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Interim Project Report 2006-137

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Committee on Health Care

Senator Durell Peaden, Jr., Chair

REVIEW PROCEDURES FOR SUBSTANTIATING AND SAFEGUARDING WRITTEN AND ORAL ADVANCE DIRECTIVES AND PROPOSE METHODS FOR INCREASING FLORIDIANS' USE OF WRITTEN ADVANCE DIRECTIVES

SUMMARY

Florida's Health Care Advance Directives law provides for a written or an oral advance directive to express a person's wishes regarding medical treatment in the event that he or she experiences physical or mental incapacity. Florida's advance directives law is considered to be among the best in the nation because it: provides for a single, comprehensive advance directive while avoiding mandatory medical forms or specific language; authorizes default surrogates (next of kin) if the patient has not named a surrogate; includes close friends in the list of permissible surrogates; and establishes a state-wide do-not-resuscitate-order protocol for emergency medical services personnel. Despite these strengths, which permit the law to serve most families, the law has come under criticism and has been extensively debated in recent years. The questions raised in this debate included how oral directives should be substantiated and how more Floridians could be encouraged to execute written directives. In addition, some Floridians expressed an apprehension that government officials might be able to negate a written directive if the officials disagreed with it.

This report finds that Florida's laws governing the substantiation and safeguarding of written advance directives work for most Floridians. The report does not recommend any statutory changes. The report describes extensive public awareness efforts to educate Floridians concerning advance directives and recommends that such efforts also be aimed at young adults in the senior year of high school and the beginning of college.

BACKGROUND

Advance Directives

In the twentieth century, as technology advanced, medical physicians were placed in a difficult position in having to decide whether to initiate or withhold life-sustaining treatment without clear direction from a dying patient. To aid in this dilemma, the medical community openly began to encourage advance directives in the 1970s.¹ Ideally, a person will specify conditions in advance under which he or she would want to refuse treatment through a written document. These wishes are generally known as advance directives.

Under Florida law, an advance directive is a "witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care...."² An advance directive may include, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift.³

In 2002, Last Acts, an initiative supported by the Robert Wood Johnson Foundation to promote improvements in care at the end of life, rated Florida's advance directives statute as one of the best in the nation. Seven states—Delaware, Florida, Hawaii, Maine, Maryland, Michigan, and New Mexico—were ranked at 4.5-5 on a scale that ranged from 0.5 to 5.0. States' policies, as established in law, were rated according to six criteria—five key elements of the

¹ Rutkow, L. "Dying to Live: The Effect of the Patient Self-Determination Act on Hospice Care", 7 N.Y.U.J. Legis. & Pub. Pol'y 393, 406 (2004).

² S. 765.101(1), F.S.

³ *Ibid.*

Uniform Health Care Decisions Act⁴, as well as the existence of a state policy for Do Not Resuscitate (DNR) orders. Policies were rated according to whether they:

- Recommend a single, comprehensive advance directive, which reduces confusion.
- Avoid mandatory forms or language for medical powers of attorney or combined living wills/medical powers of attorney, giving residents the freedom to express their wishes in their own way.
- Give precedence to the agent's authority or most recent directive over the living will, recognizing that an agent has the advantage of being able to weigh all the facts and medical opinions in light of the patient's wishes at the time a decision needs to be made.
- Authorize default surrogates (typically next of kin) to make health care decisions, including decisions about life support if the patient has not named someone.
- Include "close friend" in the list of permissible default surrogates, recognizing that "family" in today's world often extends beyond the nuclear family.
- Have a statewide (non-hospital) DNR order protocol for emergency medical services personnel, to ensure that the wishes of terminally ill patients in the community can be followed by EMS personnel.⁵

Florida law provides that an individual may execute the following types of **written advance directives**:

- A living will,
- Designation of a health care surrogate,
- Donation of anatomical gifts, and
- Amendment or revocation of a previous advance directive.

