ON DEATH AND DYING: COUNSELING THE TERMINALLY ILL CLIENT AND THE LOVED ONES LEFT BEHIND

by Georgia Akers[*]

---

* Honorable Georgia Akers, Associate Judge, Probate Court No. 3, the Honorable Rory R. Olsen, presiding, Harris County, Texas. The author would like to thank the following: Pete Schneider and Tiffani Burkholder of Grady, Schneider and Newman, L.L.P., Houston, Texas, who took my poor attempt at expressing the medical malpractice theory and redrafted this section into personal injury legalese; Law Offices of Jeff Skarda, for the review of the Social Security issues; and Brian E. Surratt, Probate Court 3 intern, for research assistance.

I. INTRODUCTION

When preparing estate planning documents, probate attorneys and their clients often face issues involving death. It is human nature that the attorneys and clients think of death in the future rather than imminent death, and often the estate planning is serious but can have lighthearted moments.

This article is not about these clients. This article is about clients and families who have been informed by their doctor that the grim reaper is around the corner and death is pending. At the end of the representation, the estate attorney's farewell said to the client is final. I remember my terminally ill clients. There are few words that can be said when they depart the office except, "Goodbye and God bless."

Terminally ill clients go through psychological stages of dying, and each stage may have an impact on estate planning.[1] These clients may also ask for unusual legal advice that is not normally what attorneys encounter. As the lawyers who draft estate planning documents, we need to be aware of these stages and prepared for unusual requests for legal advice.

After the death of the client, the estate attorney is faced with assisting the family with the management of the estate. Simultaneously, the family is going through phases of grief that can cloud their judgment and communication skills. The purpose of this paper is to better prepare attorneys for representing the terminally ill client and the family.

II. STAGES OF DEATH

In 1969, Dr. Elisabeth Kubler-Ross published her book *On Death and Dying*, which brought death out of the closet and made death acceptable to

1. *See infra* Part II.

discuss.[2] Her research included interviewing hundreds of terminally ill patients, and she discovered that persons who are dying go through stages.[3]

Most contemporary psychiatrists, however, do not agree that the terminally ill go through the phases in an orderly manner.[4] Often a patient will return to a prior phase, have a mixture of phases, get stuck in one phase, or bypass a phase entirely.[5]

A. Denial and Isolation

Upon being confronted with the diagnosis of a terminal illness, the first reaction a client will have is often, "'No, not me, it cannot be true.'"[6] This denial is present in patients who were told outright by their physicians of their terminal illness as well as those who were not explicitly informed but came to the conclusion on their own.[7] This denial, however, "is more typical in a patient who is informed prematurely or abruptly" without taking into consideration the patient's readiness to hear this disclosure.[8]

Physicians play a crucial role in helping patients understand the nature of a terminal illness.[9] Often times, a patient may not realize the implications of a particular diagnosis.[10] Physicians have even been criticized for failing to be candid with patients, which may leave patients on their own to come to the realization that their diagnosis is terminal.[11] The complexity of modern medicine has exacerbated this dilemma. Even when treatments are available, the likelihood of success varies, and many aggressive treatments of chronic diseases have side effects that greatly degrade quality of life.[12] The modern physician faces the difficult task of diagnosing illnesses, counseling the patient on available options, and helping the patient reach an informed decision that fits with the patient's intentions.[13]

Denial should not be seen as an unhealthy manifestation.[14] It is natural and "functions as a buffer after unexpected shocking news [and] allows the

---

2. *See* ELISABETH KUBLER-ROSS, ON DEATH AND DYING 52 (Scribner 1997) (1969).
3. *See id*.
4. Robert Kastenbaum, Death, Society, and Human Experience 139-47 (8th Ed. 2004).
5. *Id*. at 139.
6. KUBLER-ROSS, *supra* note 2, at 51.
7. *Id*.
8. *Id*. at 52.
9. *See* Sarah Elizabeth Harrington & Thomas J. Smith, *The Role of Chemotherapy at the End of Life: "When is Enough, Enough?",* 299 JAMA 2667, 2671 (2008) (discussing the challenges of physician-patient communications regarding chemotherapy near the end of life).
10. *See id*. at 2669.
11. *See id*. at 2676.
12. *See id*.
13. *See id*.
14. KUBLER-ROSS, *supra* note 2, at 52.

patient to collect himself."[15] Patients in denial often seek second opinions in the hope that their treating physician is wrong.[16]

A client in the denial stage will not want to meet with an attorney and will not be receptive to any estate planning, no matter how hard the family may plead and cajole the individual to "get his affairs in order." If dragged to your office, the patient will not cooperate and will consider the consultation a waste of time.

As the attorney, it may be best to listen but not ask a lot of estate planning questions. Keep the interview short and attempt to establish a rapport with the client. Likely the client will not be receptive and will not be completely tuning in to any advice offered. If clients do not want to discuss the illness or seem unrealistic about the situation, then do not push them. Since clients may be coming to you as a result of their recent diagnosis and poor prognosis, it is easy to base your attorney client relationship on their medical illness. To build a better relationship and better understand the needs of your client, spend some time getting to know the actual person.[17]

B. Anger

"When the first stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentment. . . . The logical next question becomes: 'Why me?'"[18]

The patient is very difficult to cope with from the view of family and medical staff as "anger is displaced in all directions and projected onto the environment . . . at random."[19] Comments such as "the doctors are just no good" or "the proper tests have not been ordered" are common in the anger stage.[20] The nursing staff is even more of a target, and the bell in the hospital room might ring frequently.[21]

The family also receives the brunt of the anger.[22] They are "received with little cheerfulness or anticipation."[23] Naturally, the family responds with tears, guilt, and avoidance, which makes the patient even angrier.[24]

Where is the anger coming from? The patient sees his life interrupted prematurely.[25] The family's life continues on, and they will be enjoying things he will not.[26] The patient will raise his voice, make demands, and complain.[27]

---

15. *Id.*
16. *Id.* at 51.
17. *See* KASTENBAUM, *supra* note 4, at 41.
18. KUBLER-ROSS, *supra* note 2, at 63.
19. *Id.* at 64.
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.*

He provokes anger and rejection.[28] The patient is in a desperate stage. Just like the family and medical staff, the attorney can also be a target of the displaced anger.

If a client is in the anger stage, then the attorney may see the client make cruel or unreasonable decisions regarding the client's family during the estate planning. The client may leave little of his estate to the family or place the estate in an income-only trust. The client may vocalize that he does not want his wife's next husband to enjoy his estate or that he does not want his wife to have a good time once he is dead.

Listen to the client and attempt to understand the anger.[29] Does the client's action reflect on a lifelong pattern of behavior, or is his action in line with the values he has had throughout his life? If not, then the attorney can gently point out the contradictions and let the client make sense of them.[30] If this fails, then it may be prudent to have the client go home to think about his plan for a few days.[31]

C. Bargaining

In the bargaining stage, the client may think, "God has not responded when I was angry with Him. Perhaps if I am nice, He will postpone the inevitable."[32] In other words, the client hopes good behavior may be rewarded with an extension of life.[33] The client is beginning to accept the fact that he is dying and is now hoping for more time on Earth.[34] Bargaining is an attempt to postpone death where the client may promise a life dedicated to God or good works in exchange for more time.[35]

At this stage, the attorney may see a request for an extraordinarily large bequest to a church or charity.[36] The client's family may become aware of larger than normal gifts being made to a church or charity.[37] The attorney should first determine if the client has had a pattern of charitable giving by asking whether it fits into the client's life history and values. If not, then ask the client to explain this discrepancy.

---

27. *Id.* at 64-65.
28. *Id.* at 65.
29. *Id.* at 90-92.
30. *See id.* at 63-90.
31. *See id.*
32. *Id.* at 93.
33. *Id.* at 94.
34. *See id.*
35. *Id.* at 95.
36. *See id.*
37. *See id.*

D. Depression

Once the surgeries, constant hospitalizations, symptoms, and weakened body reach a point where the terminally ill client can no longer deny the illness, he cannot simply whisk the illness away with a smile anymore.[38] In place of the client's anger, rage, and attempts at bargaining will now stand a sense of great loss.[39]

The weakening of the body is only a part of the client's losses.[40] Increasing financial burdens take their toll, as luxuries and necessities may no longer be affordable.[41] Funds previously set aside for a child's college education may need to be utilized for living expenses.[42]

An inability to function may cause the client to quit his job.[43] When this happens, the other spouse often becomes the primary support, and the children may not get the attention they once expected.[44] Depression is an emotion that the terminally ill client must undergo to prepare for death.[45]

In order to facilitate the final stage of acceptance, no one should encourage the client to look at the brighter side because this prevents him from contemplating his impending death.[46] The client needs to be allowed to express his sorrow.[47] There is no need for words because acceptance is best treated by a familiar touch or quiet company.[48] Too much interference from cheerful visitors at this time may hinder the client's emotional preparation.[49]

If a client is depressed, then the attorney may need to prompt the client and be more active.[50] If the client does not volunteer or request particular information, then the attorney should not assume the client lacks desire.[51] It may be prudent to wait a few days if a client comes to your office in a depressed state.[52] If the depression is severe and persistent for more than a couple of weeks, then refer the client to a mental health professional.

