ADVANCE DIRECTIVES FOR MENTAL HEALTH: AN ETHICAL ANALYSIS OF STATE LAWS & IMPLICATIONS FOR VHA POLICY

A Report by the National Ethics Committee of the Veterans Health Administration

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Founded in 1986, the National Ethics Committee (NEC) of the Veterans Health Administration (VHA) is an interdisciplinary group authorized by the Under Secretary for Health through the National Center for Ethics in Health Care. The NEC produces reports on timely topics that are of significant concern to practicing health care professionals. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current controversies, and outlines practical recommendations. Previous reports have been useful to VHA professionals as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA.

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Executive Summary

Advance directives are designed to give patients some measure of control over their own health care in the event they lose decision-making capacity. Originally developed in the context of decisions regarding end-of-life care, advance directives are now being promoted as a mechanism for enabling patients with severe mental illness to retain control over their psychiatric treatment in the event of a mental health crisis. Like other advance directives, MHADs allow patients to specify preferences to receive or to refuse particular interventions.

This report by VHA's National Ethics Committee examines whether current VA policy on advance directives is adequate to meet the needs of patients who receive mental health care in VA. The Committee examines this question in light of various provisions in state laws that distinguish MHADs from other types of advance directives.

In our view current VA policy, which folds MHADs into advance care health planning overall, appropriately meets the needs of patients with chronic, severe mental illness. We find many of the provisions in state statutes pertaining to MHADs to be unnecessary for VHA or even ethically problematic insofar as they make exceptions for patients completing MHADs that do not apply to patients completing general advance directives or may have the effect of limiting the rights of patients with mental illness relative to other patients.

In its present form VA policy for advance care planning supports the goals of the President's New Freedom Commission and similar initiatives, as well as VA's Mental Health Strategic Plan, to improve mental health care. By providing an opportunity for patients who are at risk of periodically losing decision-making capacity due to mental illness to make their preferences for treatment and/or surrogate decision maker known in an advance directive, current VA policy supports the goals of promoting autonomy and shared decision making and empowers patients with mental illness. Further, by addressing advance care planning for mental health care in parity with general advance health care planning VA's current policy avoids the misplaced "exceptionalism" that might impede efforts to eliminate the stigma historically associated with mental illness. Thus the National Ethics Committee concludes that, with the exception of clarifying the language Handbook 1004.2 at paragraph 9.b.(1)(b) to more clearly express the underlying intent of restricting who may serve as witness, no changes in VA policy governing advance care planning for mental health need be contemplated at this time.

Introduction

Advance directives are designed to give patients some measure of control over their own health care in the event they lose decision-making capacity. Originally developed in the context of decisions regarding end-of-life care, advance directives are now being promoted as a mechanism for enabling patients with severe mental illness to retain control over their psychiatric treatment in the event of a mental health crisis. Like other advance directives, MHADs allow patients to specify preferences to receive or to refuse particular interventions.

Advocates of mental health advance directives (MHADs), also called psychiatric advance directives, have suggested that these new instruments carry other benefits as well. For example, they suggest that using MHADs can enhance relationships between patients and mental health professionals and increase patients' adherence to therapy,[1-5] promote early treatment to prevent mental health crises, [1,6,7] decrease the need for involuntary treatment, [4] and reduce hospitalization rates for psychiatric patients.[7-10] However, like general advance directives, MHADs allow patients to specify preferences to receive or to refuse particular interventions.

VA recently revised its national policy on advance care planning to address MHADs.[11] The revised policy specifically mentions MHADs as tools for patients who are at risk for losing decision-making capacity in the future due to mental illness and explains that patients may document treatment preferences for mental health just as they may document other types of treatment preferences—that is, on a state-authorized advance directive form or on VA Form 10-0137. [12] Thus policy treats MHADs no differently from other advance directives for health care.

In light of growing advocacy for separate MHADs, questions have recently been raised about whether VA policy on advance directives is adequate to meet the needs of patients who receive mental health care in VA. This report by VHA's National Ethics Committee examines this question in light of various provisions in state laws that distinguish MHADs from other types of advance directives.

