The Advanced Medical Directive

In the beginning, our platform estate planning document set did not include documents relating to health care. The logic was that health care directives have nothing to do with estate planning, as such, and should therefore be kept separate and left in the domain of medical practitioners. That all changed in 1988 after I sat across the table with a lady who related a very sad story of how her mother's estate suffered a total "spend-down" by the hospital who had her on "life support". When the estate was depleted, the "plug" was pulled. Had there been what is now known as a "living will" directive in place on behalf of this lady's mother, that scenario would have turned out much differently. It is clear, health care directives should always be a part of anyone's estate plan.

Health care directives are a relatively new concept in comparison to customary estate planning applications. The use of trusts has been around common law since the 17th century. The first health care directive surfaced in 1967. Charles P. Sabatino, in his scholarly article "The Evolution of Health Care Advance Planning Law and Policy", wrote:

> *The first advance directive was proposed by the Euthanasia Society of America in 1967. Luis Kutner, a human-rights lawyer from Chicago who represented the society, described this concept in a 1969 article. He began with the common law and constitutional law premises that "the law provides that a patient may not be subjected to treatment without his consent". The challenge was what to do about patients who no longer were capable of making health care decisions. He suggested that the individual should indicate in writing ahead of time the extent to which he or she would consent to treatment. He referred to the document as a "living will," "a declaration determining the termination of life," or a "testament permitting death," among other names.*
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> *Kutner also compared the living will with "a revocable or conditional trust with the patient's body as the res, the patient as the beneficiary and grantor, and the doctor and hospital as the trustees". As with any trust instrument, the document sets forth the terms for managing the res, which, in the context of medical care, means the extent to which the health care providers should undertake treatment. Kutner's testamentary and trust paradigms are characteristic of the legalities that the states initially embraced in their advance medical directive legislation.*

Legislative variations of health care advance directives have since evolved beginning with California's adoption of the first living will statute in 1976. It codified the use of a

"Directive to Physicians", also known as a *living will*. The living will offered something for both individuals and physicians. To individuals, it provided a standardized tool to express their wishes about life-sustaining treatment—usually to withhold or withdraw it—in the event of a terminal condition or permanent unconsciousness. To physicians, the living will offered statutory immunity if they complied with the patient's wishes in good faith. New Jersey enacted the first combined statute in 1991, merging the living will (called an "instruction directive") and the durable power of attorney for health care (called "a proxy directive") into a single "advance directive for health care". That was a major step forward in bundling the proper health care directive applications into useable form.

There has since been "fragmentation" among various state legislators as to what is deemed appropriate for the basic requirements of implementing a valid healthcare directive. For example, some states claim that in order for a personal healthcare directive to be binding, it must also contain the signatures of two witnesses. The implication here (with a literal interpretation) is that a healthcare directive, signed by the person who is now on a hospital gurney needing emergency medical assistance, must be set aside if it did not contain the signatures of two witnesses even though the signature was notarized (for example). That seems illogical and does not address the inevitable exigencies of life.

To most states' credit, they have adopted statutory law (or would otherwise allow its application) similar to the following to help mitigate the negative effect of those disconnected "requirements":

> *"It shall be unlawful for a physician, nurse or other individual who is a health care provider or an employee of a health care facility, hospital, nursing facility, residential care facility or other health care facility to require an individual to execute a durable power of attorney for health care as a condition for the provision of health care services or admission to a health care facility."*

COMMENT: The above quoted body of law speaks volumes concerning the need for the recognition of uniform laws governing medical directives. For example, even if – in the opinion of an attending physician – the electronically signed Advanced Medical Directive [AMD] did not fit the description of a Health Care Power of Attorney under state law where he/she is practicing (because it required two witnesses, for example), the attending physician cannot deny health care services to a patient; and he/she would certainly seem to have the deemed authority – and I would add "obligation" – to recognize a MLCP Member/Client's electronically-signed Advanced Medical Directive (AMD), recorded ONLINE, and represented by the client's MLCP Medical Card.

On another important matter, as of this writing, the Uniform Electronic Transactions Act (UETA) has been adopted in 47 states and the District of Columbia. The UETA body of law (generally) reads as follows: (i) A writing SHALL NOT BE DENIED legal effect or enforceability SOLELY BECAUSE it is in electronic form. (ii) A contract shall not be denied legal effect or enforceability solely because an electronic record was used in its formation. (iii) If a law requires a record to be in writing, an electronic record satisfies the law. (iv) If a law requires a signature, an electronic signature satisfies the law.

The eStatePlan™ platform features an **Advanced Medical Directive (AMD)** that was designed to implement an AMD within the convenience of a digital environment. A Master Signatory Guarantor (MSG) document is also part of The eStatePlan (and the AMD). The MSG contains a "time-stamp" table (date and time) of ALL the electronic signature events in that took place in the Client Console, including the AMD as well as the Dynamic Trust Portfolio document set. The MSG can be "virtually" notarized by the attorney of record, through a virtual jurat notarization when the attorney is conducting the suitability review with the client. That document is then electronically posted in the Client Console Dynamic Trust Portfolio page and may be uploaded to the Client Console E-Vault Center. When The eStatePlan AMD is implemented correctly, it will record and present the personal intents of the AMD creator allowing for its confident use, if ever needed, by the client's attending physician.

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