

8 Ariz. Summit L. Rev. 447

Arizona Summit Law Review
Spring 2015

10th Anniversary Issue

A GOOD DEATH: INCREASING THE ADOPTION AND EFFECTIVENESS OF ADVANCE DIRECTIVES IN ARIZONA

Wendy Metcalf Anderson

Copyright (c) 2015 Arizona Summit Law Review; Wendy Metcalf Anderson

I. Introduction

As Benjamin Franklin's famous quote tells us, "In this world nothing is certain but death and taxes." We know when taxes are due, and, in general, we spend a significant amount of time every year considering the most strategic moves so that we can submit the tax return that is most favorable to our financial health. In stark contrast, most of us do not know when death will arrive, and, in general, we spend virtually no time considering or documenting what our final months, weeks, or days will be like and are therefore unable to direct the process to ensure this same desired outcome with regard to our death.

Advance planning for an end-of-life situation can be an effective way to ensure that we live our final days on our own terms. Advance directives, in various formats, outline the patient's desired treatment options, expressed when he is competent to make such decisions, and would be effective in the event that he loses the capacity to adequately communicate or participate in decisions regarding his own care.¹ Dying patients who have discussed their end-of-life wishes with their physician are more likely to choose fewer life-sustaining treatments and more likely to spend their final days in hospice, rather than a hospital, than those who have not engaged in this type of conversation.²

Americans, however, generally do not die in a way they would like.³ Overall, patients and their families have expressed the desire for quality of life *448 and to avoid artificially prolonging their dying process.⁴ While the majority of Americans would prefer to die at home or at hospice with less aggressive care, studies have shown that seventy-five percent die in a hospital or nursing home, with nearly twenty percent of them in the intensive care unit.⁵ As a result, chronically ill and dying Americans are receiving medical care far in excess of what they and their families want.⁶ Yet fewer than twenty-five percent of Americans have executed advance directive documents that clearly specify their wishes.⁷

This paper will discuss various advance directives currently in use and the landmark legal cases that created national awareness and debate over the last 40 years. Additionally, this paper will consider the current state of legislation regarding advance directives nationally and in Arizona and will explore the reasons that the laws inadequately serve to better encourage the use and effectiveness of these documents. As its primary purpose, this paper will propose several statutory changes designed to increase the rate of adoption of advance directives in Arizona and improve the availability of such documents when they are needed most - when a patient is physically or mentally incapable of communicating their end-of-life wishes.

II. Advance Directives

There are two primary types of recognized advance directives: instructional and proxy.⁸ Instructional directives, commonly known as living wills, are used to ensure that the patient's wishes regarding his end-of-life care are conveyed to his family and physicians, should he be unable to communicate when he is ill or if he lacks the capacity to make a decision.⁹ A living will authorizes the continuation or withdrawal of life-sustaining medical treatment if the patient suffers from the specific healthcare situations outlined in the document.¹⁰ It may refer, among other things, to the artificial administration of food and water, pain management, life sustaining procedures and instances for artificial resuscitation.

*449 A proxy directive, more commonly known as a healthcare power of attorney, gives the person named by the patient the authority to make healthcare decisions on their behalf if they are unable to do so for themselves.¹¹ The proxy can consider all circumstances regarding the patient's current medical status and prognosis and the possible care options, and can make a decision based on the patient's known wishes or the proxy's belief as to the patient's wishes.¹² The healthcare power of attorney designation can overcome any limitations of the living will because the proxy is able to react to an immediate situation, unlike a living will which was drafted previously.¹³ Advance directives are usually favored as they are seen as the closest approximation or replication of the patient's authentic preferences.¹⁴

A patient must be legally competent at the moment he is executing an advance directive since he is exercising his right to refuse future medical treatment that could result in his imminent death.¹⁵ Decision-making capacity has been described as having the ability to understand and communicate; to hold stable values and views of life; and to reason and deliberate.¹⁶ The American Bar Association's Commission on Legal Problems of the Elderly has devised an alternate three-part test: (1) that the patient is aware of his or her needs and alternatives for meeting them; (2) that the patient is able to express a preference regarding the alternatives; and (3) that the patient demonstrates a factual understanding of the risks, benefits and alternatives of treatment or no treatment.¹⁷

Legally competent adults may choose to reject medical treatment that will extend their life, even if removal might result in imminent death. In 1985, in *Tune v. Walter Reed Army Medical Hospital*,¹⁸ the court held that a competent adult patient with a terminal illness has the right to reject life-prolonging treatment or terminate artificial life support even after it has been initiated.¹⁹ The Supreme Court confirmed this position in 1997, in both *Washington v. Glucksberg*²⁰ and *Vacco v. Quill*,²¹ holding that the due process clause protects an individual's right to refuse unwanted medical intervention. The execution of a directive by a competent person is a valid method of communicating that he *450 wishes to have his life prolonged by artificial means, or not. If a patient is judged to be competent at the time of decision or when a directive was executed, the decisions must be respected.²² If determined incompetent, others will be designated as surrogate decision makers for him.²³ It is the absence of an advance directive or lack of proof of what the patient would have wanted that leads to state, and possibly judicial, intervention.

III. Landmark Cases

A. Karen Ann Quinlan

In the landmark New Jersey Supreme Court case, *Matter of Quinlan*,²⁴ Joseph Quinlan sought to be appointed guardian for his incapacitated daughter Karen so that he could have her life-sustaining medical care withdrawn.²⁵ At age twenty-one, Karen stopped breathing for reasons unknown and suffered brain damage.²⁶ She was in a chronic persistent vegetative state, unaware of anything or anyone around her and existing at only a primitive reflex level.²⁷ While there was no known remedy to improve or cure her condition, and she would never return to a cognitive life, Joseph's request to withdraw Karen's life support was opposed by her doctors, the hospital, the county prosecutor, the state of New Jersey, and Karen's guardian ad litem.²⁸ In the decision, the court reasoned that it would be Karen's own choice, if she were to become lucid for only a moment, to terminate the life-support, even knowing that it would lead directly to her death.²⁹ The court named Joseph her guardian and, using *Griswold v. Connecticut*³⁰ and *Roe v. Wade*³¹ as authority, held that Karen had a constitutionally guaranteed right to privacy to determine her own medical treatment, as expressed through him.³² The court delineated a balancing test, holding that the state's interests in the preservation and sanctity of life become *451 secondary to the patient's privacy rights as the treatment becomes more physically invasive despite a poor prognosis.³³

B. Nancy Cruzan

Following this decision, courts and legislatures explored the limits of the types of medical treatment and care that could be withheld from a patient who had no possibility of recovery as well as what standard would be required for a proxy to claim knowledge of the patient's previously stated desires regarding artificial life support.³⁴ Absent clear and convincing evidence that the patient would want to terminate the treatment, a proxy could not make the decision to remove life support.³⁵

This issue was addressed by the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*³⁶ regarding

a petition by Nancy Cruzan's parents to remove her feeding and hydration tubes.³⁷ Nancy fell unconscious and stopped breathing following a car accident at age twenty-five.³⁸ For seven years, she was in a chronic persistent vegetative state and doctors had determined that there was no possibility she would recover cognitive faculties.³⁹ The Court considered the issue of whether an incompetent person, such as Nancy, has the right to refuse life-sustaining medical treatment, as requested by her guardian, if there was no clear and convincing evidence that it would be her choice were she competent to make it.⁴⁰ The Court held that Missouri had the right to enforce the clear and convincing evidence standard and that the proof offered by the Cruzans regarding Nancy's alleged statements as to her wishes did not satisfy that standard.⁴¹ There was no assurance that her parents' substituted judgment comported with what she would have wanted had she been able to make the decision herself.⁴² This was a devastating blow to the family that only sought to end their daughter's suffering.