---

38. *Id.* at 97.
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.* at 98.
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.* at 99.
47. *Id.*
48. *Id.* at 99-100.
49. *Id.* at 100.
50. *Id.* at 100-21.
51. *Id.*
52. *Id.*

E. Acceptance

If a client has had enough time and received help working through the first four stages of death, then he will reach a stage where he is no longer depressed or angry about his fate.[53] He will have expressed his envy for those living and his anger toward those who do not share his fate.[54] The client will have mourned the approaching loss of so many people and places.[55] The client will contemplate his fate with a degree of quiet expectation.[56]

Acceptance is an unhappy stage, almost void of feelings.[57] Acceptance makes it seem as if the pain is gone and the struggle is over.[58] The client has found some peace, and his circle of interest has diminished.[59] He wishes to be left alone and is not talkative.[60] Communication becomes more nonverbal than verbal.[61] Terminally ill clients can die easier if they are not prevented from detaching themselves slowly from all the meaningful relationships in their lives.[62] During this stage, the family usually needs more support than the client needs in order to let go.[63]

During the stage of acceptance, the client finds peace in his life and in his impending death.[64] This is the ideal stage in which to do estate planning. However, it is unpredictable when and if acceptance will occur.

F. Final Thoughts

Attorneys need to be aware of these various stages of death and try to determine which stage the terminally ill client is going through. Emotional moments may cause meetings with the client to run longer than expected. Although attorneys are prone to thoroughly discussing matters, when dealing with a terminally ill client attorneys should be comfortable with silence and use it as a tool to help the client cope with the situation. If the client has an unusual request regarding his estate plan, then it is possible that the request is influenced by the client's current death stage.

There is no specific timetable as to how long a client might be in any given stage. When advising a client, the attorney comes to the client with his

---

53. *Id.* at 123.
54. *Id.*
55. *Id.*
56. *Id.* at 123-24. The client will also feel the need to sleep frequently in brief intervals, which is similar to a newborn's decreasing need for sleep but in reverse. *Id.* at 124. This is a natural part of the acceptance stage, not a symptom of depression. *Id.*
57. *Id.* at 124.
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *See id.* at 125-46.
63. *See id.*
64. *Id.*

own experiences with loss and death. These personal experiences can either help or interfere with assisting the client. It may be necessary for the attorney to perform a quick self-assessment. If the attorney is not able to put his emotions aside, then he may need to refer the client to another attorney. If the attorney has concerns about his client's capacity to execute documents, then Appendices A and B provide two short mental status exams that attorneys may utilize to assess the client's capacity.[65]

As advocates, attorneys should be aware that a client who is severely ill is sometimes treated as a person with no right to an opinion. The client may be in the company of medical personnel who in their minds are assisting him, but none of them will stop to listen to him. He becomes a thing. We might need to remind the family and medical personnel that our client has feelings, wishes, opinions, and the right to be heard.

III. RELATED LEGAL ISSUES

With a terminally ill client, the attorney may need to review estate planning documents beyond the basic arsenal.[66] Additionally, the terminally ill client may ask legal questions that the healthy client would not ask.[67] This section reviews some of the documents beyond the will, trust, or statutory power of attorney.

A. Appointment of an Agent to Control Disposition of Remains

The client may be on his second marriage and have children from a first marriage. The client may be single, estranged from his family, or have a significant other. If the client has not left written instructions, then Texas has a priority list designating the individuals with the right to control the disposition of the decedent, including the person in control of the decedent's cremation and the person liable for the reasonable cost of interment.[68] They are as follows:

1. the person designated in a written instrument signed by the decedent;
2. the decedent's surviving spouse;
3. any one of the decedent's surviving adult children;
4. either one of the decedent's surviving parents;
5. any of the decedent's surviving adult siblings; or
6. any adult person in the next degree of kinship in the order named by law to inherit the estate of the decedent.[69]

---

65. *See infra* Apps. A & B.
66. *See infra* Part III.A-C.
67. *See infra* Part VIII.G.
68. TEX. HEALTH & SAFETY CODE ANN. § 711.002(a)(1)-(6) (Vernon 2003).
69. § 711.002(a).

Any dispute between the persons listed above "shall be resolved by a court of competent jurisdiction."[70]

The written instrument referred to in the first priority is a statutory form for the appointment of an agent to control disposition of remains.[71] If the client has not executed this form, then written directions can also be found in a will or a prepaid funeral contract.[72] "If the directions are in a will, they shall be carried out immediately without the necessity of probate."[73]

B. Directive to Physicians

Texas has a statutory form for directives.[74] Attorneys drafting directives for the terminally ill client, or for any client, may need to define some of the terminology for that client.[75] The attorney may also need to consider adding more specifics to the statutory directive based on the client's exact needs.[76]

The first question is: What is a terminal condition?

> Terminal condition means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 [of the Texas Health & Safety Code] is presumed to have a terminal condition for purposes of this chapter.[77]

The second question that might follow is: What is a life-sustaining treatment?

> "Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be

70. *Id.* § 711.002(k).
71. § 711.002(a).
72. § 711.002(g).
73. § 711.002(h).
74. *Id.* § 166.033 (Vernon Supp. 2008).
75. *See id.* § 166.002 (Vernon 2003).
76. *See* § 166.033.
77. § 166.002(13) (Vernon Supp. 2008).

> necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.[78]

Additional language that the attorney may want to propose to a client may be:

1. If my physician determines that the withholding of nutrition or hydration will not cause me undue pain, then I do not want a nasogastric tube or any other type of nutrition or hydration to be administered.
2. I (do) (do not) want to be placed on a respirator.
   I (do) (do not) want cardiac resuscitation.
   I (do) (do not) want any type of naso or gastric tube feeding.
   I (do) (do not) want antibiotics or any other life-sustaining medication.
   I (do) (do not) want to be maintained in a vegetative state and (do) (do not) not want any procedures, which would prolong my death.
   I (do) (do not) want the administration of saline solutions to keep me hydrated.
3. I do want pain relief, and I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including including any pain that might occur by withholding or withdrawing treatment even if such treatment may hasten my death.

There has been considerable debate about whether or not to withhold nutrition and hydration.[79] Since attorneys are not doctors, the attorney should suggest that the client discuss this additional language with the physician so that an informed choice can be made. A printout of the possible additional language may be given to the client so that he can have specific questions to discuss with his doctor.

After being diagnosed with a terminal illness, a client may desire to work with a primary physician to formulate a written treatment plan.[80] "[A] treatment plan enables a patient to communicate personal preferences concerning medical treatment and the possibility of abating treatment . . . ."[81] The treatment plan should specifically address the type of care the client considers appropriate, such as hospice care, the type of treatment to combat the client's pain, and the types of treatment that the client does not want.[82]

---

78. § 166.002(10).

79. *See, e.g.*, Abby Goodnough, *The Schiavo Case: The Overview; Schiavo Dies, Ending Bitter Case Over Feeding Tube*, N.Y. TIMES, Mar. 23, 2005, at A1.

80. ROBERT F. WEIR, ABATING TREATMENT WITH CRITICALLY ILL PATIENTS 176 (1989).

81. *Id.*

82. *See id*. at 176-79.

C. Out of Hospital Do Not Resuscitate (DNR)

If the client is at home and the emergency medical technicians are called, then the team will resuscitate the patient unless there is an Out of Hospital DNR Order.[83] It must be signed by the patient or his guardian, agent, proxy, or managing conservator.[84] Then the Out of Hospital DNR must be witnessed and signed by the attending physician.[85]

D. Hospice Care

Some families may not be familiar with hospice care. In hospice care, the client and family have trained medical, spiritual, and psychological personnel that can be of great assistance during this very difficult time.[86] Attorneys may find themselves being asked about residential facilities for those last months if the family is unable to cope with the client dying at home. Hospice care is a facility for the family and client to consider. Some nursing homes offer a hospice section.

The National Hospice Organization defines hospice as "a centrally administered program of palliative and supportive services, which provides physical, psychological, social and spiritual care for dying persons and their families."[87]

To be eligible for hospice care, a client must meet certain criteria. First, the client's disease must be at a point when disease-oriented, life-prolonging therapies have ceased effectiveness.[88] Second, the client must have a predicted life expectancy of six months or less.[89] With hospice, there is no intent to cure the patient.[90] The goal of hospice is to support not only the patient, but also the patient's family.[91] The doctor must certify that the patient is terminal and life expectancy is less than six months.[92]

---

83. *See* TEX. DEP'T OF STATE HEALTH SERVS., STANDARD OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER (July 19, 2005), http://www.dshs.state.tx.us/emstraumasystems/dnr.pdf. At this website you can find a statutory form provided by the Texas Department of Health. *Id.*

84. TEX. HEALTH & SAFETY CODE ANN. § 166.082 (Vernon 2003).

85. § 166.082(b).

86. Robert M. Cunningham, Jr., *The Evolution of Hospice*, HOSPITALS, Apr. 16, 1985, at 124.

87. *Id.*

88. Michael H. Levy, *Living with Cancer: Hospice/Palliative Care*, 85 J. NAT'L CANCER INST. 1283, 1284 (1993).

89. *Id.*

90. *See id.* at 1283.

91. *See id.* at 1283-84.

92. Social Security Administration, Understanding Supplemental Security Income: Expedited Payments (2008), http://www.ssa.gov/ssi/text-expedite-ussi.htm.

E. Social Security

The section below provides a brief overview of Social Security; however, the author is not an expert on Social Security.[93] Therefore, if more than background material is needed, then a referral to a Social Security expert may be in order.