Florida law provides that an individual may execute the following types of **oral advance directives**:

- A living will,
- Amendment or revocation of an advance directive, and

- Amendment or revocation of the recognition of a medical proxy.

Procedures for Substantiating and Safeguarding Written and Oral Advance Directives

Living Wills

Section 765.101(11), F.S., defines "living will" or "declaration" to mean:

(a) A witnessed document in writing, voluntarily executed by the principal in accordance with s. 765.302; or

(b) A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

Under s. 765.302(1), F.S., "Any competent adult may, at any time, make a living will or written declaration and direct the providing, withholding, or withdrawal of life-prolonging procedures in the event that such person has a terminal condition, has an end-stage condition, or is in a persistent vegetative state. A living will must be signed by the principal in the presence of two subscribing witnesses, one of whom is neither a spouse nor a blood relative of the principal. If the principal is physically unable to sign the living will, one of the witnesses must subscribe the principal's signature in the principal's presence and at the principal's direction."

Under s. 765.101(11), F.S., a living will may be made by a witnessed oral statement.

A living will may be amended or revoked by means of:

- A signed, dated writing;
- The physical cancellation or destruction of the advance directive by the principal or by another in the principal's presence and at the principal's direction;
- An oral expression of intent to amend or revoke; or
- A subsequently executed advance directive that is materially different from a previously executed advance directive.

An amendment or revocation will be effective when it is communicated to the health care surrogate, health care provider, or health care facility. No civil or criminal liability will be imposed upon any person for a failure to act upon an amendment or revocation unless

⁴ The Uniform Law Commissioners approved the Uniform Health Care Decisions Act in 1993. www.nccusl.org.

⁵ *Means to a Better End: A Report on Dying in America Today*, Last Acts National Program Office, November 2002. pp. 10-11.

that person has actual knowledge of the amendment or revocation.

The dissolution or annulment of marriage of the principal revokes the designation of the principal's former spouse as a surrogate, unless the advance directive or the order of dissolution or annulment of marriage provides otherwise.

Any patient for whom a medical proxy has been recognized under s. 765.401, F.S., and for whom any previous legal disability that precluded the patient's ability to consent is removed may amend or revoke the recognition of the medical proxy and any uncompleted decision made by that proxy. The amendment or revocation takes effect when it is communicated to the proxy, the health care provider, or the health care facility in writing or, if communicated orally, in the presence of a third person.

Health Care Surrogate

A health care surrogate is a person to whom a principal has given the authority to make medical decisions for the principal in the event that he or she is incapacitated. A health care surrogate must make health care decisions based on what the patient would have wanted.

Under Part II, ch. 765, F.S., in order to designate a health care surrogate, the principal must execute a written document, specifically naming the surrogate, and sign the document with two subscribing adult witnesses present. Where a principal is unable to sign, the principal may direct with witnesses present that another person sign the principal's name.⁶ However, the person designated as surrogate is not permitted to act as witness to the execution of the document designating the health care surrogate. At least one witness must not be the principal's spouse or blood relative.⁷ An alternate surrogate may also be named in the document designating a surrogate.⁸ A proper written designation of a surrogate creates a rebuttable presumption of clear and convincing evidence of the principal's designation of the surrogate.⁹

A principal is presumed to be capable of making health care decisions unless determined to be incapacitated.¹⁰ Where capacity is in question, the attending physician

is required to evaluate the principal's capacity, and if the physician finds that the principal lacks capacity, record this finding in the principal's medical record. If a question regarding capacity remains, another physician must evaluate the principal, and if in agreement, record a similar finding of incapacity. If the principal has designated a health care surrogate or durable power of attorney, the facility must notify them in writing that the instrument has commenced.¹¹ If a principal regains capacity, the surrogate's authority ceases.¹²

Florida law identifies specific surrogate powers and responsibilities. Unless the principal expressly limits the surrogate's authority, the surrogate must:

- Have authority to act for the principal and make all health care decisions for the principal during the principal's incapacity;
- Consult promptly with health care providers to provide informed consent, and make only the health care decisions that he or she believes the principal would have made if capable, and, where there is no indication, consider the patient's best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn;
- Provide written consent using an appropriate form whenever required, including a physician's order not to resuscitate;
- Be provided access to the principal's medical records, as appropriate;
- Apply for public benefits, such as Medicare and Medicaid, for the principal, if the principal when capable would have applied, and have access to financial records in applying for benefits; and
- Authorize release of information and medical records to appropriate persons to ensure continuity of health care and authorize the admission, discharge, or transfer of the principal to or from a health care facility or long-term care facility.¹³

If a court appoints a guardian after the appointment of a surrogate, the surrogate must continue to make health care decisions for the principal, unless modified or revoked by the court.¹⁴

When there is no living will, a health care surrogate designated by the patient may make the decision to

⁶ S. 765.202(1), F.S.

⁷ S. 765.202(2), F.S.

⁸ S. 765.202(3), F.S.

⁹ S. 765.202(7), F.S.

¹⁰ S. 765.204(1), F.S.

¹¹ S. 765.204(2), F.S.

¹² S. 765.204(3), F.S.

¹³ S. 765.205(1) and (2), F.S.

¹⁴ S. 765.205(3), F.S.

withhold or withdraw life-prolonging procedures unless the designation actually limits the surrogate's authority to consent to the withholding or withdrawal of life-prolonging procedures.¹⁵ Before exercising the patient's right to forego treatment, the surrogate must be satisfied that:

- There is not a reasonable medical probability of the patient's recovering capacity.
- The patient has an end-stage or terminal condition, or is in a persistent vegetative state.¹⁶

As an alternative to the designation of a health care surrogate, an individual may execute a durable power of attorney, under s. 709.08, F.S., in which he or she designates an individual to serve as the principal's attorney in fact. Unless the power granted explicitly excludes the power to make health care decisions, the person who is granted durable power of attorney could make such decisions.

Anatomical Gifts

Part V of ch. 765, F.S., establishes procedures under which an individual may donate his or her body or parts of the body to be used for organ and tissue donation to other individuals after the donor's death. A person may make an anatomical gift in his or her will or living will, on a signed organ and tissue donor card, or by a designation on a driver's license of his or her intent to make an anatomical gift. A donor may amend or revoke an anatomical gift by:

- A signed statement delivered to the donee,
- An oral statement made in the presence of two persons, one of whom must not be a family member, communicated to the donor's family or attorney or to the donee,
- A statement during a terminal illness or injury addressed to the attending physician who must communicate the revocation of the gift to the procurement organization, or
- A signed document found on or about the donor's person.

A donation is irrevocable after the donor's death.

Do Not Resuscitate Orders

Do Not Resuscitate Orders (DNROs), established under s. 401.45, F.S., are a type of health care directive prepared in advance, though they are not strictly speaking, an advance directive. Rather, a DNRO is a

physician's order, signed by the physician and the patient, which authorizes an emergency medical technician or paramedic to withhold or withdraw resuscitation. Under rule 64E-2.031, F.A.C., the DNRO must be printed on yellow paper and have the words DO NOT RESUSCITATE ORDER printed in black across the top of the form. Any duplicate of the form must be on yellow paper to be accepted. The form produced by the Department of Health contains a miniature version of the DNRO form that a patient may keep in a wallet or wear on a chain.

A DNRO form is generally used by someone who is suffering from a terminal condition, end-stage condition or is in a persistent vegetative state. According to the Department of Health, "a DNRO deals specifically with the refusal of cardiopulmonary resuscitation in the event of cardiac or pulmonary arrest. It is a physician's order, signed and dated. Living wills, or any advance directive, deal with a broader spectrum of end of life related issues."¹⁷

Representatives of various groups that use the DNRO form—such as emergency physicians, hospices, and medical directors—have considered proposing an alternative to the DNRO form known as the Physician Orders for Life Sustaining Treatment (POLST). Developed in Oregon and adopted by several states, the POLST includes direction concerning the levels of intervention a patient would want (comfort measures only; limited additional treatment; or full treatment) as well as instruction concerning resuscitation, antibiotics, and artificially administered fluids and nutrition.

