Advance Directives in New Hampshire:  
A Statutory Review & Survey of Current Issues

This report provides information on the Advance Directives (LW and DPOAH), in order to improve their use in New Hampshire. It is one part of a much broader statewide effort to promote advance care planning—the process of understanding, reflecting on, discussing and planning for a time when you are unable to make your own medical decisions. The information compiled in this report is being used in the redesign of the advance directives brochure distributed to hospitals, other health facilities and the public. The report, along with more detailed appendices and other information on advance care planning, can be found on the Foundation for Healthy Communities website at www.healthynh.com.

Part I. Advance Directives Statutory Review

Introduction

The advance directive statutes for all 50 states were reviewed and compared with New Hampshire’s durable power of attorney for health care and living will statutes. Since state statutes and advance directives documents vary widely among the states, a description of each state’s document would be lengthy and not helpful in analyzing the impact of the different approaches. Several key legislative “decision points” were selected for review. These decision points represent choices we felt were most important to consider when analyzing the effectiveness of New Hampshire’s advance directive documents. Also included with each decision point is a summary of how New Hampshire’s current living will and durable power of attorney for health care statutes address each of the decision points. See RSA §137-H:3 (Appendix B1) and RSA §137-J:15 (Appendix B2).

Following the description of New Hampshire law is a comment section discussing the significance of each decision point. Next is a section describing some of the alternative approaches other states have taken in addressing each of these issues. Finally, there is a comment on whether the other state’s approaches, if deemed better than our approach, could be implemented by a change in the forms or would require a change in the New Hampshire DPOAH or living will statutes. Unfortunately, there is no New Hampshire case law on this issue so these comments are the result of our preliminary thinking and should not at this time be taken as considered legal opinions.

New Hampshire law sets different standards for modifying the DPOAH and the living will forms. New Hampshire’s living will “may be, but need not be,” in form and substance, substantially as written in the statutes. See RSA § 137-H:3 (Appendix B1). The durable power of attorney for health care statutes, on the other hand, must be “in substantially” the same form as provided for in the statutes. See RSA § 137-J:15 (Appendix B2). The living will form can be modified although the law contains some
components that must be included in any such form. For example, the living will must contain an “express direction” that no life sustaining procedures be performed. The living will must also include a “clear expression” of the principal’s intent to withhold or withdraw artificial nutrition and hydration. See RSA §137-H:2 (III) (Appendix B3) and RSA §137-H:6 (III) (Appendix B4).

We also conducted a search of the literature related to advance directives. While there is much thoughtful writing, the literature is not helpful in resolving the key question of which form currently in use, if any, would make a difference in improving end of life care. See e.g., Thaddeus Mason Pope, The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act, 9 Health Matrix 139 (Winter, 1999). It is not clear whether any of the identified changes that follow will make the execution of the form simpler while promoting discussion and full understanding of the decisions. It is our strong opinion that we should gather New Hampshire data on which, if any, components of our forms interfere with these goals. Without that data, there will likely be no meaningful way to choose among the options presented below.

DECISION POINTS

1. **Format of Advance Directive Documents**

   **New Hampshire**: New Hampshire’s DPOA and living will statutes create two separate advance directives documents. Both documents allow the principal to indicate his or her wishes regarding end-of-life medical treatment. See RSA §137-H:3 (Appendix B1) and RSA §137-J:15 (Appendix B2).

   **Comment**: The public remains generally confused over the purpose of the DPOAH and living will documents. Combining the two documents may help integrate the forms into a more understandable form. It may also simplify the execution process for the principal as well as provide a more meaningful connection between the patient’s treatment choices and the agent authorized to follow those choices. See RSA §137-J:2 (II) (Appendix B5) (requiring the agent to follow the wishes of the principal unless the wishes of the principal are unknown).