1. Disability

At some point, the client may become disabled and unable to work. There is a five month waiting period to be eligible for Social Security disability, but it normally takes longer than five months to become eligible.[94] If the client has a letter from his doctor stating that he is terminally ill, then the case is given expedited status by the Social Security Administration.[95] The decision of eligibility can be decided within thirty days, so that at the sixth month point the first monthly check will be received.[96]

2. Supplemental Security Income (SSI)

During the five month waiting period, if there are no other financial resources and the client is indigent, then he can qualify for SSI immediately using the presumptive eligibility process.[97]

3. Medicaid/Hospice Program

Another option that a client may also qualify for, if terminally ill and eligible for Medicaid, is the Medicaid hospice program administered by the State of Texas.[98]

4. Widow's Gap

If a client dies, the spouse is under the age of sixty, and the children are all over the age of eighteen, then there are no Social Security benefits available for the spouse upon the death of the wage earner unless she becomes disabled within eight years of the wage earner's death.[99] An application for Social

---

93. *See infra* notes 99-105.

94. SOCIAL SECURITY ADMINISTRATION, ONLINE SOCIAL SECURITY HANDBOOK § 502.1 (Jan. 30, 2006), *available at* http://www.ssa.gov/OP_Home/handbook/handbook.05/handbook-0502.html; *see, e.g.*, Brent Walth & Bryan Denson, *Getting Disability Payments Can Be a Fight to the Death*, THE OREGONIAN, Aug. 3, 2008, *available at* http://www.oregonlive.com/special/index.ssf/2008/08/getting_disability_payments_ca.html.

95. SOCIAL SECURITY ADMINISTRATION, *supra* note 94, at § 130.2.

96. *Id.*

97. 40 TEX. ADMIN. CODE § 30.10 (2008); 2008 Annual Report of the SSI Program, *available at* http://www.social security.gov/OACT/ssir/SSI08/ProgramDescription.html (last visited Aug. 20, 2008).

98. 40 TEX. ADMIN. CODE § 30.10.

99. *See* MARVIN B. SUSSMAN ET AL., HANDBOOK OF MARRIAGE AND THE FAMILY 494 (Springer 1999).

Security benefits by the spouse upon this circumstance of disability can be made ninety days prior to becoming sixty years of age.[100]

F. Medicare

Many hospitals will send Medicare eligible, terminally ill patients home after three days of hospital care and/or twenty days of skilled nursing services by informing the client that this care is all Medicare allows.[101] Hospitals will make this decision because if the patient is not going to improve, then Medicare will not pay.[102] In reviewing this regulation, the restoration potential is not "the deciding factor in determining whether skilled services are needed."[103]

G. Viatical Settlements and Life Insurance Policies

Viatical Settlements are one method of getting a client the funds necessary to live his last months in comfort, and these settlements are accomplished by selling the client's life insurance policy to a third party for an immediate lump sum of cash payment.[104] The purchaser receives all rights and proceeds from the policy while taking over the premium payments.[105] If the client does not have a spouse or children or the family will not need the insurance after his death, then the viatical settlement is an alternative when the client is unable to work and needs funds for expenses.[106]

Any type of policy from any carrier is eligible to be sold.[107] The discount is steep and can be fifty to eighty percent.[108] The insurance company that issues the policy will normally purchase the policy, but there are other companies that will also purchase policies.[109]

The proceeds of a viatical settlement are tax-free at the federal level for persons who are terminally or chronically ill.[110] "Terminally ill" is defined as a patient being diagnosed by a certified physician to have a life expectancy of under twenty-four months.[111]

---

100. SOCIAL SECURITY ADMINISTRATION, UNDERSTANDING THE BENEFITS 11 (May 2008), *available at* http://www.ssa.gov/pubs/10024.pdf.

101. *See* MEDICARE.GOV, MEDICARE AND SKILLED NURSING FACILITY CARE BENEFITS 2 (2008), *available at* http://www.medicare.gov/publications/pubs/pdf/11359.pdf.

102. 42 C.F.R. § 409.32(c) (2008); *see infra* App. G.

103. 42 C.F.R. § 409.32(c).

104. *See* U.S. Securities and Exchange Commission, Viatical Settlements, http://www.sec.gov/answers/viaticalsettle.htm (last visited Aug. 20, 2008).

105. *See id*.

106. *See* Anna D. Halechko, Viatical Settlements: The Need for Regulation to Preserve the Benefits While Protecting the Ill and the Elderly from Fraud, 42 DUQ. L. REV. 803, 803-04 (2004).

107. *See id*. at 803-22.

108. *See id*. at 822.

109. *See id*. at 804.

110. 26 U.S.C. § 101(g) (2006).

111. § 101(g)(4)(A).

Another possibility is to refer the client to a bank so that he may inquire whether the bank will loan money using the policy as collateral. Receipt and payment of a viatical settlement may affect eligibility for public assistance programs.[112]

IV. MEDICAL MALPRACTICE FOR THE UNDER-TREATMENT OF PAIN

Probate lawyers need to be cognizant of potential personal injury causes of action that often arise in the handling of an estate or guardianship.[113] Many personal injury causes of action, which can significantly add to the value of an estate or guardianship, are overlooked because the probate lawyer handling the estate does not know what to look for. This article puts forth a theory that the under-treatment of pain in terminally ill patients constitutes a medical malpractice cause of action. The purpose of this article is to describe for the probate lawyer what this proposed cause of action would look like in terms of the elements, the damages recoverable, and the procedural requirements. Further this article should remind the probate lawyer to be cognizant of causes of action to benefit an estate or guardianship.

A. Proposed Theory—Medical Malpractice for the Under-Treatment of Pain

In Texas, this theory would fall under Chapter 74, Medical Liability, of the Texas Civil Practice and Remedies Code, which governs all health care liability claims against medical care providers in Texas.[114] A health care liability claim is a cause of action against a physician or health care provider for a departure from accepted standards of medical care, health care, or safety that proximately results in injury or death of the patient.[115] In order to determine what an under-treatment of pain claim would look like, it is necessary to analyze current medical negligence law.

1. Plaintiff's Elements

The elements of a cause of action for medical negligence arising from the under-medication of pain are as follows:

(1) defendant was a medical care provider,
(2) defendant had a duty to the plaintiff,
(3) defendant breached the standard of care, and

---

112. Federal Trade Commission, A Guide for People with Terminal Illnesses (Dec. 26, 1995), http://www.ftc.gov/opa/1995/12/via.shtm.

113. *See, e.g.*, Estate of Henry James v. Hillhaven Corp., No. 89CV564 (N.C. Super. Ct., Nov. 20, 1990).

114. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(13) (Vernon 2005).

115. *Id.*

(4) defendant's breach proximately caused the plaintiff's injury.[116]

a. Defendant was a Medical Care Provider

To prove an action for medical negligence arising from the under-medication of pain, the plaintiff must first establish that the defendant was a physician or health care provider.[117] A physician is an individual licensed to practice medicine in the state, a professional association of physicians, a partnership of physicians, or a profit or non-profit company formed by physicians.[118] A health care provider is "any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including, a registered nurse, a dentist, a podiatrist, a pharmacist, a chiropractor, an optometrist, or a health care institution."[119]

b. Defendant had a Duty to the Plaintiff

To prove a claim for medical negligence arising from the under-medication of pain, the plaintiff must establish that the defendant had a legal duty.[120] A physician owes a duty of care to his patient—a duty to treat the patient with the "skills of a trained, competent professional."[121] The duty arises from a mutually consensual physician-patient relationship.[122] A physician-patient relationship is established only through a physician's consent—an express or implied agreement that the physician will treat the patient.[123]

A hospital owes a duty of care to patients admitted for treatment.[124] "The standard of care . . . is what an ordinarily prudent hospital or other medical provider would do under the same or similar circumstances."[125] A hospital, like any other employer, can be vicariously liable for the negligent acts of its employees or agents, including nurses, orderlies, and technicians.[126] Generally, a hospital is not liable for the negligent acts or omissions of independent

---

116. *Id.*; *see infra* notes 117-55.

117. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(13).

118. *Id.* § 74.001(a)(23)(A)-(E).

119. *Id.* § 74.001(a)(12)(A).

120. Clements v. Conard, 21 S.W.3d 514, 522 (Tex. App.—Amarillo 2000, pet. denied).

121. Reynosa v. Huff, 21 S.W.3d 510, 513 (Tex. App.—San Antonio 2000, no pet.); *see also* St. John v. Pope, 901 S.W.2d 420, 423 (Tex. 1995).

122. Brandt v. Surber, 194 S.W.3d 108, 128 (Tex. App.—Corpus Christi 2006, pet. denied); *see also* Salas v. Gamboa, 760 S.W.2d 838, 840-41 (Tex. App.—San Antonio 1988, no writ).

123. Jackson v. Isaac, 76 S.W.3d 177, 183 (Tex. App.—Eastland 2002, pet. denied); Day v. Harkins & Munoz, 961 S.W.2d 278, 280 (Tex. App.—Houston [1st Dist.] 1997, no writ).

124. *See, e.g.*, Harris v. Harris County Hosp. Dist., 557 S.W.2d 353, 355 (Tex. App.—Houston [1st Dist.] 1977, no writ.).

125. Tovar v. Methodist Healthcare Sys. of San Antonio, Ltd., 185 S.W.3d 65, 68 (Tex. App.—San Antonio 2005, pet. denied).

