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Governor

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John L. Clayton
Director

Please read the entire Health Care Directive form prior to completing. Initial those items you have selected to be enforced as your wishes. You and your witnesses should initial each page at the lower right hand corner in the blanks provided, to insure that the document remains complete. If you should have any questions please call me, Ray De La Rosa, Legal Services Developer at (602) 542-6440. If you need additional copies please contact (602) 542-4446.

If this Health Care Directive does not meet your needs or wishes, you may want to contact a private attorney for further assistance.

Thank You,

Ray De La Rosa
Legal Services Developer

ADVANCED DIRECTIVES FOR HEALTH CARE

Who has the right to decide how far medical treatment should be taken? Does a doctor have the right to decide for his or her patient? Does the state have a sovereign right in preserving life, or should the wishes of the individual or family take precedence?

When Congress passed the Patient Self-Determination Act (PSDA) in 1990, the right to participate in one's health care decisions was strengthened. The PSDA formalized and standardized a form of communication known as "advanced directives for health care." These directives are the means by which an individual informs health care providers of his or her beliefs and desires regarding health care procedure and treatments, when the individual is unable to communicate otherwise. An advance directive is defined by the PSDA as "a written instruction ... recognized under state law and relating to the provision of such care when the individual is incapacitated."

"In the health care setting, the right to make decisions about health care, includes the right to decline treatment even when that decision would probably or even certainly lead to death. This right ordinarily is implemented through informed consent or refusal. Although decision making for competent patients presents few legal problems, the same cannot be said for patients who have lost capacity since they no longer can make a decision, informed or otherwise."[1] The following may answer a few of the more important questions you may have about advance directives. If you need any further answers please contact your attorney or local advocate.

DECISIONS ABOUT HEALTH CARE

HOW YOU CAN PLAN FOR THE FUTURE WITH LIVING WILLS AND OTHER HEALTH CARE DIRECTIVES

The following summary was prepared by the Patient Self Determination Act committee of the Arizona Bar Association because of a 1991 Federal Law.

Who makes your health care decisions? You do, if you can make and communicate them. Your doctor should tell you about the treatment recommend other reasonable alternatives, and important medical risks and benefits of that treatment and alternatives. You have the right to decide what health care, if any, you will accept.

What happens if you become unable to make or communicate your health care decisions? You can still have some control over your health care decisions, if you have planned ahead. One way to plan ahead is by making a health care directive, which names someone to make these decisions for you, or which guides or controls these decisions. If you have not named someone in a health care directive, your doctor must seek a person authorized by law to make these decisions. A person who makes health care decisions for you is called a surrogate. Your "surrogate" is a term used to refer to one who has authority to make a medical decision for another.

[1] Uniformed Health Care Decision Act gives New Guidance D. English & A. Meisel.

What is a health care directive? It is a written statement about how you want your health care decisions made. Under Arizona law, there are three common types of health care directives:

> *A health care power of attorney*, which is a written statement in which you name an adult to make health care decisions for you. That person will make health care decisions for you only when you cannot make or communicate such decisions. (A.R.S. § 36-3221 et. seq.)
>
> *A living will*, is a written statement about health care you want or do not want. This is to be followed if you cannot make your own health care decisions. For example, a living will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover. (A.R.S. § 36-3261)
>
> *A prehospital medical care directive*, is a directive refusing cardiopulmonary resuscitation, a type of lifesaving emergency care, if you have a heart attack or can't breathe, and you are not in a hospital or in a hospital emergency room. To make one, you must complete a special orange form. (A.R.S. § 36-3251)

These directives, used separately or together, can help you say "yes" to treatment you want and "no" to treatment you don't want.

Must your health care directive be followed? Yes. Both health care providers and surrogates must follow valid health care directives.

Can you be required to make a health care directive? No. Whether you make a health care directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have a health care directive.

Can you change or revoke health care directives? Yes. If you change or revoke a health care directive, you should notify everyone who has a copy.

Who can legally make health care decisions for you if you are unable to make your own decisions and if you have not made a health care power of attorney? A court may appoint a guardian to make health care decision for you. Otherwise, your health care provider must go down the following list to find a surrogate to make health care decisions for you:

1. You husband or wife, unless you are legally separated.
2. Your adult child. If you have more than one adult child, a majority of those who are available.
3. Your mother or father.
4. Your domestic partner, unless someone else has financial responsibility for you.
5. Your brother or sister.
6. A close friend of yours, (Someone who shows special concern for you and is familiar with your health care views).