   **Optional Approaches**: Several states combine the living will and durable power of attorney for health care into one document. For example, Minnesota (Attachment 6), New Mexico (Attachment 7) and Arkansas (Attachment 8). In states that combine the documents, the principal can either complete both the durable power and living will portions of the document, or they can elect to complete only one section. An agent’s failure to designate a health care agent does not make the advance directive document void. See N.M. Stat. Ann. §24-7A-4 (Attachment 7). (More detailed text for attachment references to statutes in other states may be found at the Foundation for Healthy Communities website: www.healthynh.com)
Legislative Change: Combining the DPOAH and living will into one document would require a change in the New Hampshire durable power of attorney for health care statutes because the DPOAH would no longer be in substantially the same form as required by law.

2. **Certification of Principal’s Incapacity under the DPOAH Document**

New Hampshire: Under the DPOAH for health care in New Hampshire, the agent’s authority becomes effective only when the principal lacks capacity as certified in writing by the principal’s attending physician and filed in the principal’s medical record. See RSA §137-J:2 (III) (Appendix B5).

Comment: Declaration of an individual’s incapacity to make health care decisions without the appropriate medical evidence may raise concerns and fears about coercion and the potential of an agent to take advantage of the principal. Conversely, an additional step lengthens the overall certification process for the health care provider.

Optional Approaches: Under New Mexico law, the agent’s authority becomes effective when the principal’s primary physician and one other qualified health care professional determine that the principal is unable to make health care decisions. See N.M. Stat. Ann. §24-7A-4 (Attachment 7).

Legislative Change: A change in New Hampshire’s durable power of attorney for health care statutes would be required since this would significantly change the substance of the statutes. A change in the statutes would not be justified unless abuses could be identified in the single physician certification method.

3. **Certification of Principal’s Terminal Condition under the Living Will Statutes**

New Hampshire: Under New Hampshire law, two physicians are required to certify the principal’s condition in order for the living will to become effective. One of these physicians must be the principal’s attending physician. The two physicians must certify that the principal is in a terminal or permanently unconscious condition. See RSA §137-H:3 (Appendix B1).

Comment: This decision point is significant for two reasons: 1) The certification of the principal’s condition defines the point at which the living will becomes effective. The expertise required to make this diagnosis needs to be balanced against the patient’s right to have his or her treatment choice honored in a timely fashion. 2) The choice of terminology used in this section of the living will is important since it can contribute to the patient’s comprehension and understanding of a terminally ill or permanently unconscious condition.
Optional Approaches: With regard to the certification of a terminal condition, New Mexico requires that the patient’s primary care physician and one other health care professional make the diagnosis. See N.M. Stat. Ann. §24-7A-11(C) (Attachment 9).

With regard to the terminology issue, New Mexico’s living will becomes effective when the principal is unable to make or communicate decisions about their health care and if:
1) the principal has an incurable or irreversible condition that will result in death within a relatively short time or
2) the principal becomes unconscious or
3) the risks and burdens of treatment would outweigh the expected benefits

Oregon uses even more detailed terminology to describe the necessary medical conditions as well as the patient’s treatment choices for each identified condition. See O.R.S. §127.531 (Attachment 10).

Legislative Change: This would not require legislative change since New Hampshire’s living will document “may be, but need not be” in the format outlined in the statutes. In addition, the principal would still be providing express direction in the living will as required by the statutes.

4. Artificial Nutrition and Hydration

New Hampshire: The New Hampshire living will allows the principal to decide whether artificial nutrition and hydration will be started or, whether it can be removed if started. Principals who do not choose this option will be provided with artificial nutrition and hydration. The principal indicates his or her wishes by circling the appropriate box on the living will. See RSA §137-H:3 (Appendix B1). Artificial nutrition and hydration may not be withdrawn or withheld under a durable power of attorney for health care or living will statute unless there is a clear expression of intent made in the documents. See RSA §137-J:3 (III) (Appendix B1) and RSA §137-H:6 (III) (Appendix B4).