*452 C. Terri Schiavo

Fifteen years after the *Cruzan* decision, issues surrounding the removal of life support for patients in a persistent vegetative state captured the attention of the nation as family members fought one another regarding the best interests of Terri Schiavo.⁴³ In 1990, at age twenty-seven, Terri suffered cardiac arrest and fell into a coma, which progressed to a vegetative state.⁴⁴ Terri's husband had been named her proxy, following Florida statutory hierarchy when an incapacitated patient has not specifically named a proxy.⁴⁵ After her medical condition remained unchanged for eight years, he sought court approval to have her feeding tube removed; this would imminently lead to her death.⁴⁶ The trial judge found evidence of previous statements made by Terri that she would not have wanted to live in her current state compelling and ordered the feeding tube to be removed.⁴⁷ In affirming the lower court's decision, the appellate court reasoned that it was their role to allow the trial judge to serve as the patient's proxy to make decisions about life-prolonging treatments when families cannot agree.⁴⁸ Terri's parents fought this decision for years, appealing to all three branches of government in Florida and at the federal level, but ultimately lost.⁴⁹ A very private family situation was witnessed by the nation in 2005 as media reports covered the events of Terri's last days.⁵⁰

These three high-profile cases demonstrate the need for explicit instructions regarding one's end-of-life wishes. For Karen Quinlan and Terri Schiavo, the court believed that there was clear and convincing evidence that each would choose to discontinue to live in her current physical state and granted the requests to terminate life support.⁵¹ For Nancy Cruzan, the Supreme Court majority did not find clear and convincing evidence of her wishes and refused to grant the request of her parents to have life support removed.⁵² As women in their twenties, there would be no reason for them to believe they would suddenly and unexpectedly become incapacitated. In her concurring opinion in *Cruzan* in 1990, Justice O'Connor provided her support for advance directives, stating that surrogate decision making "may be a valuable additional safeguard of the patient's interest in directing his medical care."⁵³ Had these women *453 executed advance directives prior to their illnesses, the judiciary, even if used as a last resort, would have had tangible evidence, perhaps even clear and convincing evidence, of what each woman would have wanted for herself.

D. Arizona's Leading Case

Judicial support for legislation regarding advance directives was provided in the Arizona Supreme Court decision *Rasmussen by Mitchell v. Fleming* three years before *Cruzan*, in 1987.⁵⁴ According to her physicians, Mildred Rasmussen was in a chronic vegetative state from which there was zero probability of her returning to a higher level of functioning.⁵⁵ A public fiduciary sought appointment as her guardian so that he could authorize removal of her feeding tube.⁵⁶ There was no evidence that Mildred had ever expressed her wishes regarding her medical care in an end-of-life situation, and her only living relatives agreed to follow the advice of the physicians.⁵⁷ The court reasoned that Mildred had a right to privacy that was rooted in the United States Constitution, the Arizona Constitution and the common law.⁵⁸

Mildred died before the appellate court's ruling; however, the judges retained the matter for decision because it was a case of first impression in Arizona and the issues were of great importance to all families and healthcare professionals that would be faced with similar situations in the future.⁵⁹ In recognizing the impractical nature of resolving end-of-life disputes through the judicial system,⁶⁰ however, the court urged the Arizona legislature to explore the moral, ethical, social, medical, and legal considerations involved in disputes like *Rasmussen*,⁶¹ and to formulate guidelines that would address the rights and interests of all parties involved.⁶²

IV. National Legislation

Following the 1990 decision in *Cruzan*⁶³ and Justice O'Connor's separate opinion,⁶⁴ the states responded explosively, with virtually every state enacting *454 laws regarding some combination of instructional and proxy designations.⁶⁵ The United States Congress passed the Patient Self-Determination Act⁶⁶ (the "Act") to enable patients to actively participate in their own health care decisions, even if they are unable to communicate.⁶⁷ Additionally, part of the impetus for the Act was to encourage compliance with the states' laws.⁶⁸ The Act requires all healthcare facilities that receive Medicare or Medicaid payments to provide written information concerning "an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."⁶⁹ The information must be provided at the time of admission to the facility⁷⁰ and any patient who wishes to execute an advance directive must be given that opportunity.⁷¹ If a patient is incapacitated upon admission, the information may be given to family members or surrogates, but this is not required.⁷² Studies have shown that most healthcare facilities comply with the requirements.⁷³ However the rate of execution of advance directives by the public has not significantly increased as a result of the legislation.⁷⁴

V. State Statutes and Arizona Law

The states' advance directives statutes have several provisions in common. Typically there is a witnessing process to ensure the patient's legal capacity to execute the document.⁷⁵ The states grant immunity from civil or criminal liability for healthcare professionals who honor the wishes expressed in the patient's living will.⁷⁶ Additionally, many states permit the patient to name a proxy decision maker in a healthcare power of attorney.⁷⁷ Some statutes allow for total grant of decision making authority, while others restrict the authority to specific decisions expressed by the patient.⁷⁸

*455 A further statutory construction may be included due to the recognition that many people are not comfortable discussing their end-of-life process and will, therefore, never complete the advance directives that state laws permit.⁷⁹ Surrogacy statutes define a hierarchy of the people permitted to make decisions on behalf of an incompetent patient.⁸⁰ In general, the surrogates would be spouses, parents, adult children, adult siblings, or court-appointed guardians.⁸¹

Arizona enacted Title 36, Chapter 32 regarding living wills and health care directives in 1992.⁸² The law was amended in 2004, adding the state's Healthcare Directives Registry in Article 7.⁸³ The laws allow for an adult to prepare a living will that controls healthcare decisions made by others on their behalf; one sample living will form is provided.⁸⁴ The healthcare power of attorney is recognized as naming a specifically authorized individual to make decisions on behalf of the patient; a single sample healthcare power of attorney form is also provided.⁸⁵ In the absence of an executed living will, healthcare power of attorney, or court-appointed guardian, the surrogacy statute will determine who is authorized to make decisions on the patient's behalf, according to any known wishes.⁸⁶ The statutory hierarchy for surrogates in Arizona is spouse, adult child, parent, domestic partner, sibling, close friend, and the patient's physician.⁸⁷

The statute specifically allows for a person who is an adult to create advance directives.⁸⁸ Each document must be signed before a witness or notary, who is not related by blood, marriage, or adoption to the adult executing the documents.⁸⁹ The statute contains limitations against civil or criminal liability for the patient's physician or surrogate for decisions made on the patient's behalf according to the stated wishes in his advance directives.⁹⁰ There is a presumption that decisions are made in good faith, which is defined in the statute as actions taken according to the physician's or surrogate's reasonable belief of the patient's wishes or in the patient's best interest.⁹¹ Article 7 provides for the creation of a public, state-administered electronic database to *456 house living wills, healthcare powers of attorney, and mental healthcare powers of attorney.⁹² The registry is to be maintained by the secretary of state, who "may accept gifts, grants, donations, bequests and other forms of voluntary contributions to support, promote and maintain the registry."⁹³

An Arizona citizen is not required to register their directives with the state registry and failure to do so does not affect the validity of the documents.⁹⁴ Should a person wish to register, they will receive a printed record of the registered documents, as well as a unique and confidential file number and password.⁹⁵ Documents stored in the registry are accessible, to the patient and to their healthcare providers, only by entering the confidential file number and password, located on a wallet card mailed to the registrant, on the registry website.⁹⁶ The statute, however, does not require a physician to determine if a patient has registered any directives with the state registry.⁹⁷ Providing the file number and password to the physician is the only way a physician will know there are directives in the state registry and how to access them.⁹⁸

VI. National Registry

The U.S. Living Will Registry is a private organization founded in 1996 to store healthcare directives and retrieve them for caregivers and families in any state.⁹⁹ Once a document is registered, the registry mails a wallet card with the registration number and date the information was last updated.¹⁰⁰ Additionally, the registry sends stickers to be placed on the registrant's driver license and insurance card, indicating that there are advance directives on file at the registry.¹⁰¹ Registrants are contacted annually as a reminder to update contact information for themselves or family members, and to confirm that the documents in the registry are still accurate regarding their wishes.¹⁰² When a document is needed, the healthcare facility can retrieve it from the registry website using the registration number from the wallet card.¹⁰³ If this number is unavailable, *457 however, or if the physician is uncertain that a directive is on file, they can call the registry, provide verifying information about the healthcare facility and supply the patient's personal information, such as name, birth date, and social security number.¹⁰⁴ If there is a directive on file, registry personnel will manually send it to the physician.¹⁰⁵

VII. Barriers to Adoption of Advance Directives

Despite both national and state legislation regarding the right to execute advance directives and the legal protections for those healthcare professionals who act according to them, the majority of adults have not adopted living wills and healthcare powers of attorney.¹⁰⁶ While most people respond positively to a discussion regarding advance directives and wish their physician would bring up the topic,¹⁰⁷ there are many reasons that people do not take action.