State Approaches to Mental Health Advance Directives

In many states, generic advance directives can be used to document preferences for psychiatric treatment. However, because advance directives were originally developed to document preferences about end-of-life care, the language used in some advance directive statutes and advance directive forms is not well suited to documenting preferences for mental health treatment. For example, in some states the form used to document treatment preferences only takes effect when the attending physician determines that the patient has a "terminal condition" or is in a persistent vegetative state.[*] Moreover, some states specifically limit the degree to which advance directives can be used to make decisions about mental health care—for example, by limiting the ability of the health care agent to make decisions for psychiatric treatment.[†]

In response to these limitations, as well as the advocacy efforts of proponents of MHADs, fully half of all states have adopted separate MHAD statutes designed for psychiatric patients who experience fluctuating decision-making capacity, such as individuals with schizophrenia or bipolar disorder. These statutes often include features that are not found in traditional advance directive statutes or current VA policy. Notably, some state MHAD statutes:

- require that MHADs automatically expire after a certain period
- place special restrictions on who may serve as witness

[*] Alaska, Illinois, and Wisconsin
† North Dakota and Wisconsin

- identify special circumstances under which clinicians need not follow a MHAD
- require that clinicians assess decision-making capacity for patients completing a MHAD
- allow activation of the MHAD before the patient loses decision-making capacity
- restrict the conditions under which the patient may revoke the MHAD

The sections that follow explore whether these special features should be incorporated into VA policy.

Automatic Expiration

Automatic expiration is unique to MHADs; other advance directives remain in effect until they are revoked or until they expire on a date directed by the patient. Advocates for MHADs argue that mandating that the directive expire after a specific interval helps to ensure that these directives continue to reflect patients' preferences as new treatment options become available or their individual circumstances and goals for treatment change. [2,4] Advocates contend that requiring patients to execute new directives on a regular basis improves shared decision making and fosters constructive dialogue with mental health professionals. [2,13,14]

Ten states currently provide for automatic expiration of MHADs after a specified period, which varies from two to five years.[‡] When the directive expires, a patient in these states must take the affirmative step of executing a new advance directive for mental health treatment.

From an ethical perspective, automatic expiration is problematic in several respects. Automatic expiration seems an overly blunt instrument if the goal is to foster ongoing dialogue about the patient's treatment preferences and goals for care and to ensure that the directive reflects the patient's wishes as they change over time. On this reasoning, automatic expiration should apply equally to all treatment directives, not just those for mental health care. The desire to foster regular dialogue about advance care planning is often cited with respect to general advance directives. And we know that patients' preferences often change over the course of illness, especially as their health declines.

Moreover, automatic expiration of the MHAD imposes a unique burden on patients with severe mental illness that is not imposed on other patients—i.e., to track the age of their advance directives and take affirmative steps to keep them active. Should the directive expire while the patient believes that the document is current and active, the individual risks losing the opportunity to guide treatment that the directive affords should he or she lose decision-making capacity. The additional burden of actively "managing" the advance directive might be ethically justifiable if there were evidence to suggest that preferences expressed in mental health directives are less stable than preferences expressed in other advance directives. But we are not aware of any data to suggest that this is the case. Absent such evidence, "exceptionalizing" mental health patients through automatic expiration of advance directives seems ethically unjustified, especially at a time when advocates are seeking to reduce the stigma of mental illness and create parity for mental health care.[15]

As noted above, VA policy treats all advance directives uniformly. Current VA policy fosters routine and ongoing communication between clinicians and patients about the content of advance directives and encourages patients to regularly reassess their stated treatment preferences and goals for care by requiring that VA primary care providers review the content of the advance directive with the patient at least every three years and more often if the patient is at high risk of losing

[‡] Illinois, Louisiana, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee. Texas, Utah, and Wyoming

decision-making capacity.[§] Under VA policy all advance directives remain valid until the competent patient revokes them; patients are not burdened with the responsibility of ensuring that their advance directive remains in effect.[**]

> *Should VA advance directive policy be changed to mandate automatic expiration of advance directives for mental health? No. For the reasons noted above, the National Ethics Committee concludes that there is no compelling reason to treat mental health advance directives differently from other types of advance directives on this point.*

Witness Restrictions

Commentators have noted that a MHAD can be a potent weapon to coerce vulnerable patients to accept certain types of treatment. [3,13] They argue that patients may feel coerced by health care professionals or family to choose certain treatment options under the perceived threat of involuntary confinement and forced administration of medication. [2,17,18]

Fears of coercion or undue influence have prompted 24 of the 25 states with separate MHAD statutes (all except Montana) to restrict who can serve as a witness for a MHAD. For example, several state statutes prohibit members of the patient's family from serving as witness.[††] Many exclude members of the treatment team.[‡‡] Under most of these statues witnesses attest, among other things, that the patient executed the MHAD voluntarily.[§§] But while many studies have examined perceived coercion in mental health, most have focused on specific interventions, such as electroconvulsive therapy[19] or forced administration of antipsychotic medication.[20] There are no empirical studies on whether patients drafting a MHAD feel coerced into making certain specific treatment choices or whether the choice of particular witnesses have any impact on the patient's decisions.

