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Important Legal Planning Issues to Consider for Someone with Parkinson's Disease
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If you or your loved one has Parkinson's disease, you or your loved one will need long term care at some point. If you have advanced symptoms of the disease, you are likely focused on your care needs rather than on your legal matters. If you are in the role of caregiver, you may become so overwhelmed by the pervasiveness and stress of caregiving that you fail to consider the legal ramifications of your loved one's long term disability. However, legal planning in this situation is absolutely critical and should not be neglected.

I. Introduction to Health Care Directives

1. "Health Care Directive" means a document drafted in substantial compliance with the law, to deal with a person's future health care decisions. A.R.S. § 36-3201(5). There are four Advance Directives recognized under Arizona law. These include:

    a. Health Care Power of Attorney,

    b. Living will,

    c. Pre-Hospital Medical Care Directive, and

    d. Mental Health Care Power of Attorney (which is beyond the scope of this presentation)

2. Patient Self-Determination Act. Under the Patient Self Determination Act, 42 U.S.C. § 1396, hospitals, skilled nursing facilities, home health agencies, hospices and H.M.Os that participate in Medicare or Medicaid must provide written information to incoming patients regarding their right to formulate advance directives and to accept/refuse medical treatment. The healthcare entities must also provide written information to incoming patients regarding the Arizona law on these issues. Under this Federal law, health care facilities may not refuse admission based on whether a patient has or does not have an advance directive, but must document whether an advance directive exists.

II. Reasons to Plan Ahead by Completing Health Care Directives

Frequently a health care directive is an afterthought in estate planning, merely an adjunct to a living trust. The same "cookie cutter" form is used for every client and

little thought or effort is put into tailoring the document to the desires of a particular client. Clients are rushed into making judgments on options available on the forms often without having given the options much advance consideration and without them even understanding the importance of the documents. Health Care Directives are important to complete in advance of incapacity for the following reasons:

1. Choice in the decision maker. Absent a health care power of attorney, a surrogate decision-maker for an incapacitated person is determined by default by Arizona Statutes. See A.R.S. § 36-3231. Choosing the right person for the job is particularly important because the surrogate decision-maker must decide based on the substituted judgment standard. This means that decisions must be made according to the patient's wishes: the surrogate "stands in the shoes" of the patient. If the patient's wishes are unknown, then decisions must be made based on the patient's values. Only if the patient's known wishes and values are insufficient to give direction, should the surrogate fall back on the "best interest" standard, A.R.S. § 36-3203. Therefore, it is important that the surrogate know the patient well and be willing to advocate for his or her wishes. (See attached a list of questions as discussion piece to determine patient's wishes) Other factors in choosing a surrogate include the following:

   a. Does the surrogate reside in an area which is geographically close to the residence of the patient?
   b. Does the surrogate have the available time to do the job effectively?
   c. Does the surrogate have any experience or training in the health care-mental health care field?
   d. Does the surrogate have the type of character that would allow them to be aggressive in advocating for the patient's wishes?

2. Withdrawal of artificial nutrition and hydration. A surrogate decision-maker who is not appointed under a health care power of attorney may not authorize the withdrawal of artificial administration of food or fluid unless there is a living will authorizing the withdrawal. A.R.S. § 36-3231(D). Note however, despite there being no ethical distinction, a default statutory surrogate can authorize the withholding of artificial administration of foods or fluids.

3. Release of medical information to the surrogate. Obviously if the surrogate cannot obtain pertinent medical information regarding the patient he will not be able to do his job effectively. A.R.S. § 36-3204 provides that a health care provider has a duty to volunteer and otherwise disclose information about the patient's health status and care to the patient's surrogate to the same degree that the provider owes this duty to the patient. However, the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 U.S.C. § 1320d and 45 C.F.R. §§ 160-

164, federal law prohibits disclosure of heath care information without prior authorization from the client. This issue can be addressed in advance by including specific authorization in the health care power of attorney for release of this information to the agent under the HIPAA. HIPAA requires at a minimum that the authorization include the ability to obtain all individually identifiable health information and medical records in any form, or media, electronic, paper or oral information, including demographic information. This includes information that is; a) created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearing house; and b) related to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and information that identifies the individual; or information when there is a reasonable basis to believe that such information can be used to identify the individual. Individually identifiable information includes many common identifiers such as; name, address, birth date, and Social Security number.