A. Lack of Awareness

A primary reason that people do not draft advance directives is that they are simply unaware that they exist as an option until a medical situation arises. A common way for people to learn about advance directives is when they check into a healthcare facility. The Patient Self-Determination Act requires that medical facilities supply information regarding advance directives to all patients upon admission.¹⁰⁸ The materials generally include forms to be completed on the spot, although this is not required, and submitted to the facility for storage and retrieval should they become relevant during the patient's stay. The statute includes no provision for a follow-up conversation, so the opportunity is lost if the patient does not sign right away.

Experts agree that the most opportune time for a discussion about one's end-of-life care takes place when they are not in the midst of a health crisis,¹⁰⁹ yet this is precisely the time that the national and state laws require this conversation to occur.¹¹⁰ Patients who address advance directives when they are already ill have lost the chance to make meaningful decisions because, once they are admitted, standard hospital procedures involved in attending to patients take over and it is harder for patients to have input about their care.¹¹¹ Additionally, approximately forty percent of hospitalized patients have a diminished *458 level of decision making capacity.¹¹² Discussing advance directives with a patient who is critically ill, in pain, and perhaps only partly lucid, could result in a patient signing legal documents when they temporarily lack the capacity to do so. More likely, however, is that a patient simply will ignore the paperwork.

B. Lack of Presence of Family or Friends

A further problem with distributing advance directive paperwork at hospital admission is that a patient may not feel comfortable or capable of making such important decisions without the presence of family and friends. Determining the provisions in a living will or healthcare power of attorney is typically not a one-step process because the issues are emotionally challenging and legally complex.¹¹³ Considering the views of loved ones is critical to the process of determining how one would choose to spend their last days and how they wish to approach death. Spiritual or religious patients might wish to consult with clergy regarding the views held by their faith about end-of-life care.¹¹⁴ Ideally, communication with families and friends about end-of-life care would begin early, before the onset of any life-threatening illness or diminishment of capacity.¹¹⁵ Asking or expecting a patient to rush through this process during in-patient registration, without the assistance of the people that comprise their personal support system, is simply not effective nor truly fair.

C. Misconceptions about Advance Directives

Finally, many patients have misunderstandings about advance directives. Those who are aware often think that living wills are only for the elderly or those with chronic or terminal health conditions. This notion is far from the truth. The cases of Karen Quinlan, Nancy Cruzan, and Terri Schiavo prove how important it is for everyone to make their wishes known, regardless of age. Each of these young women suffered an unforeseeable and tragic health crisis, and the absence of executed advance directives opened the door for her medical treatment to be the subject of litigation. Without definitive proof of a patient's desires, there is no way to predict how a court will rule. It is important to note, however, that there is no case involving a disputed living will where the living will has been invalidated.¹¹⁶ The trend has been to enforce a living will over ***459** the objections of the family, the physician, and the surrogate.¹¹⁷ There is wide consensus regarding the importance of advance directives for young people as it is critical, at any age, to make one's wishes known in a legally binding document.¹¹⁸

Many people misunderstand the purpose of a directive. Rather than granting permission for the family or physician to "pull the plug," a living will outlines the conditions under which a patient's life would be extended and what medical interventions would be desired.¹¹⁹ It may specify the level of pain medication and other comfort measures that would be provided.¹²⁰ On the other hand, it may be the patient's wish to limit their physician from doing everything possible to extend his life. He can specify at what point he no longer wants certain treatments, recognizing that some may provide no medical benefit yet will increase the emotional and financial toll on his family.¹²¹ In a living will, the patient can clearly communicate his choices.

Another misconception is that a living will or healthcare power of attorney is permanent. This is not true. While a patient is alive and competent, these documents are fully amendable and revocable.¹²² In fact, a living will should be reviewed often and amended as needed, to account for changes in the patient's health and their views on end-of-life care.¹²³ According to the American Medical Association, twenty-nine percent of people will change their mind regarding the type of life-sustaining treatment they want to receive after signing a living will.¹²⁴

A power of attorney should be reviewed periodically as well, since family situations change. A valid and enforceable healthcare power of attorney may name an individual as proxy that the patient no longer desires to be in that position, such as an ex-spouse. It may also name a deceased individual. In that case, a state's surrogacy statutes will prevail, and a patient will have no choice in the matter. But, surrogacy statutes are defaults, and are ineffective if a competent person has affirmatively named a proxy that differs from the statutory hierarchy.¹²⁵ If a patient desires that a friend or domestic partner act as their proxy, naming them in a directive may be the only means to ensure this, since non-relatives are generally excluded from surrogacy statutes, or are placed low ***460** on the statutory priority.¹²⁶ Additionally, a living will can be used to disqualify a surrogate, even if that person is within the statutory hierarchy.¹²⁷ Finally, the directives should be reviewed frequently to ensure the contact information for those named as proxies is accurate. The power of attorney will be of no use if the proxies named cannot be located when needed.

Patients often believe that they have no need for directives because their family knows the type of care they would choose for themselves. This approach may be successful if families have had meaningful conversation about how they want to spend their last days. Most patients, however, hope for a medical miracle rather than fully face the issue of their death.¹²⁸ According to the Supreme Court's ruling in *Cruzan*, a state may enforce a standard of clear and convincing evidence regarding the patient's wishes, and it is not bound to accept the word of close relatives as meeting that standard.¹²⁹ In the absence of clear and convincing evidence, the state may decide if a patient has exercised his right to refuse treatment, giving no weight to the beliefs of the family.¹³⁰ Additionally, in trying to advocate for what their loved one may have wanted, a proxy is likely to project her own values and beliefs, perhaps unknowingly.¹³¹ A proxy's actual decision is often not in agreement with what the patient would have wanted.¹³² While a patient may choose to allow his family to make decisions on his behalf, there is no guarantee that the result will be as he hoped. Also, there is no guarantee that a court will accept the proxy's assertion.

These barriers to greater adoption of advance directives are possible to overcome. In general, increased education at multiple points within one's life should suffice to dispel the misperceptions and the overall lack of awareness or understanding regarding the function and utility of living wills and healthcare powers of attorney.

VIII. Barriers to Compliance with Advance Directives

A. Directives Not Available When Needed

In the instances where a patient does have valid advance directives, they are often not followed. A primary reason is that healthcare professionals do not have access to the documents. It may defy logic, but nearly sixty percent of people who execute advance directives do not give a copy to their physician or *461 their family members.¹³³ Often, a directive will not be sent to the hospital from a nursing home, or a relative simply may forget to bring it to the hospital or alert the staff that the patient has a directive.¹³⁴ Physicians and nurses are generally supportive of advance directives, especially for patients whose conditions are unlikely to improve regardless of the care provided.¹³⁵ If more directives were available when needed, there would likely be greater compliance with patients' wishes.