Moreover, concern that witnesses may influence the treatment preferences a patient documents in his or her advance directive is by no means unique to MHADs. Forty-four states also restrict who may serve as a witness for general advance directives.

VA policy requires two witnesses sign a VA advance directive.[11,12] Nonclinical employees of the VA treatment facility are authorized to serve as witness. Clinical employees are prohibited from serving as witness unless they are members of the patient's family or are employees of the Chaplain Service, Psychology Service, or Social Work Service.

The intent of VA policy is to protect patients from potential coercion by prohibiting from serving as witnesses for advance directives doctors, nurses, and other clinicians whose interests—including strongly held beliefs about appropriate care—may be significantly affected by the patient's treatment decisions. However, in the context of MHADs these provisions may not be sufficiently sensitive with respect to the potential for coercion, undue influence, or conflict of interest. Notably,

[§] We recognize that primary care providers are not uniformly well prepared to assist patients in completing or reviewing advance directives for mental health. It's important, therefore, that primary care providers ensure that patients who have MHADs review their directives with an appropriately qualified provider. Primary care providers should recognize that signs of mental decompensation should routinely trigger review of the MHAD.

[**] We should note that even an advance directive that has expired under a state statute may provide important guidance to clinicians and surrogates, supplying information about the patient's values, goals for care, and preferences. [16]

[††] Arizona, Hawaii, Idaho, Illinois, Kentucky, Michigan, New Mexico, North Carolina, Oregon, Tennessee, Texas, and Washington

[‡‡] Arizona, Hawaii, Idaho, Illinois, Kentucky, Michigan, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania., South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming

[§§] Five states [IN, ME, MD, MN, WY] do not require witnesses to MHADs to attest that the patient is executing the directive voluntarily; nor do they require that witnesses attest to the voluntariness of a general advance directive.

in mental health licensed clinical psychologists and social workers often have primary responsibility in providing therapy or directing and developing treatment plans mental health treatment. Permitting these clinical employees to witness mental health advance directives may undercut the protection otherwise afforded to patients to ensure the voluntariness of the treatment choices they express in an advance directive.

There is no clear evidence to indicate that witnesses to an advance directive have a coercive effect on the patient, but we are concerned that the intent of VA policy may not be fully realized in the case of patients completing a mental health advance directive.

> *Should VA policy be changed to place special restrictions on who may serve as a witness for a mental health advance directive? No. However, the committee urges that witnessing provisions of Handbook 1004.2, paragraph 9.b.(1)(b) be revised to prohibit any clinical employee who is providing medical or mental health treatment for a patient from witnessing that patient's advance directive.*

Override Provisions

Typically, clinicians are required to follow the patient's preferences as expressed in an advance directive except under very narrow circumstances, as when the patient's preferences fall outside the acceptable standard of care or are for treatments that are not available within the health care system, are medically ineffective, or are inconsistent with law. These are the same circumstances under which clinicians would not be required to honor the contemporaneous treatment choices of a competent patient.

Seventeen states currently give clinicians greater leeway *not* to follow a MHAD than they do with a general advance directive.[***] These same seventeen states permit a clinician not to follow a MHAD when the patient has been committed for inpatient treatment and in the event of "emergency" (which most of the statutes do not further define). A few give clinicians even greater latitude than this—e.g., Louisiana permits clinicians to disregard a patient's previously expressed refusal of psychotropic medication if the clinician deems the medication "essential."

However, allowing clinicians significant latitude to override a patient's competent, previously expressed preferences undermines the primary intent of advance care planning: to enable the patient's treatment preferences to guide care when he or she is no longer able to participate in decision making. It effectively vitiates the role of advance directives in promoting patient autonomy and self-determination.

Further, provisions that identify situations in which decision makers need not follow a patient's MHAD exhibit the kind of questionable mental health "exceptionalism" we noted above with respect to provisions for automatic expiration of MHADs. This may be both ethically and legally problematic. The sole federal case on the subject is *Hargrave v. Vermont.*[21] The court held that Vermont's override law, which applied only to persons with mental health disorders, discriminated on the basis of disability and therefore violated federal law.