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide with the advise of an ethics committee or, if this is not possible, your doctor may make these decisions after consulting with a second doctor who concurs with your doctor's decision.

You can keep anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make health care decisions for you.

A surrogate will not have the right to decide to have tubes withdrawn from you that are used to give you food or fluids unless:

* you have appointed that surrogate to make health care decisions for you in a health care power of attorney; or

* a court has appointed that surrogate as your guardian to make health care decisions for you; or,

* you have stated in a health care directive that you do not want this specific treatment.

ADDITIONAL INFORMATION FOR ANYONE WHO ALREADY HAS OR WANTS TO MAKE A HEALTH CARE DIRECTIVE

What if you already have a living will or other health care directive?

A health care directive which was valid when made anywhere in the U.S. is valid under Arizona law. However, Arizona laws have changed beginning September 30, 1992, making new choices available to you. You should review your health care directives periodically and update them as needed.

Do you need a lawyer to make a health care directive?

No. Just be sure that your directive is valid under Arizona law.

What does the law require for a health care directive after September 30, 1992?

A health care power of attorney must:

* Name a person to make health care decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.

* Be signed or marked by you and dated.

* Be signed by a notary or by an adult witness or witnesses, who saw you sign or mark the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions and cannot be providing health care to you. If you have only one witness, that witness cannot be related to you or someone who will get any of your property from your estate if you die.

A living will must:

* State how you want your health care decisions to be made in the future.

* Be signed or marked by you and dated.

* Be notarized or witnessed in the same way as described above for a health care power of attorney.

A prehospital medical care directive must:

* Be in the exact form required by law.

* Be printed on an orange background.

* Be signed or marked by you and dated.

* Be signed by a licensed health care provider and a witness.

If you have signed an orange prehospital medical care directive, you may also wear a special orange bracelet. It must state your name, your doctor's name, and the words "do not resuscitate". This bracelet will call to the attention of emergency medical personnel that you have signed the form and that you do not want the cardiopulmonary resuscitation outside a hospital or in a hospital emergency room.
You should talk to your doctor about a prehospital directive if you are thinking about signing one. Forms are available from various organizations, although any prehospital directive which is in the exact form that meets the requirements of the law may be used.

Who should have copies of your health care directives?

It is very important that you give copies to your doctor at once and to any health care facility upon admission. You should give copies to anyone you have named to make health care decisions for you in a health care power of attorney. You may also want to give copies to close family members. Be sure to keep extra copies for yourself.

HEALTH CARE DIRECTIVE

(Combined Living Will and Health Care Power of Attorney)

I, _____, currently reside in _____, Arizona, and execute this Health Care Directive in accordance with Title 36, Chapter 32, Arizona Revised Statutes. I want this directive to be in effect anytime two physicians, one of whom is my attending physician, personally examine me and certify that I am incapable of making or communicating my health care decisions.

This Health Care Directive is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this directive are separable, so that the invalidity or revocation of one or more powers shall not affect any others. This directive shall not be affected or revoked by my disability.

I hereby authorize that photocopies of this directive can be relied upon as though they were originals. This directive continues in effect for all who may rely on it except those to whom I have given notice of its revocation. I understand that I can revoke a specific part, or all, of this directive by any oral or written statement to that effect, or by any other expression of intention to revoke all or a specific part.

If a Guardian is to be appointed for me, I nominate my agent (or alternate) named below. If a court decides to appoint someone else, I ask that the court require the guardian to consult with these people concerning all health care decisions that would require my consent if I were acting for myself.

I. HEALTH CARE POWER OF ATTORNEY

I appoint:

Name:_____

Address:_____

Phone Number(s): (Home)(____)_____(Work)(____)_____

as my agent for all matters relating to my health care. This Health Care Power of Attorney is to remain in effect after my death for my agent to make decisions regarding autopsy, organ or tissue donation, or disposition of my remains, if I authorize those below.

A. *Powers.* My agent should try to discuss specific decisions with me if I am able to communicate in any manner. If I am unconscious, comatose, senile or otherwise unable to communicate, my agent may do whatever he or she deems necessary to effectuate the terms of this Health Care Directive, including, but not limited to the powers listed below:

Employ and discharge medical, social service, and other support personnel responsible for my care.