5. Statement of wishes. The living will and prehospital medical care directive (defined below) give the principal the ability to give directions in advance to the surrogate about healthcare he wants or doesn't want under particular circumstances. Absent written direction, there is no assurance that the principal's wishes will be carried out. The surrogate's job is much harder if he or she has no instruction, and life and death decisions made by the surrogate may make him feel guilty, and leave him wondering whether he did the "right thing". A statement of wishes will also lessen the likelihood of disputes between family members or between family members and healthcare providers.

6. Problems in the default decision-maker statute (A.R.S. § 36-3231). As noted below, relying on the Arizona Statutes to determine the surrogate decision-maker can create difficult situations.

III. Who Decides?

1. The patient. As long as a competent patient can make and communicate health care treatment decisions, i.e. give informed consent, as determined by his physician or other competent health care provider, the patient by law has the authority to make his own healthcare decisions. The United States Supreme Court has determined that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. Cruzan vs. Director, Missouri Department of Health, 110 S. Ct. 28841, at 2851 (1991). Informed consent is defined pursuant to A.R.S. § 36-501(17) to be "a voluntary decision following presentation of all facts necessary to form the basis of an intelligent consent by the patient or guardian with no minimizing of known dangers of any procedures".

2. A surrogate. If the patient is unable to give informed consent to treatment, then a surrogate decision-maker must be identified. It is the health care provider's responsibility to make reasonable efforts to contact and consult with a surrogate. A.R.S. § 36-3231(A). Arizona law recognizes surrogate authority in the following order of priority:

a. Court-appointed guardian (only a mental health guardian may consent to inpatient psychiatric hospitalization absent an emergency).
b. Agents designated in a health care or mental health care power of attorney as limited only by the express language of the document or by court order. A.R.S. §36-3233.
c. The individual's spouse, unless legally separated. (What if they are physically separated?)
d. An adult child of the individual. If more than one, the health care provider shall seek the consent of a majority of the adult children who are reasonably available for consultation. (Is a voting contest a good idea? What if there is a tie vote?)
e. The individual's mother or father. (Which one?)
f. The individual's domestic partner, unless someone else had financial responsibility for him or her.
g. The individual's brother or sister. (Which one?)
h. A close friend of the individual. (Someone who shows special concern for the individual and is familiar with his or her health care views). (Which one?)
i. The individual's doctor, with the advice of an ethics committee or, if this is not possible, with the approval of another doctor in the event that the health care provider cannot find an available and willing surrogate. (Does this create a conflict of interest for the doctor?)

3. Agent Appointed in a Health Care Power of Attorney. A health care power of attorney means a written designation by the "principal," the person who is the subject of a health care power of attorney (A.R.S. § 36-3201(12)), of an agent, the surrogate decision-maker, to make health care decisions. A.R.S. § 36-3201(6). A valid document pursuant to A.R.S. § 36-3221 must:

a. Be completed by an adult principal and name an adult agent;
b. Contain language that indicates that the principal intends to create a health care power of attorney;
c. Be signed or marked by the principal and dated (if the person is unable to sign or mark, the notary or each witness must verify that

the principal directly indicated to the notary or witness that the document expresses the principal's wishes and that the principal intends to adopt the power of attorney.);

d. Be signed by a notary or by an adult witness(es) who say the individual signed or marked the documents and who says that the individual appears to be of sound mind and free from duress:

1) A notary or witness cannot be the person named to make decisions and cannot be providing health care to the individual.
2) If there is only one witness, that witness cannot be related to the individual or someone who will get any of the individual's property from his/her estate if he/she dies.

e. Only come into effect when the principal is unable to make or communicate health care decisions. A.R.S. § 36-3201; A.R.S. § 36-3223;
f. Be durable, i.e., is effective for as long as the principal is incapacitated. A.R.S. § 36-3201(6).
g. Specifically grant the agent the authority to consent to inpatient psychiatric treatment if the agent is to have that power.

4. Authority for agent appointed in Health Care Power of Attorney to make Organ Donation and Autopsy Decisions. A Health Care Power of Attorney also grants the authority to the agent to make organ donation and autopsy decisions. Specific provisions regarding release of confidential medical information should also be included.

