that consolidation of ADs into one document may be important. In states that have both a living will and a durable power of attorney for health care, the possibility exists that a person may choose to complete only one type of document. If two documents are available, it is unclear to what extent people fill out both or if they preferentially complete one rather than another. In one Illinois teaching hospital, 64% of all medical ADs were durable powers of attorney for health care, suggesting this type of directive may be preferred (Gross, 1998). Other recent studies lend support to this finding. In the SUPPORT study involving five teaching hospitals in Massachusetts, North Carolina, Ohio, Wisconsin, and California, 66% of the 688 ADs from 569 patients were durable powers of attorney (Teno, Licks, et al., 1997). Likewise, Hammes and Rooney (1998) found that 65% of the ADs used by 540 decedents in a western Wisconsin community were for durable power of attorney for health care. Placing both types of directives together in one document may increase the likelihood of completion of both. Use of one comprehensive directive simplifies completion, as it only needs to be signed and witnessed once. In addition, individuals may not understand the difference between the living will and the durable power of attorney for health care and, when documents are separate, individuals may give inconsistent directions. Having the two directives combined may facilitate understanding of each and provide consistency of provisions between documents.

The Uniform Health Care Decisions Act (Uniform Law Commissioners, 1994) also called for basic standards in advance directive documents to provide consistency across states. Our research demonstrates that lack of uniformity is prevalent, particularly regarding the issues of admission to a long-term care facility and advanced illness/dementia. We agree with the Uniform Law Commissioners that uniformity of basic provisions in documents across states may be important. Ethical and treatment dilemmas may arise for individuals who become incapacitated in a state other than the state in which their AD document was completed. Some states may mandate that certain provisions for care be specifically mentioned for the agent to make a decision. Standardization of state documents to minimally include certain issues may increase the likelihood that an individual’s wishes will be honored regardless of where treatment is received. The availability of standardized documents would provide individuals with baseline provisions that address issues that could arise in any state.

Although it is unclear if the mention of specific issues in ADs actually influences end-of-life care, we suggest that it may be important to include specific issues in AD documents. The literature suggests that inclusion of issues in a document may improve a proxy’s knowledge of the patient’s wishes. Weinberg and Brod (1995) have shown that although individuals may designate a proxy, their health care wishes may not be known to the proxy. Other authors have confirmed that discordance between an individual’s wishes and the proxy’s perception of those wishes is common (Gerety, Chiodo, Kanten, Tuley, & Cor-

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Table 3. Inclusion of Key Issues in States’ Documents According to Region of the Country

<table>
<thead>
<tr>
<th>Issue*</th>
<th>Region of Country</th>
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<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Northeast (n = 9)</td>
<td>South (n = 17)</td>
<td>Midwest (n = 12)</td>
<td>West (n = 13)</td>
<td>p value of χ²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any proxy</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Personal instructions</td>
<td>9</td>
<td>100</td>
<td>17</td>
<td>100</td>
<td>12</td>
<td>100</td>
<td>13</td>
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<tr>
<td>General life-sustaining measures</td>
<td>7</td>
<td>78</td>
<td>17</td>
<td>100</td>
<td>12</td>
<td>100</td>
<td>13</td>
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<tr>
<td>Terminal illness</td>
<td>7</td>
<td>78</td>
<td>17</td>
<td>100</td>
<td>11</td>
<td>92</td>
<td>13</td>
</tr>
<tr>
<td>Artificial sustenance</td>
<td>8</td>
<td>89</td>
<td>13</td>
<td>76</td>
<td>9</td>
<td>75</td>
<td>11</td>
</tr>
<tr>
<td>Persistent vegetative state</td>
<td>6</td>
<td>75</td>
<td>14</td>
<td>82</td>
<td>7</td>
<td>58</td>
<td>11</td>
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<tr>
<td>Long-term care facility</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>35</td>
<td>5</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td>Advanced illness/dementia</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>2</td>
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</table>

*aIssue counted as included by a state if in one or more of its documents.
nells, 1993; Marbella, Desbiens, Mueller-Rizner, & Layde, 1998; Mattimore et al., 1997; Sulmasy et al., 1998; Zweibel & Cassel, 1989). Data suggest that preferences are expressed, however, when specific options about an issue are provided in an AD document (Gross, 1998; Teno, Licks, et al., 1997). Furthermore, Sulmasy and colleagues (1998) have shown that surrogate accuracy improves when the patient has previously expressed preferences to the surrogate.

Thus, an important reason to include issues in AD documents is to enhance the discussion between the principal in the specific document and the proxy. When specific issues are mentioned in a document, the opportunity is provided for the person completing the document to make sure his or her agent understands preferences for care. If the person has never thought about these issues, reference to them in the document may encourage an exploration of the specifics of the issue and some decision making. A discussion prompted by having specific issues mentioned in a document may actually be more important than the actual completion of the document. Emanuel (2000) has suggested that the best discussions and plans for care may not be documented in the directive. The use of a comprehensive AD that mentions specific issues may serve as a vehicle to promote discussion between the patient, family, proxy, and provider regarding the patient’s values and thoughts on quality of life. Orentlicher (1990) suggested that this type of comprehensive document would increase the proxy’s understanding of the patient’s wishes regarding medical care.