Among those who are considering the POLST as a possible replacement for the DNRO, there is no consensus as to who would use the form. Some proponents see the POLST as a replacement for the DNRO to be used under the same conditions as a patient now would use a DNRO. Others see the POLST as having more widespread use among frail elderly residents. One proponent in Florida recommends that all residents age 75 and older use the POLST as their advance directive. If the Legislature were to consider replacing the DNRO form with the POLST, it would be essential to clarify the circumstances under which the POLST would be used.

¹⁵ S. 765.305(1), F.S.

¹⁶ S. 765.305(2), F.S.

¹⁷ Florida Department of Health. "Do Not Resuscitate Orders."

<http://www.doh.state.fl.us/demo/trauma/dnro.html#Whatis>

Federal Requirements

The Patient Self-Determination Act¹⁸ requires hospitals, nursing homes, and certain other health care providers that receive reimbursement from the Medicare and Medicaid programs to provide information on advance directives at the time of admission and meet other requirements, including:

- Providing a written summary of a patient's right to make health care decisions,
- Providing a written description of the facility's policies with respect to recognizing advance directives,
- Asking if the patient being admitted has an advance directive, and, if so, document that fact in the patient's medical record, and
- Never discriminating against patients based on whether or not they have an advance directive.

Legal Issues

The right to refuse treatment is considered by the courts to be grounded in the common law right to informed consent. Without valid consent, medical treatment may be considered to constitute a battery.¹⁹ This judicial principle of patient self-determination was first asserted in 1914, in the case of *Schloendorff v. Society of New York Hospital* as: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."²⁰ The right to refuse medical treatment is also linked to an implied right of privacy based on the liberty interest provided under the due process clause of the U.S. Constitution.

Living wills are considered to be a written form of an advance directive, and provide guidance to health care providers about the life-prolonging measures that a person would or would not want.²¹ In situations where a person is incapacitated and no living will exists, courts have created the concept of "substituted judgment," to indicate the ability of another party, variably identified by the courts as a guardian, proxy, surrogate, family member, or the court itself, to make health care decisions based on what the patient would have wanted.

The 1976 case of *In the Matter of Karen Quinlan* involved a father/guardian who sought removal of life support for his daughter, who was in a persistent vegetative state and did not have a living will or advance directive.²² The New Jersey Supreme Court held that although the U.S. Constitution does not contain an explicit right of privacy, courts have acknowledged its existence through the penumbra of specific guarantees under the Bill of Rights.²³ After recognizing the patient's right of privacy, the court balanced the likelihood of the patient's cognitive recovery with the extent of bodily invasion required by the life support.²⁴ Here, the court determined that the patient's interests did authorize the removal of life support.²⁵ In so doing, the court relied upon the consensus reached by the following parties that no reasonable probability of medical recovery exists: the guardian and family, an attending physician, and a hospital ethics committee where the patient was located.²⁶ The court encouraged continued participation by hospital medical ethics committees in decision-making in these situations.²⁷

In the first right-to-die case to be decided by the U.S. Supreme Court, *Cruzan v. Director, Missouri Department of Health*, the court upheld a state statute requiring a clear and convincing showing of a patient's intent to have life support withheld or withdrawn.²⁸ As in *Quinlan*, the patient was in a persistent vegetative state, did not have a living will, and had no reasonable chance of cognitive recovery.²⁹ While the right of self-determination through the patient's liberty interest is provided in the due process clause of the U.S. Constitution, the court indicated, adopting procedural safeguards furthers a proper state interest, such as requiring a showing of clear and convincing evidence regarding a patient's wishes.³⁰ Here, the court upheld the lower court finding that a patient's prior observations that "she would not wish to continue her life if sick or injured unless she could live at least halfway normally"³¹ did not rise to the level of clear and convincing evidence that the patient would want withdrawal of hydration and nutrition.³²

²² 355 A.2d 647 (N.J. 1976).