5. Authority for agent appointed in Health Care Power of Attorney to make Funeral and Burial Dispositions. A.R.S. § 36-3224 gives an agent appointed under a Health Care Power of Attorney the authority to make funeral and burial dispositions if the authority is set forth in the document. The principal may direct whether he wishes to be buried or cremated, and if cremated, how the ashes will be disposed of. The agent may also direct all funeral dispositions. The surviving spouse still trumps an agent given the funeral and burial direction powers, but the agent trumps all other next of kin. See A.R.S. § 36-3224.

6. A Court Appointed Guardian

a. Guardianship:
1) Purpose: Arizona law allows family members to make health care decisions without guardianship, even if there is no health care power of attorney. However, in cases where there is

family conflict regarding health care decisions, including end of life decisions, or the ward is refusing to assent to placement, a guardianship may be necessary.

2) Powers: A guardian is appointed by the court to act for someone who cannot make responsible decisions concerning his or her person due to disability or illness. A guardian by law has all the duties and responsibilities that a parent has with respect to a minor child. The guardian typically makes healthcare and placement decisions for the ward but is not permitted to manage the finances of the ward.
3) Time period for obtaining order: A guardian can be initiated quickly on an emergency basis. In cases when there is not time to notify the patient or if such notice would cause irreparable harm, then an order can be obtained immediately without notice. If notice is required, then a temporary order can still be obtained in five to seven days typically. Obtaining a permanent guardianship order usually takes about 45 days in Yavapai County.
4) Procedure: A report by a physician, nurse or psychologist is required in support of the petition. An attorney is appointed for the proposed ward who can contest the petition. The ward must be served with the petition.
5) Fees and costs: Typically for an uncontested case the final charge, including the court appointed attorney's fees, will be approximately $4,000-6,000 depending on whether there's an emergency (this requires two hearings-one for the temporary order and one for the permanent).

IV. Written Direction on How to Decide.

1. Living Will
   a. Defined. "An adult may prepare a written statement known as a living will to control the health care treatment decisions that can be made on that person's behalf." A.R.S. § 36-3261.
   b. Purpose. The document is typically used to direct when life sustaining treatment, such as artificial ventilation and artificial nutrition and hydration, should be withheld or withdrawn when a person is terminally ill or in an irreversible coma or persistent vegetative state. However, the document can be used to direct any type of care the person does or does not want, and must be followed by the surrogate decision maker for the person, unless the document gives guiding instructions only. However, the document cannot replace a discussion on end of life issues with your family and your

physician to ensure that everyone is on the same page and understands your wishes, so questions that they might have can be answered.

c. Execution requirements. The execution requirements are the same as for the health care power of attorney. A.R.S. §36-3261(B). The document may be used as part of, or separate from, a health care power of attorney. A.R.S. § 36-3261(A).

d. Questions to Consider in Doing a Living Will:

1. Is the living will intended to give guiding or controlling instructions?
2. Who are the instructions directed to?
3. What kind of medical treatment does the living will direct be withheld, withdrawn or administered? If end of life treatment is the focus of the instructions, is the definition of life sustaining treatment or life support broadly defined so that it includes any medical treatment intended to keep the person alive, or only certain types of specified typical end of life treatments (such as artificial ventilation, artificial nutrition and hydration, dialysis and cardio-pulmonary resuscitation)?
4. Under what conditions should the medical treatment be withdrawn, withheld or administered? For example, the typical ones addressed are terminal illness, irreversible coma, persistent vegetative state, and sometimes advanced brain damage and a locked in state.
5. The document should include the option of saying the person wants treatment no matter the cost or chances of recovery, and on the opposite end of the spectrum, the option of saying that the person does not want the treatment even if the treatment may reverse the life threatening condition. Are there specific treatments you do not want no matter the chances of your recovery?
6. Should the document address quality of life factors as determinative as to whether life sustaining treatment should be withheld or withdrawn?
7. What level of certainty is required before action can be taken? Is a doctor's determination required? Does a trial period of treatment have to be attempted first? Should a legal definition of certainty be included such as "to a reasonable degree of medical certainty"?
8. It is advisable to specifically address palliative/comfort care in the document. Does the person want that type of treatment even if it might dull the person's consciousness more than it already is, indirectly shorten the person's life, or cause medication addiction or dependence?

e. Reasons Why Not Having a Living Will Is a Problem.