126. McCombs v. Children's Med. Ctr., 1 S.W.3d 256, 259 (Tex. App.—Texarkana 1999, pet. denied); *see also* Garrett v. L.P. McCuistion Cmty. Hosp., 30 S.W.3d 653, 655 (Tex. App.—Texarkana 2000, no pet.).

physicians.[127] However, a hospital may be liable for an independent physician's negligence if the physician was acting as the hospital's ostensible agent when the negligence occurred.[128] Proving that a physician was an ostensible agent for the hospital requires the plaintiff to show the following:

> (1) he or she had a reasonable belief that the physician was the agent or employee of the hospital, (2) such belief was generated by the hospital affirmatively holding out the physician as its agent or employee or knowingly permitting the physician to hold herself out as the hospital's agent or employee, and (3) he or she justifiably relied on the representation of authority.[129]

c. Defendant Breached the Standard of Care

To prove an action for medical negligence arising from the under-medication of pain, the plaintiff must prove that the defendant breached his duty—the defendant did not conform to his required standard of care.[130] The general duty of a medical professional is to act as a medical professional of reasonable and ordinary prudence would act under the same or similar circumstances.[131] Breach of the duty of care can be proven by showing that the physician or health care professional did not act with the diligence required under the applicable standard of care or lacked the minimum degree of skill, prudence, and knowledge.[132] Some of the more obvious breaches of the standard of care include operating on the wrong part of the patient's body, leaving a surgical implement in the patient's body, performing an unnecessary surgery, and choosing an unnecessary procedure.[133] The accepted standard of care is proven by qualified medical expert testimony.[134]

The under-medication of pain in terminally ill patients is a breach of the applicable standard of care.[135] Put another way, the accepted standard of care for medical professionals includes the proper management and treatment of pain in terminally ill patients through the administration of pain medication.[136] Whether under-medication arises in the hospital, in the nursing home setting, or from treatment by an independent physician, the accepted standard of care

---

127. Baptist Mem'l Hosp. Sys. v. Sampson, 969 S.W.2d 945, 947 (Tex. 1998); Espalin v. Children's Med. Ctr. of Dallas, 27 S.W.3d 675, 684 (Tex. App.—Dallas 2000, no pet.).

128. *Sampson*, 969 S.W.2d at 947; *Espalin*, 27 S.W.3d at 648; Denton v. Big Spring Hosp. Corp., 998 S.W.2d 294, 297 (Tex. App.—Eastland 1999, no pet.); Valdez v. Pasadena Healthcare Mgmt., Inc., 975 S.W.2d 43, 46 (Tex. App.—Houston [14th Dist.] 1998, pet. denied).

129. *Sampson*, 969 S.W.2d at 949; *Garrett*, 30 S.W.3d at 655-56.

130. *See Garrett*, 30 S.W.3d at 655-56.

131. Chambers v. Conaway, 883 S.W.2d 156, 158 (Tex. 1993); Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977); Palafox v. Silvey, 247 S.W.3d 310, 318 (Tex. App.—El Paso 2007, no pet. h.).

132. *See Chambers*, 883 S.W.2d at 158.

133. *See id*.

134. *Id.*

135. *Id.*

136. Duff v. Yelin, 751 S.W.2d 175, 176 (Tex. 1988).

requires that sufficient medication be administered to alleviate pain in terminally ill patients to the extent medically possible.[137]

d. Defendant's Breach Proximately Caused the Plaintiff's Injury

To prove an action for medical negligence arising from the under-medication of pain, the plaintiff must establish that the defendant's breach of duty proximately caused the plaintiff's injury.[138] To establish proximate cause in a medical negligence case, the plaintiff must prove cause-in-fact and foreseeability.[139]

To prove cause-in-fact, the plaintiff must establish a causal connection between his injuries and the negligence of one or more defendants based on "reasonable medical probability," not mere conjecture, speculation, or possibility.[140] Under the standard of reasonable medical probability, a possible cause only becomes probable "when, in the absence of other reasonable causal explanations, it becomes more likely than not that" the injury was a result of the defendant's action.[141]

To prove foreseeability, the plaintiff must show that the defendant should have anticipated the danger that resulted from his negligence.[142] The defendant does not have to know the precise way the injury will occur, but the injury must be one that might reasonably have been anticipated.[143]

In an under-medication of pain case, the obvious injury is the pain itself. Cause-in-fact is not difficult to prove. Medical expert testimony can establish that more likely than not the patient's pain was a result of the defendant's failure to administer adequate pain medication.[144] Furthermore, pain is an injury of such general character that the physician or other health care provider may reasonably anticipate it.

---

137. *Id.*

138. *Duff*, 751 S.W.2d at 176; *see also* Welch v. McLean, 191 S.W.3d 147, 156 (Tex. App.—Fort Worth 2005, no pet.); Bradley v. Rogers, 879 S.W.2d 947, 953 (Tex. App.—Houston [14th Dist.] 1994, writ denied).

139. Kiesel v. Rentway, 245 S.W.3d 96, 99 (Tex. App.—Dallas 2008, pet. dism'd); Arlington Mem'l Hosp. Found. v. Baird, 991 S.W.2d 918, 922 (Tex. App.—Fort Worth 1999, pet. denied).

140. *Bradley*, 879 S.W.2d at 953-54; *see also* Park Place Hosp. v. Estate of Milo, 909 S.W.2d 508, 511 (Tex. 1999); Burroughs Wellcome Co. v. Crye, 907 S.W.2d 497, 500 (Tex. 1995); Kramer v. Lewisville Mem'l Hosp., 858 S.W.2d 397, 400 (Tex. 1993); Hawkins v. Walker, 238 S.W.3d 517, 522 (Tex. App.—Beaumont 2007, no pet. h.).

141. Lenger v. Physician's Gen. Hosp., Inc., 455 S.W.2d 703, 707 (Tex. 1970); Parker v. Employers Mut. Liab. Ins. Co., 440 S.W.2d 43, 47 (Tex. 1969); Williams v. NGF, Inc., 994 S.W.2d 255, 256-57 (Tex. App.—Texarkana 1999, no pet.); Tsai v. Wells, 725 S.W.2d 271, 274 (Tex. App.—Corpus Christi 1986, writ ref'd n.r.e.).

142. Dallas County v. Posey, 239 S.W.3d 336, 342 (Tex. App.—Dallas 2007, no pet. h.); Arlington Mem'l Hosp. Found. v. Baird, 991 S.W.2d 918, 922 (Tex. App.—Fort Worth 1999, pet. denied).

143. CoTemp, Inc. v. Houston W. Corp., 222 S.W.3d 487, 493-94 (Tex. App.—Houston [14th Dist.] 2007, no pet. h.); Hall v. Huff, 957 S.W.2d 90, 96 (Tex. App.—Texarkana 1997, pet. denied).

144. *See* Lopez v. Carillo, 940 S.W.2d 232, 234 (Tex. App.—San Antonio 1997, writ denied).

In 2001, a California jury awarded a substantial sum of money in a case involving the under-treatment of pain.[145] *Bergman v. Chin* involved care provided to William Bergman, an eighty-five year old Californian dying of lung cancer.[146] Mr. Bergman was admitted to Eden Medical Center on February 16, 1998, complaining of intolerable pain.[147] He spent five days in the hospital and was treated by Dr. Chin, an internal medicine specialist.[148] Nurses charted pain levels ranging from 7 to 10, with 10 being the worst pain imaginable.[149] Still in agony, Mr. Bergman was discharged to die at his home. Mr. Bergman was finally able to obtain relief when his family consulted another physician who prescribed the proper pain medication.[150] He died in hospice care on February 24, 1998.[151]

In *Bergman*, medical experts testified that there were numerous deviations from the standard of care.[152] They called Dr. Chin's conduct "amazingly reckless" and "inexcusable."[153] Although the judge in *Bergman* reduced the jury award considerably, the outcome encourages health care providers to pay attention to their patient's pain and treat it appropriately.[154] Further, the fact that the judge reduced the award to comply with a statute that caps medical malpractice cases indicates that the limitations of Chapter 74 apply to under-treatment of pain cases.[155] Other jurisdictions should follow California's lead and hold healthcare providers accountable for the under-treatment of pain of the terminally ill.

2. Recoverable Damages

As discussed previously, the limitations of Chapter 74 of the Texas Civil Practice and Remedies Code apply to the under-treatment of pain cases, including limitations on recoverable damages.[156] In an action for medical malpractice arising from the under-medication of pain, the plaintiff can recover actual damages, which include physical pain, mental anguish, and medical expenses.[157] In an under-treatment of pain situation, the patient's family members are likely to suffer substantial emotional distress by watching their

145. Bergman v. Chin, No. H205732-1 (Cal. Super. Ct. June 13, 2001).
146. *Id.*
147. *Id.*
148. *Id.*
149. *Id.*
150. *Id.*
151. *Id.*
152. *Id.*
153. *Id.*
154. *See id*.
155. *See* TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301-.303 (Vernon 2005).
156. *See supra* Part IV.A.1; *see also* §§ 74.301-.303.
157. Sorokolit v. Rhodes, 889 S.W.2d 239, 243 (Tex. 1994); s*ee, e.g.*, Linan v. Rosales, 155 S.W.3d 298, 306 (Tex. App.—El Paso 2004, pet. denied).

loved one suffer in his final days.[158] However, Texas law does not permit a bystander to recover damages in medical malpractice cases.[159]

Chapter 74 replaced the Medical Liability and Insurance Improvement Act on September 1, 2003.[160] Chapter 74, much like Article 4509i, purports to limit the recovery of damages in medical malpractice cases.[161] Section 74.303, in parallel to the prior section 11.02, limits liability to $500,000 except as to past and future damages for necessary medical, hospital, and custodial care expenses.[162] Due to its recent vintage, there is a dearth of cases that interpret section 74.303. However, a body of good case law exists for the prior statute. In *Lucas v. United States*, the Texas Supreme Court declared section 11.02 unconstitutional in injury cases under the open courts provision of the Texas Constitution.[163] However, in *Rose v. Doctors' Hospital Facilities*, the Texas Supreme Court declared section 11.02 constitutional in death cases.[164] The court further held that the damages cap provision was to be calculated on a "per defendant" basis.[165]

3. Procedural Requirements

Chapter 74 of the Texas Civil Practice and Remedies Code establishes the same absolute two year statute of limitations for health care liability claims.[166] Unless the discovery rule applies, the limitations period begins to run on one of three dates: (1) the date the breach occurred; (2) the date the treatment that is the subject of the claim is completed; or (3) the date the hospitalization for which the claim is made is completed.[167]

In *Chambers v. Conaway*, the plaintiff alleged that the physician breached the standard of care by not monitoring a condition the plaintiff complained about to the physician.[168] The court held that the limitations period began to

158. *See* Cavanaugh v. Jones, 863 S.W.2d 551, 557 (Tex. App.—Austin 1993, writ denied).