²³ *Ibid.* at 663.

²⁴ *Ibid.* at 664.

²⁵ *Ibid.* at 666.

²⁶ *Ibid.* at 671-672.

²⁷ *Ibid.* at 669.

²⁸ 497 U.S. 261 (1990).

²⁹ *Ibid.* at 266, 267.

³⁰ *Ibid.* at 262, 273.

³¹ *Ibid.* at 261.

³² *Ibid.* at 263.

¹⁸ 42 USCA, ss. 1395cc and 1396a.

¹⁹ Key, C. and Miller, G. *The Tennessee Health Care Decisions Act A Major Advance in the Law of Critical Care Decision Making*, 40-AUG Tenn. B.J. 25, 26 (2004).

²⁰ 211 N.Y. 125, 129 (N.Y.C.O.A. 1914).

²¹ *Ibid.* at 406.

Although the Florida Supreme Court case of *In re Guardianship of Browning v. Herbert* involved a person who had executed a written living will containing directives for removal of life-prolonging procedures, including nutrition and hydration,³³ the court additionally indicated the same rights for a person who had orally expressed life-prolonging wishes and is now incapacitated.³⁴ Oral evidence is subject to a clear and convincing showing, however.³⁵ As the state constitution contains an express right of privacy,³⁶ the court stipulated, the government must demonstrate a compelling state interest to justify interference with this liberty interest.³⁷ The court rendered legally meaningless any distinction between artificially provided sustenance and hydration and other life-sustaining measures.³⁸

History of Florida's Advance Directives Laws

Florida's advance directives laws evolved over a number of years with comprehensive public input into the development of the laws. The 1984 Legislature enacted the Life-Prolonging Procedures Act of Florida which began with a policy statement that "The Legislature finds that all competent adults have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, withheld, or withdrawn." The law provided for:

- A written declaration directing the withholding or withdrawal of life-prolonging procedures in the event that the person had a terminal condition,
- A suggested form for the declaration,
- A procedure to be followed in the absence of a declaration, and
- Criminal penalties for willfully concealing, canceling, damaging, falsifying or forging a declaration.

In 1990, the statute was amended to specify the withholding or withdrawal of nutrition and hydration as one of the things to be addressed in the declaration.

³³ 568 So.2d 4, 8 (Fla. 1990).

³⁴ *Ibid.* at 15.

³⁵ *Ibid.* at 16.

³⁶ Article I, Section 23 of the State Constitution provides: "Right of Privacy.—Every natural person has the right to be let alone and free from governmental intrusion into the person's private life...."

³⁷ *Ibid.* at 9-10.

³⁸ *Ibid.* at 11-12.

The 1998 Legislature created the Panel for the Study of the End of Life Care to study issues related to pain management and palliative care, the use of advance directives, and regulatory and financial incentives that influence the site or setting of care providers.

*The composition of the 22-member Panel was intended to bring citizens together with policymakers, ethicists, health professionals, legislators, attorneys, educators, and regulators to gather information from the public, to discuss possible solutions to the identified issues, and to make additional recommendations to the Legislature. An additional 17 nonvoting advisors to the group were formally invited to join in the discussions at each meeting. In practice, however, the entire group generally operated as a committee-of-the-whole with consensus building as the main goal.*³⁹

An interim report by the panel led to the following legislative changes in 1999:

- Establishing uniform procedures for DNROs,
- Requesting a review of end-of-life curricula in medical and nursing schools in the state,
- Defining *end-stage condition* and *persistent vegetative state* and adding those to the list of conditions which a person could specify in an advance directive as conditions under which the directive would apply, and
- Establishing procedures for withdrawing or withholding life-prolonging procedures for persons who are in a persistent vegetative state, who have no advance directive, no family member or friend to serve as proxy, and for whom there is no evidence indicating what the person would have wanted under such conditions.⁴⁰

After the publication of the final report by the panel on end-of-life care, the 2000 Legislature:

- Clarified procedures for the use of DNROs,
- Established requirements for pain management and palliative care,
- Required the Departments of Elderly Affairs and Health and the Agency for Health Care Administration jointly to create a campaign to

³⁹ Brooks, R., Hardy, M., Moseley, R., Myrick, J., and Jones, A. "Advancing End-of-Life Care: Lessons Learned from a Statewide Panel." *Journal of Palliative Medicine*, Vol. 6, No. 5, p. 822. 2003.