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1. There is less assurance that the person's wishes are carried out if a living will has not been executed. The charge of the health care decision maker is to do what the patient would have wanted; this becomes an impossible task if the decision maker does not know anything about the principal's wishes. If the agent makes a decision that conflicts with a provision in the patient's living will, the living will provision will override the agent's decision. Therefore, it is important that the surrogate know the patient well and be willing to advocate for his or her wishes. (See attached a list of questions as discussion piece to determine patient's wishes.) The living will and prehospital medical care directive (defined below) give the principal the ability to give directions in advance to the surrogate about healthcare he wants or doesn't want under particular circumstances. Absent written direction, there is no assurance that the principal's wishes will be carried out. A statement of wishes will also lessen the likelihood of disputes between family members or between family members and healthcare providers.
2. A surrogate decision-maker who is not appointed under a health care power of attorney may not authorize the permanent withdrawal of artificial administration of food or fluid unless there is a living will authorizing the withdrawal. A.R.S. § 36-3203(E). Note, however despite there being no ethical distinction, a default statutory surrogate can authorize the withholding of artificial administration of food or fluids.
3. Pursuant to A.R.S. §§ 36-3211 and 36-3212, if there is a legal challenge, a feeding tube cannot be withdrawn or withheld unless
    - There is a health care power of attorney or living will authorizing the withdrawal or withholding, or
    - It is not medically possible to provide food and fluids, or
    - Providing food or fluids would hasten death, or
    - The patient is unable to digest or absorb the food or fluids due to the medical condition(s); or
    - A court determines that there is "clear and convincing evidence" that the patient is in a persistent vegetative state AND at some prior time had expressly given informed consent to the withdrawal or withholding of the sustenance while still legally capable and competent.
        - All appeals must be exhausted before the withdrawal of food or fluid can take place.

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4. A living will helps to alleviate guilt that a decision maker may feel in making difficult health care decisions for the principal. The surrogate's job is much harder if he or she has no instruction, and life and death decisions made by the surrogate may make him feel guilty, and leave him wondering whether he did the "right thing."

f. Advantages and Disadvantages of Different Living Will Forms

1. The Arizona Statutory Living Will Form set forth in A.R.S. § 36-3262 (attached hereto)

- Only Advantage: Although the statutory form is only a sample form, the user has assurance that it is legal and it is widely used and recognized.
- Disadvantage: The level of certainty is not addressed clearly-see bullet points above. Doesn't the answer to number 4 always have to be yes? Why would someone want life sustaining treatment withheld or withdrawn if the doctors hadn't reasonably concluded that the condition was irreversible or incurable?
- Disadvantage: Life sustaining treatment is not defined and under paragraph two why are there only three options with regard to medical treatment to be withdrawn and withheld and not others (such as artificial ventilation and dialysis)?
- Disadvantage: The form is very poorly designed and confusing. Why terminal condition is addressed in both paragraph 1 and 2? If paragraph 2 is checked off, isn't paragraph 1 redundant?
- Disadvantage: This form completely ignores the most important consideration: what about how quality of life factors into the decision as to whether life sustaining treatment should be withheld or withdrawn?
- Disadvantage: Even as a living will form that focuses on medical conditions rather than on quality of life factors as being determinative the document fails miserably. What about a person with advanced brain damage who doesn't want life sustaining treatment but who is not in a coma or vegetative state? Or someone in a locked in state? Or someone who is "ready to go" no matter what, even if treatment would be successful.
- **CONCLUSION**: It is very unfortunate that our legislature could not do better than this. The statutory form should be changed. This form is highly deficient, confusing, internally inconsistent and poorly written. This author recommends that this form not be used as long as there is an alternative. Whether it is better than nothing is

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somewhat debatable, but probably better to have this form than nothing at all.