B. Instructions in Directives are Vague

Directives whose meanings are vague or hard to understand will not always be followed. Although states have provided sample living will and healthcare power of attorney forms within their statutes, the wording is very legalistic and may be incomprehensible to patients with no legal training. Additionally, there is no required format for a valid directive. Language that differs from that in the sample is acceptable, as long as the statutory requirements for a living will are met.¹³⁶ As a result, people desiring to execute documents might create their own form or have one drafted for them, particularized to their personal needs. Numerous entities - hospitals, doctors, medical associations, lawyers, religious organizations - have designed forms for individual use, as well, creating inconsistency and ambiguity for the physicians who need to interpret their meaning.¹³⁷ While an individual may have a clear understanding of what "no chance for survival" means to them, it is possible that those same words hold different meaning for a physician.¹³⁸ Additionally, nearly two-thirds of living wills do not cover the clinical realities faced by the patients who are relying on their use to guide their physician in determining a course of action.¹³⁹ Directives will achieve more predictable outcomes when the terminology is effective for all parties and there is clear meaning about the patient's wishes.

C. Physicians May Not Adhere to Instructions in Advance Directives

Despite the presence of a valid directive, a physician may choose to disregard it for one of several reasons. Some may fear that if they follow a directive that results in an adverse outcome or the death of a patient, they will expose *462 themselves to a lawsuit from the family.¹⁴⁰ This is more perception than reality, however. Arizona statutes address this issue directly, granting immunity from civil and criminal liability for both physicians and surrogates who act in good faith reliance on an advance directive.¹⁴¹ Additionally, physicians are not subject to professional discipline for following the patient's wishes expressed in a directive.¹⁴²

Adhering to their own personal beliefs and values is also a common reason that a physician would choose to disregard a directive. Arizona statutes will not hold a physician liable for failing to follow a directive if the instructions violate a physician's conscience, but he must promptly withdraw after finding another physician to take over the patient's care.¹⁴³ Some physicians may object to a patient's desire to forego care even if the physician believes it could be beneficial. They may believe it is their duty as healers to do no harm to the patient and to utilize every available treatment to keep their patient alive as long as possible.¹⁴⁴ On the contrary, others may object to a patient's insistence on treatment, despite the futility of it. Professional ethics do not require that a physician provide treatment that will have no effect, especially if the instructions in the directive are contrary to the accepted medical standards in such a situation.¹⁴⁵

IX. Proposed Changes to Arizona Statutes

Several revisions to the current Arizona statutes related to advance directives and the healthcare directives registry will greatly increase the adoption of advance directives by citizens of this state, improve the level of compliance by physicians, and enhance the effectiveness of the registry. This part will list the proposed changes and provide rationale for each suggestion.

The proposed statutory changes include: (1) the creation of a professional committee to draft several versions of each type of

advance directive, to serve as the exclusive directives permitted in the state; (2) the permissibility of a living will executed by a minor; (3) the establishment of a government sponsored counseling program for those individuals desiring personal education or assistance in making choices for their advance directives; (4) the distribution of educational materials and sample directives through the Arizona Department of Transportation, Motor Vehicle Division; (5) operational revisions and a simplified *463 process for physicians to access directives from the Arizona Advance Directive Registry; and (6) a process to fund these proposals in full, by adding a surcharge to Motor Vehicle Division fees.

A. Standardized Forms

In the Arizona living will statute, there is a complete sample form that provides general statements about various medical treatment options with check boxes to indicate an individual's choice; the statute allows him to customize this form or use any other form that he chooses.¹⁴⁶ As one can imagine, there must be an endless number of different forms currently in use in the state, with perhaps no two formats exactly the same. A physician might have to make assumptions about the patient's meaning of the term "heroic measures" or "comfort care," rather than having concrete information about steps to be taken in a specific situation.¹⁴⁷ Doctors are tasked with interpreting a directive in the way the patient intended which may not be easy, or even possible, to do.

Rather than offer one template in the statute, Arizona should create and make available several templates, each providing the pertinent and necessary medical information, but in different styles of communication, to appeal to individual comfort levels. These few templates, however, would be the only legally accepted formats in Arizona, to allow for some measure of uniformity upon which physicians can depend. At one end of the spectrum, one format could consist of a checklist of options regarding the type of treatment a patient would want administered based on their situation. This is how most statutory samples are constructed. At the other end of the spectrum, the document could use common lay language to describe the possible treatment options for different medical situations and to describe the quality of life factors that an individual would choose at the end of his life.

Numerous formats for living wills have been proposed as a way to make the forms more effective. One such format is known as POLST - Physician Orders for Life-Sustaining Treatment. The purpose of this format is to translate a patient's end-of-life treatment wishes into actual medical orders that a healthcare provider must follow.¹⁴⁸ The POLST document is drafted cooperatively by the patient and his physician, using appropriate medical terminology, rather than legal terminology that may be difficult for a physician to understand, especially in emergency situations.¹⁴⁹ The Five Wishes format has gained much support as a document that uses everyday language to communicate end-of-life *464 choices.¹⁵⁰ The attraction of this format is that the language is readily understandable with no needed legal or medical explanations.¹⁵¹ The drafter, however, would need to ensure that a Five Wishes document did not contain legally ambiguous language so that it could withstand a legal challenge.¹⁵²

Another possible format is what one author describes as "less dogmatic, less demanding, less legalistic . . . something more folksy, a letter sharing your thoughts."¹⁵³ This format would allow the patient to address unconventional topics for a living will, such as his desire for a more peaceful death process by dying at home, rather than in a hospital, and that his family should not feel guilty for not employing all possible means for extending his life.¹⁵⁴ It can describe the conditions of life that the patient would find acceptable, and those under which he would be unwilling to continue living. Additionally, a letter like this could communicate a patient's desire that his family not exhaust all their financial resources in attempts to prolong his life.¹⁵⁵ The document would use the patient's own words to help his loved ones make an informed decision about what level of care, or withholding of care, he would choose if he were able.¹⁵⁶

The sanctioned use of living will formats such as these may seem counter to the proposed concept of standardizing the forms in Arizona. After all, no two individuals will create a personal letter to their family with the exact same factors for their family to consider. But clearly, a one-size-fits-all format is too limiting. The forms must fit statutory requirements, but the facts indicate that patients are more willing to execute a directive written in more common and understandable language.¹⁵⁷ Critics may not see the need for approved, standardized formats, and they may not believe that it is even possible to achieve given the personal nature of a document like a living will. However, the benefits of permitting just a few standard forms - some using technical legal or medical terminology, others allowing for more personalization by using the individual's own words - will outweigh the downsides as this will provide *465 some measure of consistency and clarity to aid physicians in quickly understanding a patient's wishes.

Arizona should authorize the formation of a committee of experts to create several template forms for the various directives. Each template must be legally sound and provide clear and convincing evidence of the patient's wishes so that it can withstand the scrutiny of threatened litigation by a family member or physician that does not wish to comply with its provisions. With complex issues of law, medicine, ethics, and religion to be considered, the committee should include physicians and healthcare workers, psychologists, medical ethicists, attorneys, and clergy.¹⁵⁸ This will not only ensure that the created documents address a myriad of critical issues, but also may lead to greater adoption of advance directives by Arizonans who can be sure that the directives will suit their needs.¹⁵⁹ Additionally, the state legislature will be assured that all interests were represented as the new documents were drafted.¹⁶⁰

B. Early Introduction of Concept and Documents

The tragic cases of Karen Quinlan, Nancy Cruzan, and Terri Schiavo stand as prime examples of why young adults should execute living wills. Their cases might never have gone to litigation had each woman completed a living will with her end-of-life wishes clearly specified. However, relatively few young people do this.¹⁶¹ National and Arizona statistics regarding accident injuries and deaths among young people illustrate the importance of being prepared for an unexpected injury where one might be rendered unable to advocate on his own behalf.