⁴⁰ Ch. 99-331, L.O.F.

educate the public on end-of-life care, including culturally-sensitive programs to improve the understanding, and

- Created the End-of-Life Care Workgroup in the Department of Elderly Affairs to examine reimbursement methodologies for end-of-life care, identify standards for the provision of end-of-life care by all providers along the health care continuum, and develop recommendations for incentives for appropriate end-of-life care.⁴¹

The End-of-Life Care Workgroup was supported by a grant from the Robert Wood Johnson Foundation for additional education of professionals and the public. The project included public education meetings held by 21 community coalitions, the delivery of educational programs on ethics and end-of-life care programs to 3,000 health care professionals. Over 300,000 Florida residents were reached through the public education meetings conducted in the course of the grant-funded project.

METHODOLOGY

To examine how written and oral advance directives are substantiated and safeguarded, staff reviewed relevant statutes, cases, and reports. Staff consulted with probate judges; attorneys; physicians; nurses; representatives of nursing homes, hospices, and hospitals; and the Agency for Health Care Administration, Department of Health, Department of Highway Safety and Motor Vehicles, and Department of Elderly Affairs to gather information relevant to the substantiation and safeguarding of written and oral advance directives and ways to increase the number of Floridians who have written advance directives.

FINDINGS

Substantiating and Safeguarding Written and Oral Advance Directives

As described in the background section of this report, Florida's health care advance directives statutes provide criteria for substantiating, revising, and revoking written and oral advance directives. Probate judges who were consulted during the interim project said that a very small percentage of the probate court's time—less than one percent—is devoted to disputes involving advance directives. The extensive public input that informed the legislature's development of

Florida's advance directives law and the modeling of the law on the Uniform Health Care Decisions Act have contributed to the strength of the law.

Ways to Increase Floridians Use of Written Advance Directives

The number of Floridians who have executed written advance directives is not known. National estimates from a study published in 2002 indicated that approximately 15 to 20 percent of the general population has completed advance directive documents.⁴² In a 2002 survey by the Department of Elderly Affairs, 47 percent of individuals surveyed said they did not have a living will because they "haven't gotten around to it."

Various state government entities have undertaken initiatives to increase Floridians' use of written advance directives by making information about advance directives available to the public.

The Senate webpage features a link to living will information, where there is a letter from the Senate President to encourage Floridians to complete the living will and designation of a health care surrogate forms and to discuss the forms with their loved ones. The web page provides links to the statutory forms for living wills and designation of a surrogate, to the statute that establishes the procedure for making a living will, and to the booklet, *Making Choices: Beginning to Plan for End-of-Life Care* that is produced by the Department of Elderly Affairs in collaboration with the Florida Partnership for End-of-Life Care.

The Department of Elderly Affairs makes available on the agency website the booklets *Making Choices*⁴³ in English and *A la Hora de las Decisiones* in Spanish.

The Agency for Health Care Administration publishes a brochure, "Health Care Advance Directives: The Patient's Right to Decide", that is available on the Florida Health Stat web page⁴⁴ and an "End of Life

⁴²*Means to a Better End: A Report on Dying in America Today*, Last Acts National Program Office, November 2002. p. 9.

⁴³<http://elderaffairs.state.fl.us/english/LMD/EOL/EOL.pdf>
<http://elderaffairs.state.fl.us/3A061Sp/PDF/final.pdf>

⁴⁴http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/adv_dir.pdf

⁴¹ Ch. 2000-295, L.O.F.