2. Five Wishes (attached hereto)

- Advantage: Also, widely recognized and used which is helpful when the document is being implemented.
- Advantage: Forces the person to think about quality of life issues in an in-depth manner.
- Advantage: For the most part the document is comprehensive.
- Disadvantage: It is long and takes longer to fill out which may put some people off from doing the document.
- Advantage: Has definition of life support which is consistent throughout document, and which is broadly defined as any treatment intended to keep you alive.
- Disadvantage: Why are there reminders at the beginning to the caregiver? Why not include those reminders in the rest of the main part of the directive? Why are the instructions addressed to the caregiver instead of the agent? Why does it just address wanting comfort care even if it makes the person drowsy, and not more serious issues, like addiction, indirectly shortening life, or affecting cognitive function?
- Disadvantage: In the close to death instruction, what does "I want life support treatment if the doctor believes it could help" mean. Help with what? Keeping you alive longer? That question is confusing and unhelpful?
- Disadvantage: In the close to death instruction, the document strays from the designer's philosophy of focusing on quality of life. Isn't the real question about whether you want the moment of your death delayed depend on what your quality of life would be? Are you able to communicate with others? Are you able to appreciate others? Are you dependent on others for care? Do you have untreatable pain and or discomfort? Sometimes that extra time is extremely important if you are able to recognize loved ones and to communicate with them.
- Disadvantage: In coma section why isn't vegetative state included in there also? Essentially they are the same states except as to whether the person's eyes are opened or closed.
- Disadvantage: The section on permanent and severe brain damage sounds like it is dealing with terminal illness all over again when it says " and life support would only delay the moment of my death"

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And if you can't speak or understand isn't that just a vegetative state?

- Disadvantage: What about a locked in state or advance brain damage affecting ability to communicate or understand when there IS no coma or vegetative state and treatment CAN reverse the life-threatening condition? This is a huge oversight in this highly acclaimed form. And what about someone who doesn't want treatment even if their condition is reversible with treatment, i.e. no matter what, they don't want medical treatment to keep them alive because they are ready to go whatever the life threatening situation is?
- **CONCLUSION**: This form has been in vogue for a long time with health care providers but there are many problems with the living will portion of the five wishes document. While it is better than the statutory form, there are better forms available and it is surprising how many holes there are in the document.

3. Health Care Decisions Short Form (attached hereto)
    - Disadvantage: It is short, maybe too short and simplistic and it doesn't give you many options. Some of the standards are so broad as to be unclear. What does total or near total dependence on others for care mean?
    - Advantage: This form has been really well thought out and is one of the few internally consistent ones.
    - Advantage: It is one hundred percent focused on quality of life issues. In that sense it is revolutionary.
    - Advantage: It is very easy to fill out and can be done in a short amount of time.
    - Advantage: It has a very good question that other forms do not. Are there certain treatments you don't want no matter what your chances are of recovering? This author has had a case where a client told him he "never wanted to be cut on again", another who said they never wanted chemotherapy under any circumstances, another who had been on a ventilator and then taken off who said they never wanted to be on a ventilator again no matter what.
    - **CONCLUSION**: This is a great little form and is perfect for handing out to people at seminars or events where people are encouraged to get their living will form filled out. It may not have lots of bells and whistles, but it is clean, clear and cuts

> to the chase. What does a good quality of life mean to me? And when is my quality of life so bad that I don't want to be kept alive anymore? And that is what a living will should be all about.

While these boilerplate forms address some common concerns, this author feels that the living will should be tailored for the specific needs and wishes of the individual and should include quality of life and other concerns such as:

- Do you want your living will to guide your agent's decisions or control their decisions?
- What if you are in one of the listed conditions, but appear to be happy and enjoying life?
- Is it important to you to say goodbye to your family and friends if you are able to do so?
- Are there certain treatments you never want regardless of the circumstances?
- Do you want a trial period of treatment before a decision is made on whether to prolong your life?
- What if you have a secondary reversible life threatening condition, but an irreversible chronic condition such as a lack of ability to appreciate or recognize other people or an inability to communicate?