Under current VA policy, patients who complete a mental health advance directive are afforded the same assurances as all other patients that clear treatment preferences for future care will be honored, with narrow exceptions as noted above. If there is a disagreement between the treatment team and the patient's surrogate on how to interpret the advance directive, VA policy provides a mechanism to resolve the conflict.[11]

As a general rule, patients' preferences expressed in a valid mental health advance directive should be respected just as they would if expressed in a general advance directive. Appropriate steps

[***] Hawaii, Idaho, Illinois, Kentucky, Louisiana, Michigan, Minnesota, New jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, and Washington

must be taken to protect the patient and others from harm (such as involuntary commitment, restraints, etc.), which may require overriding the preferences expressed in an advance directive. However, by itself neither involuntary commitment, emergencies, nor a determination that treatment is essential is sufficient to warrant automatically disregarding the patient's preferences as expressed in an MHAD.

> *Should VA policy identify special circumstances in which clinicians need not follow a mental health advance directive? No. The committee believes that clinicians should have no greater latitude to override mental health directives than to override general advance directives.*

Capacity Assessment

It has also been suggested that clinicians should assess decision-making capacity before the patient completes a MHAD. The argument is that clinicians may be reluctant to follow MHADs because they question whether patients with serious mental illness had sufficient decision-making capacity at the time they completed the directive.[2,7,13,22] And indeed surveys suggest that mental health clinicians would be more likely to follow instructions when the form is countersigned by a clinician attesting that the patient was competent when the document was signed. [23]

At present only two states explicitly require that a mental health professional make a clinical determination that a patient has decision-making capacity in order to complete an MHAD.[†††] In contrast, no state requires capacity assessment by a mental health professional for patients completing general advance directives. To be sure, witnesses to general advance directives are often required to attest that the patient appears to be "of sound mind" (or similar language). But these judgments are different from a mental health professional's formal assessment of decision-making capacity. Like the vast majority of states, VA does not require clinicians to formally assess the patient's decision-making capacity for purposes of completing a mental health directive.

Requiring formal clinical assessment of capacity to complete a MHAD seems yet another form of ethically unjustified exceptionalism. Typically, we do not require capacity assessment for patients who wish to complete general advance directives. Rather, patients are presumed have decision-making capacity and formal assessment is carried out only when, in the clinician's judgment, there is reason to be concerned that the individual may lack capacity. Moreover, most patients who complete advance directives do so outside clinical settings and there is thus no opportunity to assess their decision-making capacity. To our knowledge, there is no compelling evidence to suggest that patients engaged in advance care planning for mental health are any more likely to lack capacity than are individuals with a history of Alzheimer's disease, stroke, or other conditions that may impair decision-making capacity. To require that capacity routinely be determined just for patients who wish to complete a MHAD singles these patients out for "special" treatment and creates a barrier to advance care planning that other patients do not face. This could discourage patients from completing an advance directive and is not consistent with overall goals of promoting autonomy and empowering patients with mental illness, of reducing the stigma associated with mental illness, and of ensuring parity for mental health as a health care priority.[15,24]

> *Should VA policy be changed to require that clinicians automatically assess decision-making capacity for patients completing MHADs? No. The committee concludes that requiring formal capacity assessment specifically for patients who wish to complete a mental health advance directive would not be appropriate.*

††† Indiana and Louisiana

> *However, the committee recognizes that patients themselves may wish to seek assessment of their decision-making capacity at the time they complete an MHAD so that a note attesting to their capacity may be incorporated into their health record to allay potential future concerns about whether the directive represents the individual's authentic treatment preferences.*

Early Activation

One of the more controversial features of some MHAD statutes is provisions allowing activation of the directive before the patient is determined to have lost decision-making capacity. Advocates argue for early activation out of concern that patients who are approaching a mental health crisis, but who have not yet lost decision-making capacity, may make treatment choices that do not reflect their true intent[9,13] or their "true self."[25] For example, patients with bipolar disorder who are entering into a manic phase may not recognize that they are ill or may refuse medical care. Early activation of the MHAD, it is argued, would help ensure that patients like these to state in advance that they wish to be treated and therefore receive more timely treatment.[26,27] In an effort to achieve this goal, six states allow patients to designate a point before loss of decision-making capacity at which the individual wishes the MHAD to be used as the basis of decision making.[‡‡] In the remaining 19 states with separate MHAD statutes, the directive is not activated unless the patient is deemed incapable of making his or her own decisions.