Contract on my behalf for any health care related service or facility for my care, without my agent incurring personal financial liability for such contracts.

Grant any waiver or release from liability required by any hospital, physician or other health care provider.

Initials:____
Initials:____
Initials:____

Have access to medical records and information to the same extent I am entitled to.

Release my medical information to third parties, including, but not limited to, hospitals, medical clinics and insurance companies.

Give, withhold or withdraw consent to medical care, treatment, surgical procedures, diagnostic procedures, medication, hospital and related health care or treatment.

Refuse, consent to, or withdraw consent to life-sustaining procedures(s) as authorized in this directive.

Summon emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my agent may deem appropriate given my preferences regarding such care that are expressed in this directive, and my medical status at the time of the decision.

Pursue any legal action in my name, at the expense of my estate, to force compliance of my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent, and acting for myself.

B. Reimbursement. My agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

___ My agent shall be entitled to compensation for services performed under this Health Care Power of Attorney.

___ My agent shall not be entitled to compensation for services performed under this Health Care Power of Attorney.

C. Alternate Agents. If _____ is unavailable or is unable to act as my agent, I appoint the following persons to serve as my agent to make health care decisions as authorized in this directive, such persons to serve in the order listed below:

First Alternate:

Name:_____

Address:_____

Phone Number(s): (Home)(___)_____(Work)(____)_____

Second Alternate:

Name_____

Address:_____

Phone Number(s): (Home)(___)_____(Work)(____)_____

If an alternate acts for me because the first agent is unavailable, I intend that the alternate act *only* while my first agent is unavailable.

Initials:_____
Initials:_____
Initials:_____

D. Removal of Agent. If my spouse has been appointed my agent or an alternate agent, and subsequent to the execution of this directive, an action is filed to dissolve our marriage, then the filing of such action shall automatically remove my spouse as agent or alternate agent.

E. Decisions Regarding My Body After My Death. I choose the following, indicated by my initials:

____ I *do not* consent to an autopsy.

____ I *consent* to an autopsy.

____ My agent *may* give consent to or refuse an autopsy.

____ I *do not* want to make an organ or tissue donation and I *do not* want my agent or family to do so.

____ I hereby give, effective on my death:

____ Any needed organ or part.

____ The following part or organs listed: _____for:

____ Research, medical education or any other legally authorized purpose.

____ Transplant purposes.

____ I authorize my agent to dispose of my remains and make funeral arrangements.

____ I do not want my body cremated.

F. Living Will Option: _____ If I execute the Living Will portion of this Health Care Directive, I intend the initialed provisions as supplemental guidelines for my agent to make decisions in situations that may occur during any period when I am unable to make or communicate health care decisions.

____ I have completed the Living Will portion of this Health Care Directive by initialing certain statements to provide specific directions to assist my agent in making decisions.

____ I have not completed the Living Will portion of this Health Care Directive.

II LIVING WILL

A. Clear and Convincing Evidence. It is my intention that this directive constitute clear and convincing evidence of my wishes concerning medical treatment if I am unable to make or communicate my own health care decisions at that time. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this directive be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

B. Personal Value Statement. I value life; but the quality of my life is very important to me. I particularly want to avoid the conditions I have initialed below in Section I.E. of this directive. I do not want others to substitute their choices for mine or my health care agent's. If what I would want is not known, then decisions about my health care are to be made in my best interest, based on the contents of this directive and medical information provided by my physicians.

Initials_____
Initials_____
Initials_____

C. Temporary Use of Life-sustaining Treatment. Notwithstanding any other directions, I do want the use of all medical care necessary to treat my condition until my physicians reasonably conclude that I have one or more of the conditions initialed in Section II.E.1 below.