2. Prehospital Medical Care Directive (Orange Form).

   a. Defined. A prehospital medical care directive directs the withholding of cardiopulmonary resuscitation by emergency medical system and hospital emergency department personnel in the event of cardiac or respiratory arrest. A.R.S. § 36-3251(A). Cardiopulmonary resuscitation includes cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related medical procedures, but does not include measures to provide comfort care.

   b. Execution of prehospital medical care directive. The document must:

      1) Be printed on orange background;
      2) Be in the exact form required by law;
      3) Be signed or marked by the individual and dated, or if the individual is incompetent, an agent under a health care power of

attorney, or a court appointed guardian can sign on behalf of the patient;

4) Be signed by a licensed health care provider and a witness. A licensed health care provider includes the following: a physician, doctor of osteopathy, doctor of medicine, licensed physician's assistant, licensed practical nurse, registered nurse, graduate nurse or a professional nurse.

c. A bracelet and card may also be used. Note however, the bracelet itself does not comply as a directive.

d. When to use. This document will result in no resuscitation of the principal no matter the cause of the arrest, potentially resulting in death no matter the circumstances, for example, pool drowning, allergic bee sting reaction, choking on a chicken bone (not just heart attack). This document probably most appropriate for the terminally ill.

V. Revocation of Health Care Directive.

1. Requirements. A health care directive may be revoked pursuant to A.R.S. § 36-3202 by any of the following:

a. Making a written revocation;
b. Orally notifying the surrogate or health care provider;
c. Making a new health care directive;
d. Any other act that demonstrates a specific intent to revoke.

2. Capacity. The principal must have the capacity to revoke except that the principal in a Mental Health Care Power of Attorney may revoke the document even if incompetent to do so unless the document says otherwise. A.R.S. §36-3285

VI. Immunity from suit.

1. Surrogates are immune from liability for good faith decisions and decisions made in reliance on a health care directive are presumed to be made in good faith. A.R.S. §36-3203(D).

2. Healthcare providers are immune from liability for good faith decisions made in reliance on an apparently genuine health care directive. A.R.S. § 36-3205.

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VII. Obligation of Health Care Providers.

Health care providers must comply with a decision of a surrogate unless the decision is inconsistent with a health care directive.

VIII. Out of State Directive.

Directives completed out of state are valid if they were valid in the state where executed. A.R.S. § 36-3208.

IX. Judicial Enforcement.

A seldom used judicial remedy is available to determine the validity or effect of a health care directive or the decision of a surrogate. The court may enter temporary orders and final orders to:

1. Appoint a surrogate (guardian) pursuant to Title 14;
2. Remove an agent or surrogate and appoint a successor;
3. Direct compliance with a directive;
4. Direct transfer of a patient to a different facility;
5. Assess court costs and attorney fees.

X. Arizona Advance Directive Registry

1. Introduction: "In May, 2004, the Arizona State Legislature created the Arizona Advance Health Care Directive Registry. The Registry is a data base for the storage of advance directives and the Arizona Secretary of State oversees its security and operations." (Letter from Jan Brewer Secretary of State) The Advance directives that can be stored include the Living Will, Health Care Power of Attorney and Mental Health Care Power of Attorney.

2. Purpose: Registering advance directives with The Secretary of State helps to ensure the principal's documents can be found quickly in the event the principal's documents are not readily available, or if the principal is unable to give information to a health care provider due to severe illness or an accident.

3. Confidentiality: Access to the principal's documents is protected by barring access to everyone except those who have the principal's pass word. It is important that the principal's physician, health care agent and involved family members have the password.

4. Access in an Emergency: The Secretary of State issues a wallet card to the principal once the registration is completed. The password is on the card.

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5. Application Process: Application forms may be obtained by calling the Arizona Secretary of State at (602) 542-6182, or by visiting the Secretary of State on line at www.azsos.gov. Once the form is obtained it must be completed and signed. The Health Care Directive must be attached to the form and sent in with the completed form. The Secretary of State will print a record of the registration, and mail it to the principal to verify that it is correct. If it is correct, the principal indicates that no correction is required and sends the information back. There is no cost for registering. It usually takes about three weeks for the registration process to be completed and for the wallet size card to be issued.

XI. Relevant case law affecting Arizona citizens.

1. Cruzan vs. Director, Missouri Department of Health 110 S. Ct. 2841 (1990). The United States Supreme Court in 1990 decided that it was not a violation of the United States Constitution for Missouri to require clear and convincing evidence of an incompetent person's wishes before withdrawing life sustaining treatment. Fortunately, in Arizona, there is no requirement of clear and convincing evidence of the person's wishes. A guardian may make all health care decisions including the decision to withdraw life sustaining treatment. A.R.S. § 36-3231D.