According to Census Bureau reports for 2009, there were 5,505,000 traffic crashes.¹⁶² Of these, 33,030 (0.6%) involved fatalities and 1,519,380 (27.6%) involved non-fatal injuries.¹⁶³ The accident statistics specific to young people are alarming. Nationally, people aged 24 and younger account for 13.2% of all licensed drivers.¹⁶⁴ Disproportionately, drivers in this age group account for 21.2% of vehicle accidents resulting in a fatality and 27.2% of all accidents.¹⁶⁵

***466** Unintentional injuries are reported by the Centers for Disease Control. Falls, assaults, overexertion, motor vehicle accidents, poisoning/overdose, and fire injuries are among the top twenty types of unintentional injuries for people aged 24 and younger.¹⁶⁶ In 2012, there were 12,222,386 unintentional injuries nationwide in this age group within the top twenty reasons.¹⁶⁷

Injury and hospitalization information for Arizona comes from the Arizona Department of Health Services. Unintentional injury was the fourth leading cause of death, accounting for 2804 (5.8%) deaths, in Arizona in 2012.¹⁶⁸ For the three-year period 2005-2007, there were an average of 1,100 unintentional deaths from motor vehicle accidents per year, 7,500 inpatient hospitalizations due to injuries sustained in motor vehicle accidents, and 50,400 motor vehicle accident victims admitted to emergency rooms.¹⁶⁹ Adolescents and young adults aged 15-24 had the second highest mortality rates from motor vehicle accidents each year in this same period.¹⁷⁰

While this information fails to report the number of accident victims who were unable to make their own healthcare decisions, it does point to the importance of being prepared for this possibility in the event of an unintentional injury. While only adults are legally permitted to execute advance directives, it is important for minors to participate in their own healthcare decision-making because of the possibility of critical injury from unforeseen circumstances, as the statistics show.¹⁷¹ For young people afflicted with an illness or chronic condition, it is equally important because they are already aware that their health problems might render them unable to participate in decisions regarding their care at some point. Communication among families should begin early, with discussion of individual desires and needs.¹⁷² Some of the more flexible living will options may provide an easier way for young people to think about their values and overall goals for their healthcare and their ability to shape it themselves.¹⁷³

***467** Courts will respect the wishes of a minor if it is determined that she has the requisite degree of maturity to make decisions regarding her own healthcare.¹⁷⁴ In *In re E.G.*,¹⁷⁵ the Illinois Supreme Court reasoned that being younger than the age of majority "is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood."¹⁷⁶ The court remanded for the trial judge to determine if there was clear and convincing evidence that the minor could appreciate the consequences of her actions and that she could exercise the judgment of adult.¹⁷⁷ If so, the court held that she had the right to consent to or refuse medical treatment.¹⁷⁸ The Maine Supreme Court held similarly in *In re Swan*¹⁷⁹ that clear and convincing evidence of a minor child's desire to not receive continued medical treatment in the event he was in a persistent vegetative state should be adhered to and respected.¹⁸⁰ Perhaps the American Bar Association's three-part test for competence, cited herein, could provide the test for a minor's competence.¹⁸¹

Arizona should formalize this doctrine and permit minors to execute a living will, as clear and convincing evidence of their

end-of-life wishes. It would be logical to require a parent or guardian to witness the signing of the document along with an unrelated third party. Legalizing this process would encourage serious discussion among families at a time when they are not facing an acute medical situation. It would force attention on the grim statistics regarding the disproportionate number of auto accidents and fatalities among persons under age twenty-five and would be an impetus for them to memorialize their wishes in an advance directive. Critics will argue that children are incapable of making such important life-or-death decisions, and that they lack the ability to see all sides of the issue objectively. The courts, however, have developed a standard by which to evaluate a child's capacity¹⁸² and determine if this is the case or not.

C. Public Education and Counseling

Advance directives are complicated documents, both legally and emotionally. Many people may not feel confident in their ability to execute the documents *468 without support¹⁸³ and may believe that their end-of-life choices are limited to only the circumstances or treatments that would hasten their death.¹⁸⁴ To encourage greater adoption, the state should provide counseling to help patients make informed decisions.¹⁸⁵ The Arizona Attorney General's office has already created a patient education packet, a twenty-four page document describing the purpose for advance directives and explaining the state registry.¹⁸⁶ A document like this, however, is likely to be intimidating to even the most educated citizens. For those not versed in legal terminology, it would be easier to ignore the issues entirely than to tackle on their own.

The state should fund the establishment of a free counseling program to assist individuals in formulating their personal choices and completing the various documents. This program should be staffed by medical personnel who can explain the multiple contingencies that directives are intended to cover. Attorneys and clergy should be available, as well, for citizens desiring to understand the issues from a legal, religious, or philosophical standpoint.

D. Distribution of Materials through Motor Vehicle Division

The Arizona Department of Transportation operates forty-five (45) Motor Vehicle Division ("MVD") locations throughout the state.¹⁸⁷ These offices provide a full slate of services related to driving and operating a vehicle in the state.¹⁸⁸ Additionally, the MVD website handles organ donation declarations and the voter registration process.¹⁸⁹ Many of these services can be accessed online through the MVD's authorized service website¹⁹⁰ or at any of the one hundred fifty (150) authorized third party provider locations around the *469 state.¹⁹¹ Arizona residents of all ages interact with the MVD on a regular basis for these services.

The Patient Self-Determination Act¹⁹² requires that advance directive documentation be distributed upon a patient's admission to a healthcare facility,¹⁹³ but many agree that this is an inappropriate and ineffective time to introduce legal documents that have life-or-death implications.¹⁹⁴ The documents should be distributed at a time and place where an individual is not facing a medical situation of any kind; state-operated MVD offices should be this place. The current MVD infrastructure should be adjusted to support the hard-copy distribution of an Advance Directives packet to everyone that applies for an instructional or driver license or an identification card. While printed material may be seen as a wasteful use of public funds, getting something directly into people's hands is a critical step for awareness. The information should certainly be accessible online, however, the need for greater public awareness demands that the state proactively distribute the packets, rather than relying on each person's individual initiative to find the information online. For those who would argue that the DMV is an inappropriate place to deal with information not related to driver services, it should be noted that the organ donation process is currently facilitated through the DMV, as is voter registration.¹⁹⁵

In Arizona, teens can apply for an instruction permit at age fifteen and a half and a driver license at age sixteen.¹⁹⁶ National and state statistics show that young drivers disproportionately get into vehicle accidents, both fatal and non-fatal.¹⁹⁷ It follows that Arizona has an interest in educating their young drivers about vehicle safety and the possible health consequences of dangerous driving. For teens, this material will be a valuable and effective way to start conversations within families who might otherwise never discuss the topic.¹⁹⁸

E. Revisions to Registry Operations

Several revisions to the statutes in Article 7 would enhance the effectiveness of Arizona's registry and ensure that directives

would be more accessible to physicians when needed. First, the registry should establish a process of continuous communication with the individuals who have filed directives. Currently, *470 once a directive is filed in the registry, the only activity that will take place is a request by the registrant to retrieve it, transfer it to a registry in a different jurisdiction, or delete it.¹⁹⁹ However, over time, an individual's values, beliefs and end-of-life choices might change. Accuracy may become an issue as the length of time between the original execution of a directive and the possible need to apply its provisions increases.²⁰⁰ Even if an individual's choices remain consistent, medical advances may render a document out-of-date, simply because it did not contemplate the possibilities for current treatment.²⁰¹ Directives should be reviewed, modified, and re-executed on a regular basis to ensure that they truly reflect the individual's wishes based on the most current information available.²⁰² The Arizona registry would provide a valuable service by sending electronic notices, perhaps annually, to remind registrants to review their documents, to access the website to confirm that the documents on file are still accurate, or to revoke and re-register newly executed documents.²⁰³

Additionally, the state should allow for designation that directives are filed with the Arizona Advance Directives Registry on an individual's driver license. Currently, a license application includes a checkbox for those who have made an organ donation commitment.²⁰⁴ Emergency personnel are accustomed to looking on a driver license for this designation. It would be logical to add a checkbox for the Advance Directives Registry on a driver license or identification card application and to print the designation on the license as well. This would significantly enhance awareness and effectiveness of the registry and might make a physician aware of the existence of directives even if the patient could not communicate that fact himself.