Surprisingly, we found that only a minority of state AD documents mentioned issues of admission to a long-term care facility and advanced illness/dementia. With the aging of the United States population and the expanding prevalence of dementia (Report to the Secretary of Health and Human Services, 1998), anticipatory planning regarding long-term care becomes increasingly important. Specific mention of the issues of admission to a long-term care facility and advanced illness/dementia may facilitate anticipatory planning discussions with family and health care providers regarding preferences for care. The person’s values and goals for care can also be explored in the context and can guide the discussion.

There are several limitations to this analysis. First, we examined a select number of issues; other issues such as pain relief and organ donation are also important. Second, a few states did not have statutory documents. Consequently, variations exist within those states as to how AD documents are completed. Third, even for states that do have statutory documents, individuals may use AD forms other than the statutory forms. However, it is likely that forms are drafted that closely resemble statutory forms. A 1998 study found that in one hospital in Illinois, 84 of 86 living wills and 206 of 210 durable powers of attorney for health care directives were standard state forms (Gross, 1998). Fourth, we did not examine specific state statutes; some issues may be addressed in statutes but not mentioned on suggested forms. We felt that it was more relevant to evaluate the forms rather than the statutes, as communication about a specific issue may be neglected when it is not included on the form. Fifth, we did not examine differences in definitions, either in the documents themselves or in accompanying instructions. States may differ substantially in definitions of issues, including definitions of incapacity, terminal illness, and life-sustaining measures, or specific definitions may be lacking. They may also differ in how the choice about an issue is presented. This is an important area for future study.

We also did not compare state documents with the Five Wishes AD (Commission on Aging with Dignity, 2000). The Five Wishes was developed by the Florida Commission on Aging with Dignity in response to what has been perceived to be the overly legal nature of many state AD documents. The document is considered by many to be unique because it is a statement of the patient’s values, as opposed to just a statement about specific medical interventions or who the person wants to act as agent. It speaks to all of a person’s needs: medical, personal, emotional, and spiritual. Differences in state statutes have led to state-by-state variation in acceptance of this document.

Finally, we are unable to determine how these real or perceived legal standards affect clinical care. Application of the law is likely to vary depending on the provider, attorney, health care setting, or degree of advocacy for a particular patient. Specific providers may fail to understand the law or decide to ignore it. The practice setting (home, hospital, nursing home) could also have an impact on whether the standards are correctly applied, as legal oversight might be greater in one setting than another. Data from the SUPPORT study suggest that although family members feel ADs aid them in end-of-life decision making, there is no evidence that ADs affect physician management (Teno, Lynn, et al., 1997).

In summary, this study demonstrated that there are substantial differences in types of AD documents used across the United States. Only a minority of states uses a document combining living will and durable power of attorney for health care. Whereas some end-of-life issues are included in almost all state documents, issues of admission to a long-term care facility and advanced illness/dementia, which are particularly relevant to an aging population, are mentioned only infrequently. Advances in medical technology along with the clinical realities of a longer life span, an increase in the incidence of dementia in the general population, and a more mobile society are all factors that drive the need for comprehensive documents that reflect the complexities of medical decision making today.

References


**Appendix A**

**State Statute Citations**

<table>
<thead>
<tr>
<th>State</th>
<th>Statute Title</th>
<th>Citations</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Natural Death Act</td>
<td>Ala. Code §§ 22-8A-1 to 22-8A-10</td>
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<tr>
<td>Alaska</td>
<td>Rights of Terminally Ill Act</td>
<td>Alaska Stat. §§ 18.12.010 to 18.12.100</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Rights of the Terminally Ill or Permanently Unconscious Act</td>
<td>Ark. Code Ann. §§ 20-17-201 to 20-17-217</td>
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<tr>
<td>California</td>
<td>California Health Care Decisions Law</td>
<td>Cal. Prob. Code §§ 4600 to 4805</td>
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<tr>
<td>Delaware</td>
<td>Health-Care Decisions Act</td>
<td>Del. Code Ann. tit. 16, §§ 2501 to 2518</td>
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<td>District of Columbia</td>
<td>Natural Death Act</td>
<td>D.C. Code Ann. §§ 6-2421 to 6-2430</td>
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<td>Health-Care Decisions Act</td>
<td>D.C. Code Ann. §§ 21-2201 to 21-2213</td>
</tr>
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</table>

(Table continues on next page)
Appendix A

State Statute Citations (Continued)