159. Edinburg Hosp. Auth. v. Trevino, 941 S.W.2d 76, 81 (Tex. 1997); Morrell v. Finke, 184 S.W.3d 257, 270 (Tex. App.—Fort Worth 2005, pet. denied); Denton Reg'l Med. Ctr. v. LaCroix, 947 S.W.2d 941, 957 (Tex. App.—Fort Worth 1997, writ denied).

160. Act of May 30, 1977, 65th Leg., R.S., Ch. 817, § 1, 1977 Tex. Gen. Laws 2039, 2039, *repealed by* Act of June 2, 2003, 78th Leg., R.S. ch. 204, § 10.09, 2003 Tex. Gen. Laws 847.884; *see also* Jeff Watters, Better to Kill than to Maim: The Current State of Medical Malpractice Wrongful Death Cases in Texas, 60 BAYLOR L. REV. 794, 752-57 (2008).

161. *Compare* TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301-.303 *with* Act of May 30, 1977, 65th Leg. R.S. ch. 817, §§ 1, 1.02(b)(2), 1977 Tex. Gen. Laws 2039, 2040 (repealed 2003).

162. *Compare* TEX. CIV. PRAC. & REM. CODE ANN. § 74.303 *with* Act of May 30, 1977, 65th Leg. R.S., ch. 817, §§ 1, 11.02, 1977 Tex. Gen. Laws 2039, 2052 (repealed 2003).

163. Lucas v. United States, 757 S.W.2d 687, 690 (Tex. 1988).

164. Rose v. Doctors' Hosp. Facilities, 801 S.W.2d 841, 845 (Tex. 1990).

165. *Id.* at 846.

166. TEX. CIV. PRAC. & REM. CODE ANN. § 74.251.

167. Shah v. Moss, 67 S.W.3d 836, 841 (Tex. 2001); Earle v. Ratliff, 998 S.W.2d 882, 886 (Tex. 1999); Husain v. Khatib, 964 S.W.2d 918, 919 (Tex. 1998); Diaz v. Westphal, 941 S.W.2d 96, 99 (Tex. 1997); Chambers v. Conaway, 883 S.W.2d 156, 158 (Tex. 1993).

168. *Chambers*, 883 S.W.2d at 157.

run from the date of the patient's last visit to the physician.[169] In *Husain v. Khatib*, the plaintiff alleged that the physician did not establish a course of treatment because the physician misdiagnosed the plaintiff's condition.[170] The court held that the limitations period began to run from the date of the last examination that the physician had an opportunity to diagnose the condition.[171]

In *Earle v. Ratliff*, the plaintiff alleged that the physician was negligent in misdiagnosing the need for surgery by failing to disclose the attendant risks of surgery beforehand and by performing an unwarranted surgery.[172] The court found that the physician's negligence occurred on or before the date he performed the surgery and limitations on the claim began to run on that date.[173] In *Shah v. Moss*, the plaintiff alleged that the physician performed negligent surgery and negligent follow-up treatment.[174] The court held that when the date of the alleged tort or breach is ascertainable, limitations begin to run from that date and a course of treatment analysis for follow-up treatment is inapplicable.[175] In *Gross v. Kahanek*, the Texas Supreme Court found that when a claim arises from the prescription of medication as a course of treatment, the course of treatment ends and the limitations begin to run when the physician ceases prescribing the medication.[176]

It would follow for the under-treatment of pain that the limitations period would begin to run from the date of the patient's last visit to the physician or the last examination by the physician. If the exact date of the breach cannot be determined, then the limitations period begins to run on the date the medical or health care treatment was completed—the date the physician discontinued prescribing medication.[177]

In *Neagle v. Nelson*, the Texas Supreme Court ruled that an injured person's right to file a malpractice suit was not cut off if the person could not have reasonably discovered the wrong within the two year limitations period.[178] This new discovery rule states that a claimant has a reasonable time after discovering his injury in which to file suit, which differs from the traditional discovery rule that provided that a claimant had two years after the date of discovery to file suit.[179]

In *Yancy v. United Surgical Partners International, Inc.*, the older statute of limitations under Article 4590i, section 10.01 was found to not violate the open courts provision of the Texas constitution.[180] However, in *Adams v.*

169. *Id.* at 158.
170. *Husain*, 964 S.W.2d at 919.
171. *Id.* at 919-20.
172. *Earle*, 998 S.W.2d at 884.
173. *Id.* at 886.
174. Shah v. Moss, 67 S.W.3d 836, 839 (Tex. 2001).
175. *Id.* at 843.
176. Gross v. Kahanek, 3 S.W.3d 518, 521 (Tex. 1999).
177. TEX. CIV. PRAC. & REM. CODE ANN. § 74.251 (Vernon 2005).
178. Neagle v. Nelson, 685 S.W.2d 11, 12 (Tex. 1985).
179. *Id.*; § 74.251(a).
180. Yancy v. United Surgical Partners Int'l, Inc., 236 S.W.3d 778, 786 (Tex. 2007).

Gottwald, section 74.251 was found to be unconstitutional as applied to minors under the open courts provision of the Texas constitution.[181]

4. Notice and Expert Report Requirements

A plaintiff must provide sixty days notice before filing a negligence claim against a physician or health care provider.[182] Providing notice under section 74.051 tolls the statute of limitations for seventy-five days.[183] Chapter 74 of the Texas Civil Practice and Remedies Code requires a plaintiff to provide an expert report for each named physician or health care provider against whom a claim is asserted within 120 days.[184] If the plaintiff fails to file an expert report within the period specified, then, on the defendant's motion, the court must dismiss the action with prejudice and award attorney fees and court costs to the defendant.[185] If the expert report is found to be deficient, then the court may grant one thirty day extension to allow the claimant to cure the deficiency.[186]

Chapter 74 imposes many limitations on medical malpractice suits.[187] The personal injury attorney must jump through many hoops in order to comply with the statute.[188] The probate lawyer should review for the existence of personal injury causes of action when handling estate matters.[189] Medical negligence for the under-medication of pain is one example of the many personal injury causes of action that might arise in the estate or guardianship setting. In order to maximize the value of the estate, the probate lawyer must be able to recognize medical negligence causes of action when they exist. The under-medication for pain is a new possible cause of action that may be prevalent with terminally ill clients.

V. A REVIEW OF CASES REGARDING THE TERMINALLY ILL AND WITHDRAWAL OF TREATMENT

The withdrawal of treatment falls under the Due Process Clause of the United States Constitution.[190] Persons have a right to privacy and liberty interest in their medical treatment choices.[191] This right extends to surrogate decision-makers upon a showing by clear and convincing evidence that the patient extended this right to his surrogate.[192]

---

181. Adams v. Gottwald, 179 S.W.3d 101, 102-03 (Tex. App.—San Antonio 2005, pet. denied).
182. TEX. CIV. PRAC. & REM. CODE ANN. § 74.051 (Vernon 2005).
183. *Id.*
184. *Id.* § 74.351(a).
185. *Id.* § 74.351(b); *see also* Murphy v. Russell, 167 S.W.3d 835, 839 (Tex. 2005).
186. TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(c).
187. *See id.*§§ 74.001-.507 (Vernon 2005).
188. *See, e.g.*, § 74.351.
189. *See* § 74.351(a).
190. *See* Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 281 (1990).
191. *Id.*
192. *Id.* at 282.

A. Client in Vegetative State or Incapacitated—Not Terminal—Surrogate Decision Making

1. In re Quinlan

In *In re Quinlan*, Karen Quinlan was in a vegetative state for a year when her guardian father requested to discontinue all treatment, including the use of a respirator, but the hospital refused.[193] The court ruled that the patient's constitutional right to privacy could be asserted by her guardian after consultation with the family and concurrence with the hospital's ethics committee that there was no reasonable possibility of emergence from her comatose condition.[194] At this point, the court found that treatment could be discontinued.[195]

The court gave an in-depth analysis of the Catholic Church's agreement that Mr. Quinlan's request to discontinue treatment was morally correct.[196] Mr. Quinlan was a devout Catholic and sought advice from the Church about discontinuing treatment.[197] The reasoning was expressed in an address to anesthesiologists on November 24, 1957, by Pope Pius XII when he dealt with the question:

> Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modern artificial respiration apparatus, even against the will of the family?

His answer made the following points:

1. In ordinary cases the doctor has the right to act in this manner, but he is not bound to do so unless this is the only way of fulfilling another certain moral duty.
2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly gives him the permission.
3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no obligation to use them or to give the doctor permission to use them.