Comment: The choice to provide or not to provide artificial nutrition and hydration is probably one of the most significant and perhaps the one creating the greatest confusion for individuals completing the New Hampshire documents. Individuals are often motivated to complete advance directives because they do not want to be hooked up to tubes or machines. The principal’s ability to adequately indicate his or her preferences here is essential. The patient’s autonomy is not protected if the expression of intent is not clear.

Optional Approaches: Minnesota’s living will form provides blank spaces where the principal can express in their own words any feelings and wishes regarding
artificially administered sustenance should the person have a terminal condition. See Minn. Stat. §145B.04 (Attachment 6).

New Mexico separates nutrition and hydration, allowing the principal to make a decision whether to continue or discontinue either of these. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

Mississippi does not separate nutrition and hydration. Artificial nutrition and hydration are either provided, withheld or withdrawn in accordance with the choice the principal makes to either prolong life or not to prolong life. If the principal marks a box, artificial nutrition and hydration must be provided regardless of the choice not to prolong life. See Miss. Code Ann. § 41-41-209 (Attachment 12)

Legislative Change: A change in the New Hampshire living will statutes would be required if the optional approach did not provide a clear expression of the principal’s intent to remove artificial nutrition and hydration. The Mississippi document may not meet the clear expression standard required by New Hampshire law. Changing the living will to a format similar to that of Mississippi would therefore require a change in the New Hampshire living will statutes. The Minnesota option also may not provide a clear expression of intent and would therefore also require a change in the statutes. The New Mexico option still provides a clear expression of the principal’s intent to withdraw or withhold nutrition and hydration. Adopting this option would not require a change in the New Hampshire statutes.

5. Disclosure Statement

New Hampshire: New Hampshire law requires that every person wishing to execute a durable power of attorney for health care be provided with a disclosure statement. See RSA §137-J:3 (Appendix 11). The form of the statement must be substantially in the form set forth in RSA § 137-J:14 (Appendix 13).

Comment: The disclosure statement is an opportunity to provide the principal with basic information that can easily guide the principal in completing the document. However, it is a very lengthy and complex document.

Optional Approaches: Instead of a separate disclosure statement, several states include a shorter, more succinct informational statement as part of the advance directive document. See Minn. Stat. §145B.04 (Attachment 6). See also N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

Legislative Change: Under Federal law, health care providers participating in Medicare and Medicaid are required to provide a written statement of the state’s advance directives laws to individuals receiving medical care. See 42 U.S.C.S. § 1395cc(f). Accordingly, New Hampshire must continue to provide an
informational statement. The DPOAH statutes would need to be changed if modifications were made to the disclosure statement that substantially changed the document.

6. **Notary and Witnesses**

**New Hampshire:** Both the New Hampshire DPOAH and living will statutes require the signature of the principal as well as the signature of two witnesses. Both forms must also be notarized. See RSA §137-H:3 (Attachment 1) and RSA §137-J:15 (Attachment 2).

**Comment:** The notary and witness requirements provides an extra level of protection for the principal, but it can create an additional hurdle when completing the document if a notary and witnesses are not available. This becomes even more of an issue when the advance directive is being completed in a hospital.

**Optional Approaches:** New Mexico only requires the signature of the principal on its advance directives document. Signatures of witnesses are suggested but are not required. There is no requirement that the document be notarized. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

In addition to the principal’s signature, Mississippi allows the document to be either notarized or witnessed. See Miss. Code Ann. § 41-41-209 (Attachment 12).

**Legislative Change:** A change in the witness and/or notary provision would require a change in the New Hampshire statutes since these are currently required under New Hampshire law.

7. **Agent’s Address and Phone Number**

**New Hampshire:** The New Hampshire DPOAH document does not include a section for the agent’s address or phone number.

**Comment:** A delay in locating an agent could potentially prolong the principal’s wish to terminate life-sustaining treatment.