There is some merit to the argument that the patient may be in the best position to judge whether he or she is in danger of losing capacity and is in need of mental health intervention based on his or her own past experience.[5] Yet allowing early activation—that is, allowing the patient to specify situations other than loss of decision-making capacity at which he or she intends a valid MHAD to be implemented—can be problematic, *if the expectation is that the treatment directive (or a decision by the patient's health care agent) will prevail over contemporaneous preferences expressed by a patient who has not yet been determined to have lost decision-making capacity.*

A number of states allow patients with valid general advance directives who have decision-making capacity to ask others to make decisions for them, guided by the directive.[§§§] But by completing advance directives patients do not relinquish their autonomy or their right to participate in decisions about their health care. A patient who has decision-making capacity can always make decisions different from the preferences expressed in his or her advance directive or from decisions made by the agent to whom the patient delegated decision-making authority. That is, the patient who has not been determined to have lost decision-making capacity can always override the directive.

This principle holds equally for MHADs, as recognized even in those statutes that allow patients executing such directives to define situations other than loss of capacity as criteria for implementing the directive.

VA policy likewise upholds the principle that until and unless a patient has been deemed not to have decision-making capacity, his or her contemporaneous decision should prevail over wishes stated in an advance directive. VHA Handbook 1004.2 specifically states that "an advance directive is not to be used as the basis for decision making while the patient has decision-making capacity. The existence of an advance directive never precludes the requirement to discuss treatment options with a patient who has decision-making capacity."[11]

‡‡ Hawaii, Maine, New jersey, New Mexico, Pennsylvania, and Washington

§§§ In fact, in a number of states the directive becomes effective upon signing, unless the patient specifies an alternate activation date.(Alaska, California, Georgia, Hawaii, Illinois, Indiana, Maine, Maryland, Michigan, Missouri, New Mexico, Vermont, and Wyoming)

The MHAD can be a valuable tool for engaging the patient in conversation about treatment decisions whether or not the patient's situation meets the criteria under which the directive is to be implemented. Clinicians can review with the patient the preferences expressed in a valid MHAD to help guide decision making, drawing on the directive to remind patients who are in the early stages of a mental health crisis of what they previously said they wanted as part of a process of shared decision making.

When a patient who was previously able to make treatment decisions now appears to be unwilling or unable to do so, it may be evidence that the individual may have lost decision-making capacity. Under VA policy, this kind of situation should trigger a clinical assessment of decision-making capacity.[11] The clinician should explore with the patient why he or she is unwilling to make a decision; if the patient cannot communicate the reason underlying his or her reluctance or inability to decide this is evidence that the individual has in fact lost decision-making capacity.

Early activation can be problematic in other regards as well. Allowing activation of the directive before loss of decision-making capacity would single out patients who have MHADs for special treatment, potentially reinforcing the stigma of mental illness and undermining the goal of parity for mental health care. In addition, whether early activation in fact accomplishes the stated goal of facilitating early intervention and decreasing the need for hospitalization is an empirical question about which there is little evidence at present. The only two studies conducted to date were small and yielded inconsistent results.[28,29]

Should VA policy be changed to allow a patient to specify a point prior to loss of decision-making capacity at which a mental health advance directive becomes active? No. To the committee, early activation seems unnecessary to achieve the goal of supporting timely intervention in keeping with a patient's previously expressed treatment preferences.

Revocation After Loss of Decision-Making Capacity

Linked to early implementation is the issue of whether patients who have lost decision-making capacity may revoke an advance directive for mental health treatment. This has been a concern raised by some clinicians.[23,30]

In most states (36 out of 50) a patient may revoke a general advance directive at any time, even if he or she has lost decision-making capacity. In contrast, most states that have MHAD statutes (18 out of 25) are more restrictive in that they only allow revocation of MHADs if the patient has decision-making capacity. Like the majority of MHAD statutes, VA policy restricts revocation of advance directives to patients who have decision-making capacity—even for general advance directives.[11]

The rationale behind restricting revocation of advance directives to capacitated patients is that, in general, the reasoned choices specified in advance and committed to writing in a formal document are more likely to reflect the authentic values of the patient than the choice of an incapacitated patient.[25,31,32] Autonomy is best served by respecting decisions the patient made while fully able to consider values and goals of care and able to thoughtfully weigh the risks and benefits of different treatment options.