193. *See* In re Quinlan, 355 A.2d 647, 656-57 (N.J. 1976).
194. *Id.* at 663-65.
195. *Id.*
196. *Id.* at 659.
197. *Id.* at 657-58.

4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.
5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.[198]

Since this pontifical address, the Church has further defined its position, stating that it is permissible to interrupt the administration of medicines,[199] but that it is immoral and not permissible to remove or withhold water and food.[200]

2. In re L.C.D.

In *In re L.C.D.*, the guardian of a severely disabled child brought a motion seeking instructions as to whether it would be in the child's best interest to consent to a directive to physicians.[201] The Ninth District Court of Appeals in Beaumont held that when the trial court ordered the guardian to execute the directive, the trial court exceeded its authority. The ward's appointed guardian already had the power to consent to medical, psychiatric, and surgical treatment without court intervention.[202]

A guardian's decision to withhold or withdraw life-sustaining treatment must be based on knowledge of what the ward would desire.[203] If the ward previously executed a directive, then the directive will serve to guide the guardian's choices.[204] If there is no directive, then the guardian must develop evidence by interviewing family, friends, and neighbors or by reviewing medical records to determine the wishes of the ward.[205] If this is not available, then the guardian must decide what course of treatment is in ward's best interest, after consulting with the treating experts.[206]

198. *Id.* at 658.

199. Prefect Franjo Cardinal Seper, Declaration on Euthanasia from the Sacred Congregation for the Doctrine of Faith (May 5, 1980), *available at* http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

200. Pope John Paul II, Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (Mar. 20, 2004), *available at* http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

201. *In re* L.C.D., 16 S.W.3d 153, 154 (Tex. App.—Beaumont 2000, pet. granted).

202. *Id.* at 156 (citing TEX. PROB. CODE ANN. § 767(4) (Vernon Supp. 2007)).

203. *Id.* at 155.

204. *See id*.

205. *See id*.

206. *See id*.

3. Cruzan v. Missouri Department of Health

In *Cruzan v. Missouri Department of Health*, the court held that a competent person has a liberty interest under the Due Process Clause to refuse unwanted medical treatment.[207] A surrogate may act for an incompetent patient upon a showing by clear and convincing evidence that this action would be the patient's wish if the patient was competent.[208]

4. Workmen's Circle Home & Infirmary for the Aged v. Fink

In *Workmen's Circle Home & Infirmary for the Aged v. Fink*, the children of a comatose woman did not want doctors to insert a gastro-feeding tube; instead, the children wanted the removal of the intravenous tube and cessation of antibiotic treatment.[209] The court ruled that the children must satisfy the highest burden of proof in a civil case: clear and convincing evidence as to mother's intention.[210] The patient has a right to determine treatment under the constitutional Due Process right of liberty and privacy.[211]

5. Wendland v. Wendland

In *Wendland v. Wendland*, a conservator-wife wanted the feeding tube removed from her husband but his mother and sister objected.[212] The conservatee-husband was not in a persistent vegetative state or suffering from a terminal illness.[213] His wife wanted to use good faith decision making as the standard, but the court held that his wife must show by clear and convincing evidence that the conservatee wished to refuse such treatment or to withhold such treatment would be in his best interest.[214] This standard requires proof to be so clear and convincing as to leave no substantial doubt.[215]

6. Schiavo *ex rel* Schindler v. Schiavo

In *Schiavo ex rel Schindler v. Schiavo*, the husband and guardian of an incapacitated woman on artificial life support sought to have food, fluids, and medical treatment removed.[216] In an extended legal battle, her parents

---

207. Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 278 (1990).
208. *Id.* at 280.
209. Workmen's Circle Home and Infirmary for the Aged v. Fink, 514 N.Y.S.2d 893, 894 (N.Y. Sup. Ct. 1987).
210. *Id.* at 895.
211. *Id.*
212. Wendland v. Wendland, 28 P.3d 151, 154 (Cal. 2001).
213. *Id.* at 174.
214. *Id.* at 175.
215. *Id.* at 173.
216. Schiavo *ex rel.* Schindler v. Schiavo, 358 F. Supp. 2d 1161, 1164 (M.D. Fla. 2005).

exhausted all of their legal options to prevent the removal of life support.[217] Ultimately, however, the husband and guardian won a court order to remove life support.[218] Her parents then appealed to the Eleventh Circuit, which held that neither the hospice nor the husband violated the Americans with Disabilities Act, the ward's Eighth Amendment rights, or her substantive due process rights.[219]

7. Miller *ex rel* Miller v. HCA, Inc.

In *Miller ex rel. Miller v. HCA, Inc.*, the parents brought an action against a hospital asserting claims of battery and negligence arising from emergency medical treatment administered to their child who was born severely premature and in distress but not certifiably terminal.[220] The court held the following:

> (1) [T]he hospital was not required to seek court intervention before providing emergency treatment to the child without parental consent; (2) the hospital was not negligent in allowing neonatologist to perform emergency medical treatment without parental consent; and (3) the federal "Baby Doe" statute did not apply to determination whether neonatologist committed battery by providing emergency medical treatment to infant without parental absent [sic].[221]

8. Stolle v. Baylor College of Medicine

In *Stolle v. Baylor College of Medicine*, the parents brought a medical malpractice action against the hospital and its physicians on their daughter's behalf for alleged disregard of the parents' instructions to not use any heroic efforts or artificial means to extend the life of their daughter, who was born brain damaged.[222] The court held under both common law and the Natural Death Act that hospitals and physicians could not be liable for resuscitating children.[223]

From this series of cases, it can be surmised that if the client does not have a Directive to Physicians, a family member can be a surrogate decision maker, but the decision should be based on what the client would want.[224] Should this issue become contested, the burden of proof will be clear and convincing evidence.[225] An exception to this general rule occurs in cases involving a

---

217. *Id.* at 1167.
218. *See id*.
219. Schiavo *ex rel.* Schindler v. Schiavo, 403 F.3d 1289, 1289, 1299-302 (11th Cir. 2005).
220. Miller *ex rel.* Miller v. HCA, Inc., 118 S.W.3d 758, 759 (Tex. 2003).
221. *Id.*
222. Stolle v. Baylor Coll. of Med., 981 S.W.2d 709, 710 (Tex. App.—Houston [1st Dist.] 1998, pet. denied).
223. *Id.*
224. *See In re* Quinlan, 355 A.2d 647, 658 (N.J. 1976).
225. *See* Wendland v. Wendland, 28 P.3d 151, 154 (Cal. 2001).

newborn in medical distress.[226] In such situations, Texas courts are reluctant to hold hospitals liable for providing emergency care, even if emergency care is provided against the wishes of parents.[227]

B. Incompetent and Terminal

1. Belchertown State School v. Saikewicz

In *Belchertown State School v. Saikewicz*, a mentally retarded adult was diagnosed with fatal form of leukemia.[228] The court ordered withholding chemotherapy treatment, which had serious side effects that the patient could not understand and would not cure the disease.[229] These actions squared with the testimony of physicians, the generally accepted views of the medical profession, and the patient's right to privacy.[230]

2. In re Conroy

In *In re Conroy*, the guardian of an eighty-four year old bedridden nursing home patient with a short life expectancy and serious, irreversible mental and physical impairments sought court permission to remove the patient's primary source of nutrition, a nasogastric feeding tube.[231] However, the patient's guardian ad litem opposed application.[232] The court found that a competent adult normally has the right to reject medical treatment and that this right is not lost upon incompetency.[233]

The court developed two variations of the "best interest" approach to guide surrogate decision-making when the ward either has never achieved competency or has left scant evidence of treatment preferences.[234] The first variation is a purely objective standard, used only when there is no evidence of the ward's wishes.[235] Withdrawal of life sustaining treatment is permitted only if the burdens of the patient's life with the treatment outweigh the benefits the patient derives from life and the patient is suffering from severe pain.[236] The second variation is a limited objective test that permits withdrawal of treatment when there is some evidence that the patient would have refused treatment and that the surrogate believes the burdens of the patient's life outweigh the

226. *See Stolle*, 981 S.W.2d at 713-14.
227. *See id*.
228. Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 420 (Mass. 1977).
229. *Id.* at 419.
230. *Id.* at 421, 430.
231. *In re* Conroy, 486 A.2d 1209, 1209 (N.J. 1985).
232. *Id.*
233. *Id.*
234. *See id*. at 1231-32.
235. *See id*. at 1232.
236. *Id.*

benefits of continued life.[237] The court, however, found that the evidence in this case did not satisfy either of these tests.[238]

C. Competent but not Terminal

1. Bartling v. Superior Court of Los Angeles County

In *Bartling v. Superior Court of Los Angeles County*, a seriously ill patient with a non-terminal but incurable illness wanted to be disconnected from the respirator, which would ultimately result in his death.[239] The court ruled that the patient had the right to refuse unwanted, although life-sustaining medical treatment.[240]

2. Bouvia v. Superior Court of Los Angeles County

In *Bouvia v. Superior Court of Los Angeles County*, a competent patient who was severely crippled and in constant pain expressed desire to die and had stopped eating.[241] The hospital inserted a feeding tube against her will.[242] The court found that the state and federal Constitutions both vested a fundamental right in a patient's right to refuse treatment.[243]

3. Satz v. Perlmutter

In *Satz v. Perlmutter*, a seriously ill patient with a non-terminal but incurable illness sought to have his respirator removed, which would result in his death within an hour.[244] The court held that a patient's constitutional right to privacy protected his right to refuse or discontinue medical treatment because the following conditions were met: (1) the patient was a competent adult; (2) the patient's condition was terminal, his situation wretched, and the continuation of his life was temporary and dependent on artificial means; (3) the patient's family agreed with his wishes to discontinue medical treatment; and (4) the patient's desire to live under his own power, coupled with the fact that the patient did not self-induce his affliction, indicated that the patient's refusal of treatment could not be classed as attempted suicide.[245]

---

237. *Id.*
238. *Id.* at 1243.
239. Bartling v. Super. Ct. of L.A. County, 163 Cal. App. 3d 186, 186 (Cal. Ct. App. 1984).
240. *Id.* at 193-95.
241. Bouvia v. Super. Ct. of L.A. County, 179 Cal. App. 3d 1127, 1136 (1986).
242. *Id.*
243. *Id.* at 1137.
244. Satz v. Perlmutter, 362 So. 2d 160, 161 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. 1980).
245. *Id.* at 162-63.