**Optional Approaches:** New Mexico includes a space for the address, work and home phone numbers for the primary agent as well as two alternate agents. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

**Legislative Change:** Including the agent’s address and phone number would not require a change in New Hampshire’s current legislation since the document would remain in “substantially” the same form as required by the DPOA statutes.
8. **Guardianship**

New Hampshire: The New Hampshire DPOAH statutes does not allow the principal to nominate a guardian on the DPOAH statutes, should appointment of a guardian become necessary. The DPOAH is revocable under New Hampshire law by notification by the principal to the agent or to a health care provider orally or in writing, or by any other act evidencing a specific intent to revoke the power. See RSA §137-J:6 (I) (a) (Appendix 14). New Hampshire’s guardianship law allows any competent person to nominate one or more persons as a guardian of his person by a written instrument. The statutes also permits the competent adult to name any persons he or she wishes to exclude from consideration as a guardian. See RSA §464-A:10 (II) (Appendix 15).

**Comment:** Allowing the principal to nominate a guardian on an advance directive form may add a level of convenience as well as providing the principal with an opportunity to make a more thoughtful and informed decision at the same time he or she is completing the advance directive.

**Optional Approaches:** The New Mexico advance directive document includes a provision that if a guardian needs to be appointed on the principal’s behalf, the principal nominates the health care agent designated in the document or the alternate agents. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

**Legislative Change:** Inclusion of a provision in the New Hampshire DPOAH document allowing a principal to nominate the DPOAH agent as a guardian would not require a change in the New Hampshire DPOAH statutes. Incorporating a portion of the New Hampshire guardianship statutes into the DPOAH document would not substantially modify the DPOAH document. It is important to note, however, that there is no case law addressing the issue of substantial modification. It would not require a change in the New Hampshire guardianship statutes since the statutes allows for the nomination of a guardian in writing.

9. **Relief from Pain**

New Hampshire: New Hampshire currently does not have a provision in the living will whereby the principal indicates his or her desire to be provided with the care necessary to help ensure they will be free from pain once the principal’s living will becomes effective.

**Comment:** A document that acknowledges the principal’s right to be treated with dignity during his or her final days may help alleviate some of the anxiety associated with completing an advance directive document.
Optional Approaches: New Mexico allows the principal to choose the best medical care be provided to keep them clean, comfortable and free from pain or discomfort so that dignity is maintained, even if this care hastens the death of the principal. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

Legislative Change: Since the New Hampshire living will document does not have to be in the form provided for in the statutes and since a provision of this type would be an “express direction,” the addition of a relief from pain section would not require a change to the current New Hampshire legislation. Altering question #4 on the current New Hampshire DPOAH document to include pain medication would not substantially change the intent of the document.

10. Authority of the Health Care Agent

New Hampshire: In New Hampshire, the health care agent only has authority to act when the principal’s incapacity is certified. The agent must follow the wishes of the principal unless the wishes of the principal are unknown. See RSA §137-J:2 (II) (Attachment 5).

Comment: The principal may wish to designate decision-making authority to a health care agent when special circumstances, other than incapacity, make it desirable.

Optional Approaches: Under New Mexico law, the agent can make health care decisions for the principal if the principal so designates, even if the principal is still capable of making their own decisions. Incapacity is not required. See N.M. Stat. Ann. § 24-7A-4 (Attachment 7).

Legislative Change: This would be a substantial change in the substance of the current DPOAH, requiring a change in the statutes.

11. Surrogate Decision Making

New Hampshire: New Hampshire does not provide a default provision for surrogate decision making in cases where a health care agent has not been designated by the principal.

Comment: In situations where the principal has not designated an agent, it may be difficult for health care providers to determine exactly who has decision-making authority concerning end-of-life treatment options.

Optional Approaches: Colorado law authorizes a surrogate decision-making process in cases where a health care agent has not been appointed by a patient. Upon the determination that an adult patient lacks decisional capacity, the physician or his/her designee shall make reasonable efforts to contact “interested persons.” Interested persons include the patient’s spouse, either parent of the
patient, any adult child, sibling, or grandchild of the patient, or any close friend of
the patient. It then becomes the responsibility of the interested persons to reach a
consensus as to who among them shall make medical treatment decisions on
behalf of the patient. See C.R.S. 15-18.5-103 (3) and (4) (Attachment 16).