Should VA policy be changed to make revocation of MHAD more restrictive than revocation of general advance directives? No. The committee concludes that VA's current policy provisions requiring that patients have decision-making capacity in order to revoke an advance directive is already sufficiently restrictive to protect the interests of all patients..

CONCLUSION

Advance directives for mental health are relatively new instruments and the deliberative process in state legislatures has resulted in several approaches to MHADs. Like half of the states, VA considers advance directives for mental health to be part of overall advance health care planning.

As we have seen, some states—including several with very narrowly drawn general advance directive statutes—have enacted special provisions that apply only to advance directives for mental health. However, there is little practical experience with MHADs and as yet there are very few studies that address the use or effectiveness of this tool. Nor has the utility of treating MHADs differently from other types of advance directives been well studied. Case law regarding MHADs is equally limited. Finally, there is as yet no clear consensus in the professional community regarding "best practice" in advance care planning for mental health treatment.

Given these considerations, in our view current VA policy, which folds MHADs into advance care health planning overall, appropriately meets the needs of patients with chronic, severe mental illness. We find many of the provisions in state statutes pertaining to MHADs to be unnecessary for VHA or even ethically problematic insofar as they make exceptions for patients completing MHADs that do not apply to patients completing general advance directives or may have the effect of limiting the rights of patients with mental illness relative to other patients.

In its present form VA policy for advance care planning supports the goals of the President's New Freedom Commission and similar initiatives, as well as VA's Mental Health Strategic Plan, to improve mental health care. By providing an opportunity for patients who are at risk of periodically losing decision-making capacity due to mental illness to make their preferences for treatment and/or surrogate decision maker known in an advance directive, current VA policy supports the goals of promoting autonomy and shared decision making and empowers patients with mental illness. Further, by addressing advance care planning for mental health care in parity with general advance health care planning VA's current policy avoids the misplaced "exceptionalism" that might impede efforts to eliminate the stigma historically associated with mental illness. Thus the National Ethics Committee concludes that, with the exception of clarifying the language Handbook 1004.2 at paragraph 9.b.(1)(b) to more clearly express the underlying intent of restricting who may serve as witness, no changes in VA policy governing advance care planning for mental health need be contemplated at this time.

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Mental Health Advance Directives Statutes

Arizona - Ariz. Rev. Stat. Ann. §§ 36-3281 to 36-3292

Hawaii - Haw. Rev. Stat. §§ 327G-1 to 327G-14

Idaho - Idaho Code §§ 66-601 to 66-613

Illinois - Ill. Comp. Stat. Ann. ch. 755, §§ 43/1 to 43/115

Indiana - Ind. Code Ann. §§ 16-36-1.7-1 to 16-36-1.7-5

Kentucky - Ky. Rev. Stat. Ann. §§ 202A.420 to 202A.432

Louisiana - La. Rev. Stat. Ann. §§ 28:221 to 28:235

Maine – Me. Rev. Stat. Ann. Tit. 18-A §§ 5-802(i) and Tit. 34-B §§ 3831 to 3862

Maryland - Md. Code Ann., Health-Gen. §§ 5-602.1 to 5-604

Michigan - Mich. Comp. Laws Ann. §§ 700.5506

Minnesota - Minn. Stat. Ann. § 253B.03 Subd. 6d

Montana – Mont. Code Ann. § 53-21-153

New Jersey - N.J. Stat. Ann. §§ 26:2H-102 to 26:2H-125

New Mexico - N.M. Stat. Ann. §§ 24-7B-1 to 24-7B-16

North Carolina - N.C. Gen. Stat. §§ 122C-71 to 122C-77

Ohio - Ohio Rev. Code Ann. §§ 2135.01 to 2133.14

Oklahoma - Okla. Stat. Ann. Tit. 43A, §§ 11-101 to 11-112

Oregon - Or. Rev. Stat. §§ 127.700 to 127.737

Pennsylvania - Pa. Cons. Stat. Tit. 20 §§ 5801 to 5845

South Dakota - S.D. Codified Laws §§ 27A-16-1 to 27A-16-18

Tennessee - Tenn. Code. Ann. §§ 33-6-1001 to 33-6-1015

Texas - Tex. Civil Practice & Remedies Code Ann. §§ 137.001 to 137.011

Utah – Utah Code Ann. §§ 62A-15-1001 to 62A-15-1004

Washington - Wash. Rev. Code Ann. §§ 71.32.010 to 71.32.260

Wyoming - Wyo. Stat. Ann. §§ 3-22-301 to 3-22-308

General Advance Directive state statutes

Alabama
Natural Death Act, Ala. Code §§ 22-8A-1 to 22-8A-10
Durable Power of Attorney Act, Ala. Code § 26-1-2