Issues” pamphlet can be found on the Agency’s website⁴⁵

The Department of Management Services web page contains information about living wills under the Human Resources Management Link. A letter from the department secretary is followed by links to ch. 765, F.S., the Aging with Dignity web site, the living will and health care surrogate links on the Senate web page, the Partnership for Caring, the *Making Choices* booklet, and legal Zoom, a site that provides laws and forms from all 50 states.

The Department of Health web site provides information about DNROs.

The Attorney General’s website provides links to the statutory forms for a living will and the designation of a health care surrogate, provides questions and answers concerning advance directives and provides a link to *Making Choices*.

In two judicial circuits in South Florida, probate judges have provided workshops for clergy on the subject of advance directives.

A number of private institutions work to increase the number of individuals who use advance directives:

- Project Grace distributes an Advance Care Plan Document free of charge to any individual or group that requests a copy or copies.
- Aging with Dignity distributes the Five Wishes document to workplaces, colleges and universities, places of worship, and state agencies. The cost for the Five Wishes document ranges from \$5 for a single copy to fifty-cents per copy under a licensing agreement.
- The Florida Catholic Conference distributes the Catholic Declaration on Life and Death to Catholic institutions throughout Florida.

Participants in a workshop convened for this interim project suggested the following possible locations as places where individuals might receive information that could lead to the signing of a written advance directive.

- County public health units
- High schools, community colleges, universities
- Medical schools

- Physicians’ offices
- Pharmacies
- Religious Institutions—churches, synagogues, mosques.
- Public libraries
- Drivers License Offices

The Need for Advance Directives

In the twenty-first century, medical advances make the situation at the end of life ever more complex. Most hospitals have equipment that can keep blood flowing, lungs inflated, and nutrients ingested after a person no longer has the ability to do any of those things on his or her own. The power and variety of medical interventions available, which might prompt an individual to specify in advance conditions under which he or she would want to receive or refuse treatment, ultimately could have the opposite effect by being so complex that an individual would have difficulty specifying which interventions he or she might want under unforeseen circumstances. Medical, legal, and religious leaders who propose policies and professionals who advise individuals concerning advance directives do so in the midst of ongoing innovation in medical care and technology.

Attorneys, health care providers, and clergy point out the importance of having a conversation with one’s family, friends, and surrogate about one’s beliefs, wishes, and priorities as an initial step in advance care planning. This conversation is essential because the purpose of an advance directive is to communicate clearly with those who will see to it that one’s wishes are carried out.

In order to execute an advance directive that is appropriate for one’s own moral beliefs, choices and family circumstances, a person must have general information concerning advance directives and must have a discussion with the people he or she relies upon and trusts to carry out the provisions of the advance directive. Given the personal nature of the decisions involved and the diversity of Florida’s population, a variety of approaches aimed at fostering conversations among families and friends would seem appropriate.

If a public or private entity were to undertake an initiative to increase the use of written advance directives, an effort aimed at young adults in the senior year of high school and in college would educate individuals at the earliest age at which they could sign advance directives—age 18. Whether or not young

⁴⁵<http://www.floridahealthstat.com/publications/endoflife.pdf>.

adults signed advance directives at that time, they would be beginning their adult lives with the knowledge necessary for advance care planning.

RECOMMENDATIONS

1. Florida's laws governing the substantiation and safeguarding of written and oral advance directives work for the majority of Floridians. This report does not recommend any statutory changes.

2. Initiatives to increase Floridians use of written advance directives should include the education of young adults in the senior year of high school or the beginning of college. Such education could be delivered in collaboration with groups that provide advance directive forms and education at minimal cost or at no cost. In high school, where the curriculum does not afford a place for a new subject and where a school board likely would require parental involvement, the information might best be provided on campus for all seniors with parents involved in the event. In universities, a course introducing freshmen to college could be a likely place for advance directive instruction.