New Mexico takes a slightly different approach, providing a hierarchy of
authority for surrogate decision making. If more than one member of a class
assumes authority to act as surrogate, and they do not agree on a health care
decision, the health care provider shall comply with a majority of the members of
that class. See N.M. Stat. Ann. § 24-7A-5 (B) and (F) (Attachment 17).

Legislative Change: Inclusion of a surrogate decision-making provision in New
Hampshire’s advance directives document would require the passage of a
surrogate decision-making statutes. It would not require a change in the DPOAH
or living will statutes since the substance of these documents would not change.

12. Miscellaneous

a) The Designation of Primary Care Physician and Alternate: New Hampshire
currently does not authorize a principal to designate a primary care physician
and alternate on either the DPOAH or living will. Including this provision
may help a health care agent locate the principal’s physician more easily.
Locating the principal’s primary care physician may help clarify the patient’s
treatment choices. New Mexico’s advance directive contains a provision
allowing the principal to designate a primary care physician and an alternate.
See N.M. Stat. Ann. § 24-7A-4 (Attachment 7). This would not require a
change to either the New Hampshire DPOAH or living will since it would not
significantly change the document.

b) Notification of the Agent: New Hampshire’s DPOAH document does not
require the agent’s signature nor does it include a statement suggesting that
the agent be notified. Notification of the agent by the principal may help
promote important health care discussions between the principal and the
agent, providing a means for the principal to more fully communicate his or
her wishes. While the signature requirement may help ensure that the health
care agent understands his or her responsibilities, it may also make it more
difficult for the principal to complete the document if the agent is not readily
available. New Mexico’s advance directive includes a statement reminding
the principal to talk with the agent to make sure he or she understands his or
requires that the durable power of attorney for health care sign the advance
directive. See Mich. Comp. Laws § 700.496 (6). Including this type of
provision would not require a change in the New Hampshire DPOA statutes.

c) Five Wishes Advance Directive: “Five Wishes” is an alternative advance
directive document developed by Aging with Dignity, an organization based
in Tallahassee, Florida in 1997. See www.agingwithdignity.org. The creation of this advance directive was an attempt at addressing the medical, spiritual, emotional and personal needs of the principal in one document. This document is not legally valid in New Hampshire because it lacks the express clarity required under New Hampshire law.

d) Values Survey: Values surveys may help individuals reflect more deeply upon their feelings concerning the termination of life-sustaining treatment. Values surveys may also help a principal more fully communicate his or her treatment choices to the health care agent. Values surveys are not legally valid documents.

e) Medically Ineffective Treatment: Under New Hampshire law, the agent has authority to make decisions regarding life saving treatment, including Cardio Pulmonary Resuscitation. See RSA §137-J:15 (Attachment 2). Conflicts may arise when a health care provider determines that a treatment, such as CPR, would be medically ineffective, but the agent insists that CPR be administered. New Mexico’s statutes includes an express provision stating that a health care provider may decline to comply with an individual instruction or health care decision that requires medically ineffective health care which would not benefit the patient. See N.M. Stat. Ann. § 24-7A-7(F) (Attachment 18). This would require the addition of a new provision in the physician’s responsibilities section of the New Hampshire living will statutes.

Part II. Advance Directives Survey Results

Introduction
The Foundation for Healthy Communities mailed a total of 675 surveys to practicing attorneys and health care providers within the state of New Hampshire during the month of July 2000. Of these 675 surveys, 456 were mailed to New Hampshire Bar Association attorneys practicing primarily in the area of estate planning. The remaining 219 surveys were mailed to health care providers (e.g. social workers, nurses, etc.) who assist patients with the completion of advance directive documents. The health care providers work primarily in hospitals, nursing homes, home health care agencies and hospices. A total of 45 attorneys completed and returned the survey, while 70 of the health care providers responded.