Alaska
Health Care Decisions Act, Alaska Stat. §§ 13.52.010 to 13.52.395
Statutory Form Power of Attorney Act, Alaska Stat. §§ 13.26.332 to 13.26.358

Arizona
Living Wills and Health Care Directives Act, Ariz. Rev. Stat. Ann. §§ 36-3201 to 36-3262

Arkansas
Rights of the Terminally Ill or Permanently Unconscious Act, Ark. Code Ann. §§ 20-17-201 to 20-17-217
Durable Power of Attorney for Health Care Act, Ark. Code Ann. §§ 20-13-104

California
California Health Care Decisions Law, Cal. Prob. Code §§ 4600 to 4948

Colorado
Medical Treatment Decision Act, Colo. Rev. Stat. §§ 15-18-101 to 15-18-113
Patient Autonomy Act, Colo. Rev. Stat §§ 15-14-501 to 15-14-509 and 15-14-601 to 15-14-611

Connecticut
Removal of Life Support Systems Act, Conn. Gen. Stat. Ann. §§ 19a-570 to 19a-580d
Statutory Short Form Durable Power of Attorney, Conn. Gen. Stat. Ann. §§ 1-42 to 1-54a

Delaware
Health-Care Decisions Act, Del. Code Ann. Tit. 16, §§ 2501 to 2518

District of Columbia
Natural Death Act, D.C. Code Ann. §§ 7-621 to7-630
Health-Care Decisions Act, D.C. Code Ann. §§ 21-2201 to 21-2213

Florida
Health Care Advance Directives Act, Fla. Stat. Ann. §§ 765.101 to 765.404

Georgia
Living Wills Act, Ga. Code Ann. §§ 31-32-1 to 31-32-12
Durable Power of Attorney for Health Care Act, Ga. Code Ann. §§ 31-36-1 to 31-36-13

Hawaii
Uniform Health-Care Decisions Act, Haw. Rev. Stat. §§ 327E-1 to 327E-16
Durable Power of Attorney for Health Care Decisions Act, Haw. Rev. Stat. §§ 551D-1 to 551D-7

Idaho
Natural Death Act, Idaho Code §§ 39-4501 to 39-4509

Illinois
Living Will Act, Ill. Comp. Stat. Ann. ch. 755, §§ 35/1 to 35/10
Powers of Attorney for Health Care Act, Ill. Comp. Stat. Ann. ch. 755, §§ 45/4-1 to 45/4-12
Health Care Surrogate Act, Ill. Comp. Stat. Ann. ch. 755, §§ 40/1 to 40/55

Indiana
Living Wills 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 to 30-5-10

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
Natural Death Act, Kan. Stat. Ann. §§ 65-28,101 to 65-28,109
Durable Power of Attorney for Health Care Decisions Act, Kan. Stat. Ann. §§ 58-625 to 58-632

Kentucky
Living Will Directives Act, Ky. Rev. Stat. Ann. §§ 311.621 to 311.644

Louisiana
Natural Death Act, La. Rev. Stat. Ann. §§ 40:1299.58.1 to 40:1299.58.10
Power of Attorney Act, La. Civ. Code Ann. art. 2997

Maine
Uniform Health-Care Decisions Act, Me. Rev. Stat. Ann. Tit. 18-A §§ 5-801 to 5-817
Powers of Attorney Act, Me. Rev. Stat. Ann. Tit. 18-A §§ 5-501 to 5-506

Maryland
Health Care Decisions Act, Md. Code Ann., Health-Gen. §§ 5-601 to 5-618

Massachusetts
Health Care Proxies by Individuals Act, Mass. Ann. Laws ch. 201D

Michigan
Durable Power of Attorney for Health Care Act, Mich. Comp. Laws Ann. §§ 700.5501 to 700.5515