____ If I experience any of the conditions initialed in Section II.E.1 below, but my physician believes that temporary use of life-sustaining treatment would probably restore acceptable quality of life:

____ I want life-sustaining treatment for up to_____days/weeks/months.

____ I still do not want life-sustaining treatment.

D. Pregnancy. Notwithstanding my other directions, if I am known to be pregnant:

____ I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

____ I do want my Health Care Directive to remain in effect.

E. Determination of Condition: If two physicians agree that I am unable to make or communicate health care decisions, and I have one or more of the conditions I have initialed in Section II.E.1 below, I want my medical care to be controlled by the statements I have initialed in Section II.E.2 below, regarding preferred health care treatment:

1. Conditions.

____Life-threatening condition; or

____Irreversible coma or a persistent vegetative state from which ability to think and communicate probably will not be recovered; or

____Unconsciousness lasting___days/weeks/months; or

____Loss of the ability to think or communicate effectively caused by brain disease or brain damage that probably is not reversible; or

____Total dependence on others for my care, because of physical or mental deterioration that probably is not reversible; or

____Senile dementia such that I cannot live independently or recognize family members or friends; or

____Severe pain that will probably never be eliminated; or

____Pain that can be eliminated only by so much pain medication that ability to communicate verbally is lost.

____Other circumstances in which I do not want life-sustaining treatment include:

_____

_____

_____

Initials_____
Initials_____
Initials_____

2. Treatment.

____ PROVIDE FULL COMFORT CARE, including supplemental oxygen (mask or nasal canula), pain medication, and sedation, even though their use may lead to permanent physical damage, cause addiction or even hasten the moment of my death.

____ DO NOT RESUSCITATE: No chest compressions; No cardiac shock; No artificial ventilation (no positive pressure mask or bag ventilation; no endotracheal tube; no mechanical ventilation); No cardiovascular medication.

____ DO PERFORM FULL, UNLIMITED RESUSCITATION AND TREATMENT.

____ DO PERFORM PARTIAL RESUSCITATION to determine if I respond positively:

____ No chest compressions

____ No cardiac shock

____ No artificial ventilation (no positive pressure mask or bag ventilation; no endotracheal tube; no mechanical ventilation)

____ No cardiovascular medication

____ Other_____

____ DO NOT ARTIFICIALLY ADMINISTER FOOD AND FLUIDS if they would only serve to prolong artificially the moment of my death, even though I may then die from malnutrition or dehydration rather than from my injury, disease, illness, or condition.

____ DO NOT WITHHOLD ARTIFICIALLY ADMINISTERED FOOD AND LIQUIDS if I would die from malnutrition or dehydration rather than from my injury, disease, illness, or condition.

____ PROLONG MY LIFE TO THE GREATEST EXTENT POSSIBLE.

____ DO NOT PROLONG MY LIFE by providing life-sustaining or death-delaying treatment, including artificially administered food and nutrition, if the burdens of the treatment outweigh the expected benefits. My agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

____ DO NOT PERFORM:
____ Minor surgery.
____ Major surgery.
____ Invasive diagnostic tests, such as cardiac catheterization.
____ Transfusion of blood or blood products.
____ DO NOT ADMINISTER:
____ Antibiotic treatment. _____ Insulin.
____ Chemotherapy. _____ Kidney dialysis.

Initials:_____
Initials:_____
Initials:_____

_____ DO NOT TAKE ME TO A HOSPITAL IF ALL AVOIDABLE.

The treatments that my agent may give, withhold, or withdraw consent to is not limited to those items listed above, but is a general reference to the types of treatment I, if capable, would either request or refuse.

I,_____, the Principal, sign my name to this Health Care Directive and hereby declare that I understand the full import of this directive, that I have the emotional and mental capacity to execute this Health Care Directive, and that I signed and executed this directive as my free and voluntary act.

_____

We, the below signed witnesses, sign our names to this Health Care Directive, being first duly sworn and hereby declare to the undersigned authority that the Principal signs and executes this directive willingly and each of us in the presence and hearing of the Principal sign as witness and each believes the Principal to be of sound mind, having fully understood the significance of this directive, and the Principal has the emotional and mental capacity to make this Health Care Directive. Each witness affirms that he or she: (1) is at least 18 years old; (2) is not related to the Principal by blood, marriage or adoption; (3) is not an agent named in this Health Care Directive; (4) is not directly involved in the Principal's health care; (5) is not, to his or her knowledge, a beneficiary of the Principal's will or any codicil; and (6) has no claim against the Principal's estate.

_____/_____

WITNESS RESIDING AT

_____/_____

WITNESS RESIDING AT

State of Arizona)

)ss:

County of _____)

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this date:

_____ by _____, and by the above named

witnesses _____ and _____

My Commission Expires: _____ _____

NOTARY PUBLIC

Initials:_____

Initials:_____

Initials:_____