Finally, the registry should adopt new procedures for physicians to access their patients' directives. According to the statute, a physician can access documents by typing the patient's registry file number and password on the website portal.²⁰⁵ Sixty percent (60%) of people with valid advance directives do not give copies to their doctors or their families.²⁰⁶ It would be unreasonable to think that someone who does not share their actual directives with their physician or family would share their registry file number and password. Without this, however, a physician is unable to access the documents. This process *471 stands as a barrier to achieving the registry's purpose and should be changed. Perhaps the U.S. Living Will Registry process would make sense for Arizona.²⁰⁷

These represent only three suggestions, although important ones, that could be implemented to make the Arizona registry more robust. A survey of other existing state registries will undoubtedly reveal additional operational processes that could further improve its productivity. The state should establish a fact-finding committee to seek out information from other registries and to determine best practices that could be adopted here.

F. MVD Surcharge to Fund Proposals

The recommendations above are not, unfortunately, entirely free of cost. It may be possible to establish volunteer committees to research and draft new versions of the various advance directives recognized in Arizona statutes and research best operational practices of other state registries. Since these committees would exist for a single and finite purpose, once it is accomplished the committee can disband. It would be worth the effort to identify appropriate individuals for these committees and request their service on a non-compensated basis.

Incremental expense would be required to print hard copies of the informational packet and approved template versions for distribution through MVD offices. Additionally, launching a counseling program and staffing multiple locations throughout the state would be incremental budget items, as would allocating funds to update and maintain a more robust registry.

The principles of preventive law can be used to help justify this increase in state budget. Preventive law focuses on the positive results that can be achieved by advanced legal planning.²⁰⁸ The concept is that an attorney and client work together in determining the client's long term goals so that future conflict is minimized.²⁰⁹ In the area of end-of-life planning, determining one's legal options and preferences for their own healthcare can be emotionally empowering, lifting the psychological burdens imposed by the lack of control that many people face when they are ill.²¹⁰

*472 The preventive law doctrine also recognizes that there can be significant negative emotional and financial implications to litigation and that planning for a contingency before it has occurred will minimize the chances of a poor outcome.²¹¹ Preventive law supports the creation of advance directives because the legally binding instructions will remove doubt about the patient's choices, alleviating problems that would have arisen due to uncertainty about the patient's wishes. By funding the counseling

and registry programs, Arizona would be providing valuable assistance in helping its citizens take the personal responsibility and initiative in making choices about their future healthcare.

From a legal perspective, the existence of an advance directive would be advantageous should a situation advance to litigation. It is evident that judges do not relish the position of deciding issues of life and death for incapacitated patients, as expressed in *Schiavo*:

. . . in the end, this case is not about the aspirations that loving parents have for their children. It is about Theresa Schiavo's right to make her own decision, independent of her parents and independent of her husband. In circumstances such as these, when families cannot agree, the law has opened the doors of the circuit courts to permit trial judges to serve as surrogates or proxies to make decisions about life-prolonging procedures. It is the trial judge's duty not to make the decision that the judge would make for himself or herself or for a loved one. Instead, the trial judge must make a decision that the clear and convincing evidence shows the ward would have made for herself. It is a thankless task, and one to be undertaken with care, objectivity, and a cautious legal standard designed to promote the value of life.²¹²

Similarly, expressing relief that the patient in the case is conscious and lucid, the judge in *Tune* states that "the Court is fortunately not called upon to address the difficult issues presented when the patient is comatose or otherwise incompetent, and a 'substituted judgment' must be made."²¹³

In the *Cruzan* case, the Justices found that only clear and convincing evidence of Nancy's choice to refuse medical treatment would allow for the artificial *473 feeding and hydration to be removed.²¹⁴ A fully executed living will might have provided this clear and convincing evidence. The state should encourage a patient to express his own desires in a written medical directive by providing funding for uniform documents and information, providing access to counseling, and supporting the operations of an enhanced registry.

It is possible that the voluntary contributions to the registry fund will support the recommended changes; if not, the state should initiate a dedicated revenue-generation program. This program could be self-funding, by adding a surcharge to existing MVD license and identification card fees. Since it is the people using the MVD for their driver and vehicle services that would be receiving the advance directives packet, there is logic in proposing that they be the ones to pay for it. While an exact figure cannot be determined until the costs for the packet production, counseling program, registry upgrades, and management are known, the revised statute could mandate an upper limit on this surcharge. Any cost in excess of the donated funds to the registry and this MVD surcharge could be funded by the state's general treasury. This would guarantee that those people who complete and register advance directives, to minimize their risk for later legal conflict, could be certain of the registry's security. If it is to house critical documents for people in the final stages of their life, there should be no fear that the registry will cease operations due to a lack of funds.

X. Conclusion

Benjamin Franklin told us something we already know: it is certain that everyone will die. But how we die can be somewhat controlled by the creation of a living will and healthcare power of attorney. These documents will ensure that our own wishes are honored even if we are incapacitated and unable to personally communicate with our loved ones. However, not even twenty-five percent of adults have living wills,²¹⁵ with the result that many people do not spend their last days as they wish. The laws are in place, recognizing that advance directives are legally binding and releasing the physicians and surrogates who rely on them from liability. Nevertheless, the statutes do not go far enough to provide awareness of directives nor to encourage their use.

In Arizona, the changes proposed above would significantly improve this situation. Citizens of Arizona, both adults and minors, deserve to know that if they execute one of the approved directives and place them on file with the state registry, the documents will be available and accessible when needed. If a family member or physician cannot access a directive, there is no purpose to *474 even having created it. We will be back to dying in ways that we do not want because no one can find the document that tells them what we do want. If there must be a death, at least it should be a good death. Revising the Arizona statutes can assure this.

Footnotes

- a1 Wendy Metcalf Anderson received her J.D. from Arizona Summit Law School in 2014, graduating as valedictorian of her class. She received her B.A from the University of Pennsylvania. Prior to law school, Wendy was a marketing and advertising director for several Phoenix-based companies for more than twenty years, focusing on consumer media, sports marketing and strategic planning. She would like to thank her husband, Scott, daughters Hayley and Jenna and her parents for their unconditional support and understanding during law school, and her advisor, Professor Susan Daicoff, for her guidance with this article.
- 1 Michael Ash & Stephen Arons, *Economic Parameters of End-of-Life Care: Some Policy Implications in an Era of Health Care Reform*, 31 W. NEW ENG. L. REV. 305, 314 (2009).
- 2 Joshua E. Perry, *A Missed Opportunity: Health Care Reform, Rhetoric, Ethics and Economics at the End of Life*, 29 MISS. C L. REV. 409, 423 (2010).
- 3 Catherine Silburn, *Respecting and Responding to End-of-Life Choices*, COLO. LAW. 57 (October 2005).
- 4 *Id.*
- 5 60 Minutes, *The Cost of Dying* (CBS television broadcast Nov. 22, 2009), <http://www.cbsnews.com/news/the-cost-of-dying/>.
- 6 Perry, *supra* note 2, at 426.
- 7 Dorothy D. Nachman, *Living Wills: Is It Time to Pull the Plug?*, 18 ELDER L.J. 289, 299 (2011).
- 8 Dennis P. Stolle, *Advance Directives, AIDS, And Mental Health: TK Preventive Law For The HIV - Positive Client*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HEALING PROFESSION 83, 98 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick eds., Carolina Academic Press, 2000).
- 9 *Id.* at 96.
- 10 *Id.*
- 11 *Id.*
- 12 *Id.*
- 13 Stolle, *supra* note 8.
- 14 CAROL KROHM, M.D. & SCOTT SUMMERS, ADVANCE HEALTH CARE DIRECTIVES: A HANDBOOK FOR PROFESSIONALS 24 (American Bar Association, 2002).