Hawaii
Uniform Health-Care Decisions Act, Haw. Rev. Stat. §§ 327E-1 to 327E-16
Idaho
Natural Death Act, Idaho Code §§ 39-4501 to 39-4509
Illinois
Indiana
Living Will and Life-Prolonging Procedures Act, Ind. Code Ann. §§ 16-36-4-1 to 16-36-4-21
Powers of Attorney Act, Ind. Code Ann. §§ 30-5-1-1 to 30-5-10-4
Iowa
Life-sustaining Procedures Act, Iowa Code Ann. §§ 144A.1 to 144A.12
Power of Attorney Act, Iowa Code Ann. §§ 144B.1 to 144B.12
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Health Care Proxies by Individuals Act, Mass. Ann. Laws ch. 201D
Michigan
Minnesota
Mississippi
Uniform Health-Care Decisions Act, Miss. Code Ann. §§ 41-41-201 to 41-41-229
Missouri
Montana
Durable Power of Attorney for Health Care, Mont. Code Ann. §§ 72-5-501 to 75-5-502
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
Health-Care Proxy Act, N.Y. Pub. Health Law §§ 2980 to 2994
North Carolina
Rights of the Natural Death Act, N.C. Gen. Stat. §§ 90-320 to 90-322
North Dakota
Uniform Rights of the Terminally Ill Act, N.D. Cent. Code §§ 23-06.4-01 to 23-06.4-14
Durable Powers of Attorney for Health Care Act, N.D. Cent. Code §§ 23.06.5-01 to 23.06.5-18

(Table continues on next page)
Appendix A

State Statute Citations (Continued)

Ohio
Modified Uniform Rights of the Terminally Ill Act, Ohio Rev. Code Ann. §§ 2133.01 to 2133.15
Power of Attorney for Health Care Act, Ohio Rev. Code Ann. §§ 1337.11 to 1337.17

Oklahoma
Rights of the Terminally Ill or Persistently Unconscious Act, Okla. Stat. Ann. tit. 63, §§ 3101.1 to 3101.16

Pennsylvania

South Carolina

South Dakota
Living Wills Act, S.D. Codified Laws §§ 34-12D-1 to 34-12D-22
Durable Powers of Attorney Act, S.D. Codified Laws §§ 59-7-2.1 to 59-7-2.8, 59-7-8

Tennessee
Durable Power of Attorney for Health Care Act, Tenn. Code. Ann. §§ 34-6-201 to 34-6-214

Texas
Advance Directive Act, Tex. Health & Safety Code Ann. §§ 166.001 to 166.166

Utah
Personal Choice and Living Will Act, Utah Code Ann. §§ 75-2-1101 to 75-2-1119

Vermont

Virginia

Washington
Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.920

West Virginia

Wisconsin
Declaration to Physicians and Do-Not-Resuscitate Orders Act, Wis. Stat. Ann. §§ 154.01 to 154.29

Wyoming

Appendix B

Definitions and Other Accepted Names for Document Types

<table>
<thead>
<tr>
<th>Document</th>
<th>Working definition</th>
<th>Other names for document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Will</td>
<td>Document that allows competent adult to give directions for future care in the event of incapacity due to terminal illness or impending death.</td>
<td>Declaration to Physicians, Directive to Physicians</td>
</tr>
<tr>
<td>Durable Power of Attorney for Health Care</td>
<td>Health care proxy document that allows a person to name a trusted person to act as agent with broad powers to make health care decisions in the event of incapacity.</td>
<td>Appointment of a Health Care Representative, Health Care Proxy</td>
</tr>
</tbody>
</table>
## Definitions and Equivalent Language Examples for Key Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Working Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proxy</td>
<td>Person designated to make surrogate decisions. Designation of proxy may be for limited or broad purposes.</td>
<td>Personal representative Agent Surrogate</td>
</tr>
<tr>
<td>Personal Instructions</td>
<td>Designation of any specific desires about treatment, provisions for care or limitations on medical care.</td>
<td>Other wishes Special provisions</td>
</tr>
<tr>
<td>General Life Sustaining</td>
<td>Treatment without which the patient will die, excluding artificial nutrition and hydration.</td>
<td>Life prolonging Death delaying treatment Mechanical respiration</td>
</tr>
<tr>
<td>Terminal Illness</td>
<td>Incurable condition from which there is no recovery, to a reasonable degree of medical certainty, and death is likely to occur within a relatively short time.</td>
<td>Incurable or terminal condition</td>
</tr>
<tr>
<td>Artificial Sustenance</td>
<td>Provision of food and water through a tube or intravenous line.</td>
<td>Artificial nourishment and hydration Tube feeding</td>
</tr>
<tr>
<td>Persistent Vegetative State</td>
<td>Condition expected to last permanently, without improvement, and in which thought, sensation, purposeful action, social interaction, and awareness of self are absent.</td>
<td>Permanently unconscious Comatose with no reasonable expectation of regaining consciousness</td>
</tr>
<tr>
<td>Admission to a Long-Term Care Facility</td>
<td>Authorization for admission to a facility providing extended skilled and/or intermediate nursing care.</td>
<td>Nursing home Nursing care facility Health care facility Place where person gets care</td>
</tr>
<tr>
<td>Advanced Illness/Dementia</td>
<td>Irreversible end-stage condition characterized by severe and permanent deterioration and dependency.</td>
<td>Severe dementia End-stage condition</td>
</tr>
</tbody>
</table>