In Part I of this report, key advance directive “decision points” were identified. In order to connect this earlier research to the survey responses, the survey results are reported in terms of those key decision points. To begin this process, each completed survey was initially analyzed for the key issues and suggestions it raised. Those issues and suggestions were then grouped under the appropriate decision point and the frequency with which those issues appeared was then tallied. This appears as a numerical value
after each issue. This process was conducted separately for the attorneys and the health care providers. The analysis starts by identifying the top ten combined responses for both the attorney and the health care providers. While arguably, the open-ended nature of the survey questions makes the results somewhat difficult to quantify, every effort was made to report the results as accurately and objectively as possible.

Top 10 Major Concerns About The Advance Directive Document:

- Artificial hydration & nutrition language
- Size of print
- The four questions in the DPOAH
- Too wordy
- Separate documents adds to confusion
- CPR/DNR is not addressed
- Witness & notary requirements
- No organ donation or burial information
- Need more space to answer four questions in DPOAH
- Guardianship issues not addressed

Some of these concerns can be readily addressed (e.g., print size) and others (e.g., notary requirement) cannot change without going to the legislature to revise the statutes. Our legal analysis indicates that the LW can be more readily changed than the DPOAH.

Health Care Providers (n=71)
(The number of health care providers reporting no problems with the documents = 2)

1. Format of the Documents

Issues:
- Print is too small, make print larger and darker (26)
- Too wordy, overall language confusing, complicated and too legal (19)
- DPOAH questions #1 - #3 are confusing (9)
- Patients want to know why they have to complete two documents (7)
- Not enough room on the forms for signatures, initials, agents, addresses, etc. (5)
- People want to know what they should include in question #4 on the DPOAH (4)
- Patients confuse the health care DPOAH with a legal/financial DPOAH (3)
- If someone gets a new address or phone number do I have to complete new forms or can these be changed? (2)
- Should the address I list be a mailing or a residential address? (2)
- People don’t understand how and when these documents become effective (1)
- People don’t understand some of the terminology, like what “permanently unconscious means” (1)

Suggestions:
- Keep the language at an 8th grade level
- Use black ink
- Include specific treatment options for question #4 in DPOAH, such as CPR, no hospital transfer, no IV’s, no tube feedings, chemotherapy, dialysis, etc.
- Combine questions #1, #2 and #3 on the DPOAH into one question
2. **Certification of Incapacity (DPOAH)**
   **Issues:**
   - The DPOAH does not state how it is determined that someone cannot make his or her own decisions (1)
   
   **Suggestions:**
   - Include a statement explaining how it is determined someone cannot make his or her own decisions, similar to the requirement for two physician statements in the LW

3. **Certification of Terminal Condition (LW)**
   **Suggestions:**
   - Include definitions of medical terminology (i.e. terminal condition)

4. **Artificial Nutrition and Hydration**
   **Issues:**
   - Artificial nutrition and hydration questions are confusing (33)
   - Some people want to be able direct the agent to withhold food taken by mouth (1)

   **Suggestions:**
   - Replace the terms “artificial nutrition and hydration” with layman’s terms
   - Eliminate the double negative in the LW and/or DPOAH regarding artificial nutrition and hydration
   - Allow people to designate the length of time they wish to receive artificial nutrition and hydration
   - Choices should be indicated by a check mark, not a yes or no answer

5. **Disclosure Statement**
   **Issues:**
   - Disclosure statement is too lengthy and causes confusion (1)

6. **Notary and Witnesses**
   **Issues:**
   - Difficulty in finding or paying a notary (4)
   - Difficulty in finding a witness (4)
   - On the living will, a witness shouldn’t attest to the fact that the declarant was of sane mind and under no constraint or undue influence (1)
   - There are different witness and attestation requirements in the DPOAH and LW (1)