Minnesota
Living Will Act, Minn. Stat. Ann. §§ 145B.01 to 145B.17
Durable Power of Attorney for Health Care Act, Minn. Stat. Ann. §§ 145C.01 to 145C.16

Mississippi
Uniform Health-Care Decisions Act, Miss. Code Ann. §§ 41-41-201 to 41-41-229

Missouri
Life Support Declarations Act, Mo. Ann. Stat. §§ 459.010 to 459.055
Durable Power of Attorney for Health Care, Mo. Ann. Stat. §§ 404.800 to 404.872

Montana
Rights of the Terminally Ill Act, Mont. Code Ann. §§ 50-9-101 to 50-9-11, §§ 50-9-201 to 50-9-206
Durable Power of Attorney Act, Mont. Code Ann. §§ 72-5-501 to 75-5-502

Nebraska
Rights of the Terminally Ill Act, Neb. Rev. Stat. §§ 20-401 to 20-416
Power of Attorney for Health Care Act, Neb. Rev. Stat. §§ 30-3401 to 30-3432

Nevada
Uniform Act on the Rights of the Terminally Ill, Nev. Rev. Stat. Ann. §§ 449.535 to 449.690
Durable Power of Attorney for Health Care Act, Nev. Rev. Stat. Ann. §§ 449.800 to 449.860

New Hampshire
Living Wills Act, N.H. Rev. Stat. Ann. §§ 137-H:1 to 137-H:16
Durable Power of Attorney for Health Care, N.H. Rev. Stat. Ann. §§ 137-J:1 to 137-J:16

New Jersey
Advance Directives for Health Care Act, N.J. Stat. Ann. §§ 26:2H-53 to 26:2H-81

New Mexico
Uniform Health-Care Decisions Act, N.M. Stat. Ann. §§ 24-7A1 to 24-7A-18
Durable Power of Attorney Act, N.M. Stat. Ann. §§ 45-5-501 to 45-5-502

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
Health Care Power of Attorney Act, N.C. Gen. Stat. §§ 32A-15 to 32A-26

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

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
Hydration & Nutrition for Incompetent Patients Act, Okla. Stat. Ann. tit. 63, §§ 3080.1 to 3080.5

Oregon
Health Care Decisions Act, Or. Rev. Stat. §§ 127.505 to 127.660 and 127.995

Pennsylvania
Advance Directive for Health Care Act, Pa. Cons. Stat. Tit. 20 §§ 5401 to 5416
Durable Powers of Attorney Act, Pa. Cons. Stat. Tit. 20 §§ 5601 to 5607

Rhode Island
Rights of the Terminally Ill Act, R.I. Gen. Laws §§ 23-4.11-1 to 23-4.11-15
Health Care Power of Attorney Act, R.I. Gen. Laws §§ 23-4.10-1 to 23-4.10-12

South Carolina
Death with Dignity Act, S.C. Code Ann. §§ 44-77-10 to 44-77-160
Power of Attorney Act, S.C. Code Ann. §§ 62-5-501 to 62-5-505

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
Tennessee Right to Natural Death Act, Tenn. Code Ann. §§ 32-11-101 to 32-11-112
Durable Power of Attorney for Health Care Act, Tenn. Code. Ann. §§ 34-6-201 to 34-6-218
Health Care Decisions Act, Tenn. Code. Ann. §§ 68-11-1801 to 68-11-1815

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
Terminal Care Document Act, Vt. Stat. Ann. Tit. 18 §§ 5251 to 5262 and Tit. 13 § 1801
Durable Powers of Attorney for Health Care Act, Vt. Stat. Ann. Tit. 14 §§ 3451 to 3467

Virginia
Health Care Decisions Act, Va. Code Ann. §§ 54.1-2981 to 54.1-2993

Washington
Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.920
Durable Power of Attorney Act, Wash. Rev. Code Ann. §§ 11.94.010 to 11.94.900

West Virginia
Health Care Decisions Act, W. Va. Code §§ 16-30-1 to 16-30-25

Wisconsin
Declaration to Physicians and Do-Not-Resuscitate Orders Act, Wis. Stat. Ann. §§ 154.01 to 154.29
Power of Attorney for Health Care Act, Wis. Stat. Ann. §§ 155.01 to 155.80

Wyoming
Living Will Act, Wyo. Stat. Ann. §§ 35-22-101 to 35-22-109
Durable Power of Attorney for Health Care Act, Wyo. Stat. Ann. §§ 3-5-201 to 3-5-213