2. Rasmussen vs, Fleming, 154 Ariz. 207 (1987). The seminal case in Arizona regarding the withdrawal of life support is Rasmussen vs. Fleming. This case has been largely superseded by Arizona's statutory scheme addressing life support issues. However, the court found that the right to privacy in Arizona's State constitution encompasses an individual's right to refuse medical treatment. The court balanced state and private interests and determined that the guardian in the case, under the substituted judgment standard, had a right to refuse unwanted treatment for a Ward even though the Ward was incompetent to express her wishes.

3. Terry Schiavo Case (Florida). Guardian/husband of Terry Schiavo petitioned the court asking permission to pull feeding tube from his wife, Terry. Terry's parents filed numerous legal actions in both State and Federal courts to attempt to block the termination of life support and ultimately were unsuccessful. The parents believed Terry was not in a persistent vegetative state and that she would not have wanted life support terminated. Her husband believed that she would not have wanted the treatment and that she was in a persistent vegetative state. Autopsy showed Terry's brain damage was consistent with her being in a vegetative state at the time of her death.

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XII. Assisted Suicide

1. Legislation in Other States. Currently, only five states, Washington, Oregon, Vermont, California, and Colorado, and the District of Columbia, have legalized assisted suicide via legislation. Under all four states' laws, the patient must:

- Be aged 18 or older;
- Be a resident of the state;
- Be terminally ill with six months or less to live, as certified by two physicians;
- Make two oral requests, at least 15 days apart; and
- Make a written request, which must be witnessed by two people, one of whom cannot be a relative by blood, marriage or adoption, the patient's heir or devisee, attending physician or an owner, operator or employee of the health care facility in which the patient resides or is receiving medical treatment. If the patient resides in a long-term care facility at the time the written request is made, one of the witnesses must be an individual designated by the facility who meets qualification set forth by the Department of Health.

2. Legislation in Arizona. Arizona law does not currently authorize assisted suicide or mercy killing. A.R.S. §36-3210. It is a felony to assist someone to commit suicide. A.R.S. § 13-1103. In January 2016, the Death with Dignity Act, which mirrors the five states' laws, was introduced in Arizona Senate Bill 1136 and House Bill 2347, but it was stalled in committee. It was reintroduced in January 2018 as Senate Bill 1414 and House Bill 2102, which are currently in committee. However, the Arizona Senate has also passed Senate Bill 1439, which was signed by the governor on March 24, 2017 and codified under A.R.S. § 36-1321 et seq. This new law prohibits discrimination against health care entities, providers, and employees who refuse to provide assisted suicide services, which may leave Arizonans with little or no means of implementing assisted suicide, even if the Death with Dignity Act eventually passes. This law also prohibits legal actions against health care entities regarding their refusal to provide assisted suicide services. This law has no current effect on assisted suicide because the current Arizona law makes assisted suicide illegal.

3. Case Law on Assisted Suicide. In 1997, in Vacco v. Quill, 117 S. Ct. 2293 (1997), the United States Supreme Court held that it was not unconstitutional under the equal protection clause of the 14th Amendment for a state to outlaw assisted suicide. In Washington v. Glucksberg, 117 S. Ct. 2258 (1997), the United States Supreme Court ruled that it was not unconstitutional for a state (Washington) under the Due Process Clause of the United States Constitution to outlaw assisted suicide because the right to assistance in committing suicide is not a fundamental liberty interest protected by the due process clause.

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4. Ruling Based on State Constitution. In 2009, the Montana Supreme Court ruled that physician-assisted suicide was legal in that state due to privacy, dignity and equal protection rights delineated in Montana's Constitution. The Court ruled that a terminally ill, competent patient has a legal right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution. That includes a right to "use the assistance of his physician to obtain a prescription for a lethal dose of medication that the patient may take on his own if and when he decides to terminate his life." It further held that the right protects physicians who prescribe a lethal drug for the patient.

XIII. Conclusion.

For the reasons noted above, planning ahead is important. Everyone over the age of 18 should have a health care power of attorney and living will, and a pre-hospital medical care directive ("orange form") may also be appropriate for some people. Planning ahead with advance directives can lessen the chance of conflict among family members and the necessity of court proceedings.