   **Suggestions:**
   - Be consistent between the witness requirements of the LW and DPOAH. These should be uniform
   - Legislate compensation for notaries who go to the homes of homebound patients
7. **Agent’s Address and Phone Number**  
*Issues:*  
- This issue was not raised by any of the health care providers responding to the survey

8. **Guardianship**  
*Issues:*  
- Can mentally challenged people execute an advance directive? (1)  
- People have a hard time understanding why dementia precludes execution of an advance directive and necessitates guardianship (1)  
- There are occasions when mentally challenged people want to execute advance directives, which raises questions about the extent of guardianship (2)  
- Many residents/admissions are at a point where they cannot make decisions, which means that guardianships need to be established (1)

9. **Relief from Pain**  
*Issues:*  
- Pain is a concern for those choosing no artificial nutrition and hydration (1)

10. **Authority of the Health Care Agent**  
*Issues:*  
- People have trouble in deciding who to designate as a health care agent (1)

11. **Surrogate Decision Making**  
*Issues:*  
- This issue was not raised by any of the health care providers responding to the survey

12. **Organ Donation**  
*Issues:*  
- Patients want a section for organ donation, funeral pre-planning, burial and cremation (1)

13. **Miscellaneous**  
   a) **designation of physician**  
   - This issue was not addressed by any of the health care providers responding to the survey
   
   b) **notification of agent**  
   - Include the signature of the agent and a statement that he or she knows he or she is appointed and agrees to the responsibility (1)
   
   c) **Five Wishes**  
   - I provide people with the “Five Wishes” document to use as a worksheet before completing the NHHA form (1)
   
   d) **values survey**  
   - A statement should be included that says these forms should be reviewed every few years. Values can change overtime. (1)  
   - We use a medical choices statement to help people clarify their LW choices (1)
   
   e) **medically ineffective treatment**
• CPR/ DNR directives should be addressed in these documents, the CPR issue is confusing, CPR is listed on the documents, but physicians are required to address this issue separately (12)
• People want to know if these documents can be used to stop medical assistance in emergencies when someone calls 911 (1)

14. **Additional Issues/Suggestions from Health Care Providers**

- Patients want to know if the LW can be transferred from state to state
- People are superstitious about filling these out or express distaste about filling them out
- One sentence in the LW is greater than 100 words!
- Audio cassettes should be developed for the visually impaired
- Produce a pamphlet directed at those who approach patients
- Include a statement that lawyers and others who assist in the execution of forms assist with getting copies to the primary care provider and hospital
- A video entitled “On Your Behalf” does a good job of explaining these issues
- Even those with advance levels of education have trouble with these documents
- The difficulty of the language makes people reluctant to complete the forms
- Often people feel they have covered certain areas with their attorney when upon reviewing the form completed by the attorney, those areas have not been covered
- The biggest problem is the availability of someone comfortable with these documents and who can take the time to discuss them. The letter of the law is given its due, but the spirit of the advance directive planning process is deficient
- People haven’t fully thought through what their wishes are
- The forms say that a copy should be kept in the “permanent medical record.” People don’t understand what that means
- Making multiple copies for distribution is difficult for some people. It should be printed on NCR paper
- Many people are already at a point where they can’t make decisions

**Advance Directives Survey Results:**

**Attorneys (n=45)**

(Number of attorneys reporting no problems with the documents = 5)

1. **Format of the Documents**

**Issues:**

- Clients don’t understand the distinction between the two documents. Which document controls? (13)
- DPOAH questions are confusing (13)
- Print is too small, information is too densely packed (4)
- Overall language in both documents is confusing (4)
- Include lay definitions in the packet of terms like “permanently unconscious” and “terminally ill” (3)
- Clients think they have a general power of attorney or a financial power of attorney when they complete these documents (2)
- Without guidance, no one completes anything on DPOAH question #4 (1)
- Not enough space to write in treatment choices on DPOAH question #4 (1)
- Confusion about where the original of the document should go (1)
Suggestions:
- Larger print, more white space
- Combine the forms, revise the NH statutes to create one form
- Include more explicit information regarding who has authority if both forms are used
- Reduce the number of questions
- Make a large print version
- NH Association for the Blind has info on best color combinations to use
- Revise the New Hampshire statutes to create one form
- DPOAH shouldn’t switch from 2nd person to 1st person
- Directions shouldn’t be in bold print in some places and regular print in others
- Combine all three DPOAH questions into one
- Our office provides sample language regarding treatment options for DPOAH #4
- Include a statement that explains the need for a financial DPOAH
- Forms could be made more aesthetically pleasing

