

# Legal restrictions compromise effectiveness of advance directives

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Current legal restrictions significantly compromise the clinical effectiveness of advance directives, according to a study by researchers at the University of California, San Francisco.

Advance directives allow patients to designate health care decision-makers and specify health care preferences for future medical needs. However, "the legal requirements and restrictions necessary to execute a legally valid directive prohibit many individuals from effectively documenting their end-of-life wishes," said lead author Lesley S. Castillo, BA, a [geriatrics](#) research assistant in the UCSF Department of Medicine.

The authors suggest that advance directive law and advance care planning evolve from what they call a current "legal-transactional approach" into a "flexible, relationship-and communication-based model," in which any type of advance care planning tool or discussion, including advance directives, can help guide clinical care.

Currently, tension exists between advance directive law and what occurs in clinical practice, noted principal investigator Rebecca Sudore, MD, an assistant professor of medicine at UCSF. In the clinical setting, she said, "advance directives often are just one piece of information among many that are used as guidelines when determining a patient's wishes and health care preferences." Conversely, said Sudore, advance directive law "takes a much more rigid approach to advance care planning – one that is more akin to signing a will than having a conversation between

physicians and family members."

Castillo and her co-authors list a number of legal barriers to the clinical effectiveness of advance directives, including requirements that certain legal terms be used, regardless of the patient's reading comprehension level or native language; restrictions on who may serve as a patient's health care agent or surrogate, such as anyone who works for a clinician including a case manager; and technical hurdles such as not allowing oral advance directives and requiring a witness's or notary signature for advance directives to be legally valid.

Other barriers include lack of reciprocity from state to state, lack of attention to religious, social and cultural preferences – for example, allowing family instead of an individual to serve as the surrogate, and encouraging documentation of specific death rituals.

"Vulnerable populations are most likely to be affected by these barriers," said Castillo. "These include patients with limited literacy levels and limited English proficiency, same-sex or domestic partners, and patients who are isolated and without friends."

To improve the clinical efficacy of advance directives, the researchers suggest doing away with mandatory legal language to improve readability; relaxing [health care](#) agent and surrogate limitations to expand the potential pool of medical decision-makers, including non-medical professionals who may be close to unbefriended adults; promoting universal acceptance of oral advance directives; and eliminating witness and notary requirements.

They also recommend that all states adopt nonrestrictive reciprocity laws for directives from other states, regardless of the location or type of advance care planning tool used, and urge that patients be allowed to document their religious, social, and cultural values and preferences for

end-of-life care.

**More information:** The study, which surveys medical and legal literature from across the United States, appears in the January 18, 2010 issue of the *Annals of Internal Medicine*.

Provided by University of California - San Francisco

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