D. Role of Nursing Homes and Hospitals on Withdrawal of Treatment

1. In re Jobes

In *In re Jobes*, a man filed an action for a court order authorizing removal of his comatose wife's j-tube.[246] The lower court held in favor of granting the spouse authority to remove the tube but allowed the nursing home to decline to participate.[247] The Supreme Court of New Jersey ruled that, because the nursing home failed to notify the family of its policy not to withhold or withdraw artificial feeding, the nursing home could not refuse to participate in removal.[248]

2. Gray v. Romeo

In *Gray v. Romeo*, the husband of an unconscious patient in a persistent vegetative state sought to remove his wife's feeding tube and life support.[249] The U.S. District Court held that the patient had a right to decline medical treatment.[250] Additionally, the court found that if the hospital could not promptly transfer the patient to a hospital that would accede to her wishes, then the hospital would be required to accede to those wishes.[251]

E. Suicide

At common law, suicide was a criminal offense that resulted in forfeiture of the decedent's goods and chattels.[252] Eventually, these sanctions were abolished in recognition of unfairness of penalizing the family.[253]

Clients fear dying, but the fear of a painful death is even more terrifying. A client may wish to explore the legalities of suicide or assisted suicide. Attorneys will want to review all life insurance policies to determine if there is an exclusion clause regarding suicide. In addition, retirement policies and benefits may be affected by the date of death. A client's desire for suicide should be a signal to a physician that greater efforts are needed to provide more adequate pain relief.[254]

Contrary to the prevailing belief among medical practitioners and laypersons, studies have indicated that narcotics, which are given to control

246. *In re* Jobes, 529 A.2d 434, 437 (N.J. 1987).
247. *Id.*
248. *Id.* at 450.
249. Gray v. Romeo, 697 F. Supp. 580, 581-82 (D.R.I. 1988).
250. *Id.* at 585-86.
251. *Id.* at 591.
252. John A. Alesandro, *Physician Assisted Suicide and New York Law*, 57 ALB. L. REV. 819, 825 (1994).
253. *Id.* at 829.
254. John Glasson, *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES L. & MED. 91, 95 (1994).

pain, are not addictive.[255] Morphine, a drug often administered for severe pain, is not addictive.[256] Central to the care of the terminally ill is controlling pain.[257] "Many people who request physician-assisted suicide withdraw that request if their depression and pain are treated."[258]

VI. ASSISTED SUICIDE

A. Oregon Death with Dignity Act

The only state that recognizes physician-assisted suicide is Oregon in the Death with Dignity Act.[259] All other states have legislation forbidding assisted suicide.[260] In response to the passing of this act, the Attorney General of the United States promulgated federal regulations in an attempt to stop physician-assisted suicide in Oregon.[261] On November 9, 2001, Attorney General Order No. 2534 - 2001 was published.[262]

According to the order, assisting suicide was not a "legitimate medical purpose" within the meaning of Chapter 21, section 1306.04 of the Code of Federal Regulations, and prescribing, dispensing, or administering federally controlled substances to assist suicide violated the Controlled Substances Act (CSA).[263] Such conduct by a physician registered to dispense controlled substances may "'render his registration . . . inconsistent with the public interest' and therefore subject to possible suspension or revocation under" Chapter 21, section 824(a)(4) of the United States Code.[264]

The State of Oregon brought an action against the U.S. Attorney General preventing federal enforcement or application of the order.[265] The court ruled that the United States had exceeded its authority and that Congress did not intend for the Controlled Substances Act to override state decisions concerning what constitutes the practice of medicine.[266]

---

255. Julie A. Steele, *Cancer Pain: Its Management Emerges as Public Health Issue*, 82 J. NAT'L CANCER INST. 646, 646 (1990).

256. Rex Greene, *Towards a Policy of Mercy: Addiction in the 1990's*, 3 STAN. L. & POL'Y REV. 227, 228 (1991).

257. Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 OHIO N.U. L. REV. 755, 758 (1994).

258. Washington v. Glucksberg, 521 U.S. 702, 730 (1997).

259. Glen R. McMurry, *An Unconstitutional Death: The Oregon Death with Dignity Act's Prohibition Against Self-Administered Lethal Injection*, 32 U. DAYTON L. REV. 441, 444 (2007); *see* OR. REV. STAT. ANN. §§ 127.800-.925 (West 2007).

260. McMurry, *supra* note 259, at 444.

261. Dispensing of Controlled Substances to Assist Suicide, 21 C.F.R. § 1306.01 (2001).

262. *Id.*

263. *Id.*

264. *Id.*; 21 U.S.C. § 824(a)(4) (2000).

265. Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1079-80 (D. Or. 2002).

266. *Id.* at 1085; *see also* 21 U.S.C. §§ 801-971.

The district court was very critical of the Attorney General's actions.[267] The U.S. Attorney General appealed the decision to the Ninth Circuit Court of Appeals in San Francisco.[268] The court ruled that the Federal Regulation was unlawful and unenforceable, that the Attorney General had exceeded his scope of authority, and that this was a states' rights issue.[269]

The Attorney General appealed to the United States Supreme Court, and the Court granted certiorari. The Court, in a 6-3 ruling, affirmed the Ninth Circuit and held that the Attorney General did not have power under the CSA to prohibit physicians from prescribing drugs for use in physician-assisted suicide.[270] The CSA recognizes state regulation of medicine and is silent on the practice of medicine in general.[271] Therefore, the CSA did not define the scope of legitimate medical practice or authorize the Attorney General to promulgate the order.[272]

B. The Dutch Law

The only country that recognizes assisted suicide is Holland.[273] The Dutch recognize the legal concept of "force majeure" under which someone who acts against the law, but does so for reasons that the public prosecutor is prepared to accept as compelling, may escape prosecution for the assistance, which is unlawful.[274]

Far from allowing or encouraging doctors to end life arbitrarily, these strict criteria stipulate that the doctor:

1. must be convinced that the patient has made a voluntary and well-considered request to die;
2. must be convinced that the patient is facing interminable and unendurable suffering;
3. has informed the patient about his situation and his prospects;
4. together with the patient, must be convinced that there is no other reasonable solution;
5. has consulted at least one other independent doctor who has seen the patient;
6. and has given his written assessment of the due care requirements as referred to in the points above; and
7. has helped the patient to die with due medical care.[275]

---

267. *Ashcroft*, 192 F. Supp. 2d at 1086.
268. Oregon v. Ashcroft, 368 F.3d 1118, 1118 (9th Cir. 2004).
269. *Id.* at 1124-27.
270. Gonzales v. Oregon, 546 U.S. 243, 274 (2006).
271. *Id.* at 272.
272. *Id.* at 258.
273. 71 VE News, Companion Journal of the Voluntary Euthanasia Society 6 (2001).
274. *Id.*
275. British Broadcasting Company, Regulation of Euthanasia, http://www.bbc.co.uk/ethics/euthanasia/

Oregon has similar criteria but with additional stringent requirements.[276]

C. New York Task Force on Assisted Suicide

The State of New York established a task force to study questions surrounding assisted suicide in New York (Task Force).[277] The Task Force summarized the risks associated with the legislation of assisted suicide as follows:

1. Undiagnosed or untreated mental illness
2. Insufficient attention to the suffering and fears of dying patients
3. Improperly managed physical symptoms
4. Vulnerability of socially marginalized groups
5. Devaluation of the lives of the disabled
6. Sense of obligation
7. Patient deference to physician recommendations
8. Increasing financial incentives to limit care
9. Arbitrariness of those proposed limits, and
10. Impossibility of developing effective regulation.[278]

In order to dissuade a client from deciding that suicide is the only alternative, the Institute of Medicine following recommends:

1. People with advanced, potentially fatal illnesses and those close to them should be able to expect and receive reliable, skillful, and supportive care.
2. Physicians, nurses, social workers, and other health professionals must commit themselves to improving care for dying patients and to using existing knowledge effectively to prevent and relieve pain and other symptoms.
3. Because many deficiencies in care reflect system problems, policymakers, consumer groups, and purchasers of health care should work with health care providers and researchers to:
    a. strengthen methods for measuring the quality of life and other outcomes of care for dying patients and those close to them;
    b. develop better tools and strategies for improving the quality of care and holding health care organizations accountable for care at the end of life;

---

infavour/infavour_1.shtml (last visited Sept. 10, 2008). Criteria A and B imply a longstanding doctor-patient relationship, which in effect restricts voluntary euthanasia to residents of the Netherlands. *Id.*

276. VE News, *supra* note 273, at 6.

277. The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (1997 Supp.), *available at* http://wings.buffalo.edu/faculty/research/bioethics/suppl.html.