15 *Id.* at 37.

16 *Id.*

17 *Id.* at 34.

18 *Tune v. Walter Reed Army Med. Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985).

19 *Id.* at 1456.

20 *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

21 *Vacco v. Quill*, 521 U.S. 793, 796-97 (1997).

22 KROHM & SUMMERS, *supra* note 14, at 37.

23 *Id.*

24 *Matter of Quinlan*, 355 A.2d 647 (N.J. 1976).

25 *Id.* at 653.

26 Nachman, *supra* note 7, at 295.

27 *Matter of Quinlan*, *supra* note 24 at 655.

28 *Id.* at 653, 655.

29 *Id.* at 663.

30 *Griswold v. Connecticut*, 381 U.S. 479 (1965). The *Griswold* Court held that, in forbidding the use of contraceptives, rather than in regulating their manufacture or sale, the Connecticut law was unnecessarily broad and it invaded an area of privacy protected by numerous fundamental constitutional guarantees.

31 *Roe v. Wade*, 410 U.S. 113 (1973). The *Roe* Court held that the right to personal privacy was appropriate, but not unqualified as it must be measured against compelling state interests, in this case, the viability of a fetus.

32 *Matter of Quinlan*, *supra* note 24 at 663-64.

33 *Id.* at 664.

34 Nachman, *supra* note 7, at 295.

35 *Id.* at 296.

36 *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261 (1990).

37 *Id.* at 265.

38 M. Rose Gasner, *The Unconstitutional Treatment of Nancy Cruzan*, 7 N.Y.L. SCH. J. HUM. RTS. 1 (1990).

39 *Cruzan*, *supra* note 36 at 266-67.

40 *Id.* at 280.

41 *Id.* at 284-85.

42 *Id.* at 286.

43 Lois Shepherd, *Terri Schiavo: Unsettling the Settled*, 37 LOY. U. CHI. L.J. 297 (2006).

44 *Id.* at 301.

45 *Id.* at 305.

46 *Id.* at 304.

47 *Id.* at 306.

48 *In re Guardianship of Schiavo*, 916 So. 2d 814, 818 (Fla. Dist. Ct. App. 2005).

49 Shepherd, *supra* note 43, at 299.

50 *Id.* at 311-12.

51 *Matter of Quinlan*, *supra* note 24; Shepherd, *supra* note 43, at 306.

52 *Cruzan*, *supra* note 36 at 284-85.

53 *Id.* at 291-92.

54 [Rasmussen by Mitchell v. Fleming, 741 P.2d 674 \(Ariz. 1987\).](#)

55 *Id.* at 679-80.

56 *Id.* at 687, 690.

57 *Id.* at 680, 685.

58 *Id.* at 681-83.

59 Fleming, *supra* note 54 at 680.

60 *Id.* at 691 n4. In note 4, the court cited numerous cases where opinions were issued long after the patient had died to illustrate its belief that the judiciary was not the best forum for resolving end-of-life disputes.

61 *Id.*

62 *Id.* at 692.

63 Cruzan, *supra* note 36.

64 *Id.* at 287-92.

65 Susan Adler Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577, 591, 628 (1999).

66 Patient Self Determination Act, 42 U.S.C. § 1395cc (1990).

67 Patient Self-Determination Act, in 22 ILL. PRAC., THE LAW OF MEDICAL PRACTICE IN ILLINOIS § 32:3 (3d ed., 2013).

68 Channick, *supra* note 65, at 591.

69 42 U.S.C. §1395cc.

70 *Id.*

71 Jo-Anne Herina Jeffreys, *Advance Directives: Are They Worth the Paper They're Written On?*, NEW JERSEY LAWYER, THE MAGAZINE, N.J. LAW 17 (April 1998).

72 Patient Self-Determination Act, *supra* note 67.

73 *Id.*

74 Channick, *supra* note 65, at 592.

75 Gasner, *supra* note 38, at 16.

76 *Id.*

77 *Id.*

78 *Id.* at 17.

79 *Id.* at 18.

80 Gasner, *supra* note 38, at 16.

81 KROHM & SUMMERS, *supra* note 14, at 136.

82 1992 Ariz. Legis. Serv. Ch. 193 (WEST).

83 AZ ST T. 36, Ch. 32, Art. 7, Refs & Annos.

84 [ARIZ. REV. STAT. ANN. §§ 36-3261- 3262 \(1992\).](#)

85 [ARIZ. REV. STAT. ANN. §§ 36-3223- 3224 \(1992\).](#)

86 [ARIZ. REV. STAT. ANN. § 36-3231 \(1992\).](#)

87 *Id.*

88 [ARIZ. REV. STAT. ANN. § 36-3221 \(1992\).](#)

89 *Id.*

90 ARIZ. REV. STAT. ANN. § 36-3203, §36-3205 (1992).

91 *Id.*

92 ARIZ. REV. STAT. ANN. § 36-3292 (2004).

93 ARIZ. REV. STAT. ANN. § 36-3291 (2004).

94 ARIZ. REV. STAT. ANN. § 36-3293 (2004).

95 ARIZ. REV. STAT. ANN. § 36-3294 (2004).

96 ARIZ. REV. STAT. ANN. §§ 36-3294- 3295 (2004).

97 ARIZ. REV. STAT. ANN. § 36-3296 (2004).

98 *Arizona Advance Directive Registry*, ARIZONA SECRETARY OF STATE, iavailable at http://www.azsos.gov/adv_dir/Default.htm, (last visited March 14, 2014).

99 U.S. LIVING WILL REGISTRY, available at <http://www.uslivingwillregistry.com/default.asp>, (last visited March 14, 2014).

100 *Id.*

101 *Id.*

102 *Id.*

103 *Id.*

104 U.S. LIVING WILL REGISTRY, *supra* note 99.

105 *Id.*

106 Nachman, *supranote* 7, at 299.

107 KROHM & SUMMERS, *supra* note 14, at 48.

108 Patient Self Determination Act, *supra* note 66.

109 KROHM & SUMMERS, *supra* note 14, at 48.

110 *Id.*

111 Channick, *supra* note 65, at 632.

112 Kevin B. O'Reilly, *Defective Directives? Struggling with End-of-Life Care*, AM. MED. NEWS (Jan. 5, 2009), <http://www.amednews.com/article/20090105/profession/301059970/4/>, (last visited March 14, 2014).

113 KROHM & SUMMERS, *supra* note 14, at 57.

114 *Id.* at 120.

115 Ash & Arons, *supra* note 1, at 327.

116 Silburn, *supra* note 3, at 58.

117 Nachman, *supra* note 7, at 312.

118 Silburn, *supra* note 3, at 61; KROHM & SUMMERS, *supra* note 14, at 147.

119 Silburn, *supra* note 3, at 50.

120 *Id.*

121 *Id.*

122 *Id.* at 151.

123 *Id.*

124 O'Reilly, *supra* note 112.

125 KROHM & SUMMERS, *supra* note 14, at 136.

126 *Id.* at 70.

127 12 DARREN T. CASE, BRENT W. NELSON & T.J. RYAN, PHYSICIAN'S DIRECTIVES: CREATION OF LIVING WILL, ARIZ. PRAC., ESTATE PLANNING AND PROBATE HANDBOOK § 2:8 (2013).

128 60 Minutes, *supra* note 5.