2. **Certification of Incapacity for DPOAH**
   - This issue was not raised by any of the attorneys responding to the survey

3. **Certification of Terminal Condition for Living Will**
   - This issue was not raised by any of the attorneys responding to the survey

4. **Artificial Nutrition and Hydration**
   **Issues:**
   - The language is difficult, especially as it pertains to the artificial nutrition and hydration questions. Clients get confused when they have to circle “yes” when they really mean “no” (15)

   **Suggestions:**
   - Eliminate the double negatives in the DPOAH and LW
   - Separate out nutrition and hydration
   - Health care professionals need to be educated about the consequences of removing artificial nutrition and hydration

5. **Disclosure Statement**
   **Issues:**
   - Instructions are too lengthy (1)

   **Suggestions:**
   - Provide an information sheet for the living will similar to the one that is provided for the DPOAH

6. **Notary and Witnesses**
   **Issues:**
   - Witnesses and notaries are a problem (3)
   - Forms are often not properly executed (1)
   - There is not enough room on the DPOAH to say who the acknowledgement is by (1)
   - Different witness and attestation requirements between the DPOAH and the LW (1)
Suggestions:
• Add a statement that if these forms are not properly witnessed and acknowledged that they shall not be valid and enforceable
• Eliminate the two witness requirement

7. **Agent’s Address and Phone Number**
   - This issue was not raised by any of the attorneys responding to the survey

8. **Guardianship**
   **Issues:**
   • Clients want to be able to pre-appoint a guardian (1)

9. **Relief from Pain**
   **Issues:**
   • Clients want to know if it is more painful to die while being provided with hydration or not being provided with hydration (1)

10. **Authority of the Health Care Agent**
    **Issues:**
    • Clients wonder how decision making will be handled if more than one child is named as an agent (1)

    **Suggestions:**
    • Add a section that the agent is authorized to admit the principal into a nursing home if the principal can’t do it himself
    • Include some kind of an explanation on the form describing who is an appropriate agent
    • Reverse the order of the DPOAH and LW in the advance directives brochure since the DPOAH controls
    • State on the DPOAH that it takes precedence over the LW
    • Revise the forms so that it is assumed the designated agent has authority to remove life support unless otherwise specified

11. **Surrogate Decision Making**
    **Issues:**
    • This issue was not addressed by any of the attorneys responding to the survey

12. **Organ Donation**
    **Issues:**
    • Clients ask about organ donation when completing these documents (4)
    • Clients want to include burial instructions on the forms (1)

13. **Miscellaneous**
    a) **designation of physician**
    • This issue was not addressed by any of the attorneys completing the survey
b) notification of agent
   • Instructions should be added for the agent

c) Five Wishes
   This issue was not addressed by any of the attorneys completing the survey

d) values survey
   • This issue was not addressed by any of the attorneys completing the survey

e) medically ineffective treatment
   • Clients confuse advance directives with DNR orders (2)

14. Additional Issues/Suggestions Raised by the Attorneys
   • Start fresh with New Hampshire law rather than try to apply patchwork fixes
   • Train hospital staff in how to counsel people about advance directives
   • May want to include a suggestion on the advance directive form that an appointment can be
     made at the hospital to complete the forms
   • Explain the need for a financial DPOAH
   • Questions arise regarding religious implications and Christian Science practitioners
   • Clients often ask the attorney questions they should be asking their physician