129 Silburn, *supra* note 3, at 58.

130 *Id.*

131 Shepherd, *supra* note 43, at 332.

132 KROHM & SUMMERS, *supra* note 14, at 71.

133 O'Reilly, *supra* note 112.

134 KROHM & SUMMERS, *supra* note 14, at 107.

135 *Id.* at 95.

136 CASE, NELSON & RYAN, *supra* note 127.

137 Nachman, *supra* note 7, at 293-94.

138 O'Reilly, *supra* note 113.

139 *Id.*

140 Vicki Joiner Bowers, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 700-01 (1996).

141 ARIZ. REV. STAT. ANN. § 36-3203, § 36-3205 (1992).

142 ARIZ. REV. STAT. ANN. § 36-3205 (1992).

143 *Id.*

144 KROHM & SUMMERS, *supra* note 14, at 95.

145 *Id.* at 105.

146 ARIZ. REV. STAT. ANN. § 36-3262 (1992).

- 147 Thomas J. Murphy, *Drafting Living Wills After Schiavo*, MAR ARIZ. ATT'Y 36, 37 (2006).
- 148 Keith E. Sonderling, *POLST: A Cure for the Common Advance Directive - It's Just What the Doctor Ordered*, 33 NOVA L. REV. 451, 456 (2009).
- 149 *Id.* at 472-73.
- 150 Ray J. Koenig III & MacKenzie Hyde, *Be Careful What You Wish for: Analyzing the 'Five Wishes' Advance Directive*, 97 ILL. B.J. 242 (2009). The document outlines "(1) the person you want to make health care decisions for you when you cannot make them for yourself, (2) the kind of medical treatment you want or do not want, (3) how comfortable you want to be, (4) how you want people to treat you, and (5) what you want your loved ones to know."
- 151 Ruth F. Maron, *Who Has A Will to Live? Why State Requirements for Advance Directives Should Be Uniform(Ly Revised)*, 24 REGENT U. L. REV. 169, 195 (2012).
- 152 Koenig & Hyde, *supra* note 150, at 243.
- 153 Kenney Hegland, *Suggestions, Not Demands Rethinking Living Wills*, OCT. ARIZ. ATT'Y 14, 15 (October 2004).
- 154 *Id.* at 15-16.
- 155 Murphy, *supra* note 147, at 38.
- 156 Hegland, *supra* note 153, at 14-17 generally.
- 157 Nachman, *supra* note 7, at 331.
- 158 Maron, *supra* note 151, at 197.
- 159 *Id.*
- 160 *Id.*
- 161 Channick, *supra* note 65, at 628.
- 162 *The 2012 Statistical Abstract, Table 1112*, UNITED STATES CENSUS BUREAU, available at http://www.census.gov/compendia/statab/cats/transportation/motor_vehicle_accidents_and_fatalities.html (last visited March 14, 2014). A "crash" is defined as a police-reported event that produces injury and/or property damage involving a vehicle in transport and occurs on a trafficway or while the vehicle is in motion after running off the trafficway.

163 *Id.* The remaining 3,958,095 crashes (71.9%) involved only property damage.

164 *Id.* at Table 1114.

165 *Id.*

166 *Leading Causes of Nonfatal Injury Reports, 2012*, CENTERS FOR DISEASE CONTROL AND PREVENTION, available at <http://webappa.cdc.gov/sasweb/ncipc/nfilead2001.html>, (last visited March 14, 2014).

167 *Id.*

168 *Leading Causes of Death*, ARIZONA DEPARTMENT OF HEALTH SERVICES, available at <http://www.azdhs.gov/plan/report/ahs/ahs2012/pdf/text2b.pdf>, (last visited March 14, 2014).

169 Christopher K. Mrela & Clare Torres, *Injuries and Deaths of Arizona Residents in Motor Vehicle Accidents*, ARIZONA DEPARTMENT OF HEALTH SERVICES 59, available at <http://www.azdhs.gov/plan/report/mva/mva07/index.htm>, (last visited March 14, 2014).

170 *Id.* at 8.

171 KROHM & SUMMERS, *supra* note 14, at 144.

172 Perry, *supra* note 2, at 424.

173 Maron, *supra* note 151, at 190.

174 Bowers, *supra* note 140, at 709.

175 *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).

176 *Id.* at 325.

177 *Id.* at 327-28.

178 *Id.*

179 *In re Swan*, 569 A.2d 1202 (Me. 1990).

180 *Id.* at 1205-06.

- 181 See text accompanying note *supra* 17.; KROHM & SUMMERS, *supra* note 14, at 34.
- 182 See *supra* text accompanying notes 175-180.
- 183 See *supra* text accompanying notes 113-115.
- 184 See *supra* text accompanying notes 119-121.
- 185 KROHM & SUMMERS, *supra* note 14, at 101.
- 186 *Life Care Planning*, ARIZONA ATTORNEY GENERAL TOM HORNE, available at <https://www.azag.gov/seniors/life-care-planning>, (last visited March 14, 2014). These documents appear to be very comprehensive concerning the issues that need to be decided as well as the process for completing healthcare powers of attorney, mental healthcare powers of attorney, living wills, organ donation, funeral arrangements and pre-hospital medical care directives.
- 187 ARIZONA DEPARTMENT OF TRANSPORTATION, available at <http://www.azdot.gov/>, (last visited March 14, 2014).
- 188 *Id.* At an Arizona MVD location, a resident can obtain a new, renewed or reinstated driver license for a personal vehicle, motorcycle or commercial vehicle, as well as vehicle title, registration, renewal registration and license plates. Non-drivers can obtain identification cards.
- 189 *Id.*
- 190 SERVICE ARIZONA, ARIZONA DEPARTMENT OF TRANSPORTATION, available at <http://servicearizona.com/>, (last visited March 14, 2014).
- 191 ARIZONA MOTOR VEHICLE DIVISION, DRIVER LICENSE AUTHORIZED PROVIDERS, available at <http://www.azdot.gov/apps/thirdpartyreportsviewpdf?lngReportImageID=23>, (last visited March 14, 2014).
- 192 Patient Self Determination Act, *supra* note 66.
- 193 *Id.*
- 194 Maron, *supra* note 151, at 192.
- 195 ARIZONA DEPARTMENT OF TRANSPORTATION, *supra* at note 187.
- 196 *Id.*
- 197 See text accompanying *supra* notes 162-170.

198 O'Reilly, *supra* note 112.

199 [ARIZ. REV. STAT. ANN. §§ 36-3294- 3295 \(2004\)](#).

200 Jeffreys, *supra* note 71, at 19.

201 Stolle, *supra* note 8, at 96.

202 *Id.*

203 This reminder service is provided by the U.S. LIVING WILL REGISTRY, *supra* note 99.

204 ARIZONA DEPARTMENT OF TRANSPORTATION, *supra* at note 187.

205 [ARIZ. REV. STAT. ANN. § § 36-3295 \(2004\)](#).

206 O'Reilly, *supra* note 112.

207 *See* U.S. LIVING WILL REGISTRY, *supra* notes 104-106.

208 Dennis P. Stolle, David B. Wexler, Bruce J. Winick & Edward A. Dauer, *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, in *PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HEALING PROFESSION 6* (Dennis P. Stolle, David B. Wexler & Bruce J. Winick eds., Carolina Academic Press, 2000).

209 *Id.*

210 Stolle, *supra* note 8, at 84.

211 Susan Daicoff, *The Role of Therapeutic Jurisprudence with the Comprehensive Law Movement*, in *PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HEALING PROFESSION 474* (Dennis P. Stolle, David B. Wexler & Bruce J. Winick eds., Carolina Academic Press, 2000).

212 *In re* Guardianship of Schiavo, *supra* note 48 at 818.

213 Tune, *supra* note 18 at 1454.

214 Cruzan, *supra* note 36 at 286-87.

215 *See* text accompanying *supra* note 7.

8 AZSUMLR 447

End of Document

© 2016 Thomson Reuters. No claim to original U.S. Government Works.