278. *Id.*

c. revise mechanisms for financing care so that they encourage rather than impede good end-of-life care and sustain rather than frustrate coordinated systems of excellent care; and
d. reform drug prescription laws, burdensome regulations, and state medical board policies and practices that impede effective use of opioids to relieve pain and suffering.[279]

VII. CASE LAW: PHYSICIAN ASSISTED SUICIDE

A patient has a right to refuse life-sustaining treatment.[280] A doctor can provide aggressive palliative care even if painkilling drugs may hasten death, but the physician's purpose must be only to ease pain and not to cause the patient's death.[281] In *Vacco v. Quill*, the door was left open when Justice Stevens observed that this holding "'does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom' . . . [but the] case would need to present different and considerably stronger arguments than those advanced by respondents here."[282] The Court refused to recognize an open-ended constitutional right to commit suicide under either the Equal Protection Clause or the Due Process Clause of the Constitution.[283]

The Court upheld the state's ban on physician assisted suicide because there is no fundamental liberty interest in the "right" to assistance when committing suicide; therefore, it is not protected by the Due Process Clause.[284] The state's ban was rationally related to a legitimate government interest to preserve life and to uphold the medical profession's integrity and ethics.[285]

Physician assisted suicide is not legal anywhere in the United States except Oregon.[286] If a client asks about suicide, then the attorney can inform the client that it is illegal everywhere but Oregon and that Oregon has strict residency requirements.[287] There have been 341 physician-assisted suicides in Oregon from 1998 through December 2007.[288]

---

279. INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE 266-67 (Marilyn J. Field & Christine K. Cassel eds., 1997).

280. Vacco v. Quill, 521 U.S. 793, 797 (1997).

281. *Id.* at 802-03.

282. *Id.* at 807 n.13 (citing Washington v. Glucksberg, 521 U.S. 702, 751-52 (1997) (Stevens, J., concurring)).

283. *Id.* at 799.

284. *Id.* at 728 (majority opinion).

285. *Id.* at 728, 732.

286. *See* discussion *supra* Part VI.A.

287. *See* McMurry, *supra* note 259, at 455.

288. Kevin B. O'Reilly, *Oregon Still Stands Alone: Ten Years of Physician-Assisted Suicide*, AMERICAN MEDICAL NEWS, May 12, 2008, *available at* http://www.ama-assn.org/amednews/2008/05/12/prsa0512.htm.

VIII. THE FAMILY

A. Changes in the Household and Effects on the Family with a Terminally Ill Member

When a husband contracts a serious illness and must be hospitalized, the household may undergo relevant changes.[289] The wife "may feel threatened by the loss of security and the end of her dependence on her husband."[290] She will have to do "many chores once done by her husband and will have to adjust her own to the new demands."[291] She may have to get more involved in business and financial affairs.[292]

With the worries about her husband and added responsibility also come increased loneliness and often resentment.[293] "The expected assistance from relatives and friends may not be forthcoming . . . ."[294] On the other hand, an understanding friend "who does not come to 'hear the latest'" medical bulletin but comes to relieve the wife of some of her tasks, such as cooking or taking care of the children, can be appreciated.[295]

A wife's terminal illness may be a greater loss for her husband because he may be less accustomed to caring for himself, taking the children to school activities, making meals, and going shopping.[296] Instead of getting some rest after a long workday, he may watch his wife sitting, reading, or watching television while he prepares dinner and takes care of the children.[297] No matter how much the husband understands the need for these changes, he may still resent them.[298]

During this time, children are sometimes neglected as the adult members are coping with the changes.[299] A parent should involve and include the children because it gives them comfort in sharing responsibility and knowing they are not alone in their grief.[300]

Family members undergo stages of adjustments similar to the ones that the terminally ill go through. The family will go through a phase of preparatory grief when it can work through the anger, resentment, and guilt. The more this grief can be expressed before death, the less unbearable the grief becomes after death.

---

289. KUBLER-ROSS, *supra* note 2, at 166.
290. *Id.*
291. *Id.*
292. *Id.*
293. *Id.*
294. *Id.*
295. *Id.*
296. *See id*.
297. *See id*.
298. *Id.* at 167.
299. *See id*.
300. *See id*.

"Just as the terminally ill patient cannot face death all the time, the family member cannot and should not exclude all other interactions for the sake of being with the patient exclusively."[301] The family "should handle their energies economically and not exert themselves to a point that they collapse when . . . most needed."[302]

A neutral outsider who is not emotionally involved, such as the attorney, can be of great assistance in listening to the family's concerns, wishes, and needs.[303] "The dying patient's problems come to an end, but the family's problems go on."[304] The attorney can serve an important role in assisting the family to make the transition.

"The most heart breaking time . . . for the family is the final phase, when the patient is slowly detaching himself from his world including his family."[305] The family does not understand that a dying person who has accepted his death "will have to separate himself, step by step, from his environment, including most of his loved ones. . . . When the patient asks to be visited only by a few more friends, then by his children and finally only his wife, it should be understood that that is the way of separating himself gradually."[306] During this time, the family needs more support than the dying patient.[307]

B. The Family After Death

"The first few days [after death] may be filled with busy work, with arrangements and relatives. . . . It is at this time that family members feel most grateful to have someone to talk to . . . who can share anecdotes of some good moments" from the deceased's life.[308] The family will feel void and empty after the funeral and after the departure of relatives.[309]

Afterwards, the family may often "talk to the deceased as if he was alive."[310] For some, isolating themselves from the living is the only way they can cope during this difficult time.[311] The family should be taken out of their isolation gradually.[312] They need to be able to talk, cry, or scream if necessary, and the attorney should allow them this ventilation.[313]

---

301. *Id.*
302. *Id.*
303. *See id.*
304. *Id.* at 168.
305. *Id.* at 177.
306. *Id.*
307. *Id.*
308. *Id.* at 184.
309. *See id.*
310. *See id.*
311. *See id.*
312. *Id.*
313. *See id.*

C. Grieving Well

"Grieving well means moving consciously through the pain rather than prolonging suffering through avoidance and denial."[314] Grief cannot be avoided or denied, but grief can be dealt with in a constructive manner.[315]

As the attorney representing the family, it is important to understand that grief involves the entire self and not just a batch of financial concerns.[316] Intimidated clients may try to avoid areas of decision-making and be slow to respond to inquiries that the attorney needs answered.[317]

Another type of client may make hasty, ill-considered decisions and tell their attorney after-the-fact, leaving him with the frustrating duty of "damage control."[318]

D. Elements of Grief

Grief is a natural response to life and a change in life.[319] Families do not grieve for a loved one; instead, they grieve for their own loss because they have a hole in their life.[320] Because the loss or change disrupts the familiar in our life, it is possible to grieve without being sad.[321] Shock, confusion, loneliness, fear, guilt, anger, or a combination of these are other acceptable responses.[322] There is no proper way to grieve.[323] However, important healthy grieving is characterized by movement.[324]

Attorneys are not expected to diagnose a client's emotional condition.[325] However, certain behavioral clues allow attorneys to evaluate the stress the client is facing.[326] The likelihood of misunderstandings between attorneys and clients, which might negatively affect the attorney-client relationship, may increase due to the grief transition.[327] Therefore, attorneys should be sensitive to factors for grieving.[328]

Attorneys cannot assume that a person is not grieving because the person does not exhibit grief in the manner that an attorney assumes a grieving person

---

314. Nan L. Baker, *Increasing Your Effectiveness Through Griefwork*, WILLS AND PROBATE INSTITUTE 907, 910 (State Bar of Tex., Prof'l Dev. 1997) (emphasis omitted).
315. *Id.* at 911.
316. *Id.*
317. *See id*.
318. *See id*.
319. *See id*. at 914.
320. *See id*. at 916.
321. *Id.* at 915.
322. *Id.*; *see infra* App. B.
323. *Id.*
324. *Id.* at 917-18.
325. *Id.* at 915.
326. *Id.*
327. *Id.*
328. *Id.* at 915, 930.

should.[329] There are seven primary elements to grief, and there is fluid movement between the following seven elements:

1. Shock/Emptiness;
2. Sadness/Loneliness;
3. Separation anxiety/Fear;
4. Guilt;
5. Depression;
6. Anger; and
7. Acceptance vs. Resignation[330]

For example, a husband watching his wife suffer through a degenerative disease may feel relief and a release of anger in her passing because her pain ceases. However, when he returns to a normal schedule, he might suddenly feel a sense of shock as his loss becomes more palpable. Several factors affect the movement among the elements of grief.[331] If the client is faced with a great deal of responsibility, then he may feel that he has less latitude to express grief.[332] If he confronts his grief, then it will deter efficiency.[333]

Avoidance and denial represent flawed choices.[334] If the clients become accustomed to hiding, then they run the risk of allowing a festering wound to become a serious threat to themselves.[335] There is no timetable for grieving—it is an individual process.[336] However, grieving longer than six to twelve months may require the aid of a mental health professional.[337]

E. Going Through the Process

Clients must go with the flow of their feelings and accept that their feelings are normal.[338] Their feelings should not be classified as good, bad, normal, or abnormal.[339] Clues that clients are denying emotions include the use of words such as "should" or "ought to" and the drawing of comparisons between how they grieve and how others grieve.[340]

Clients should be reassured that it is okay to feel tired, to be unable to perform a typical work schedule, and to laugh, smile, and feel relief.[341]

---

329. *Id.* at 916.
330. *Id.* at 916-17.
331. *Id.* at 918.
332. *Id.*
333. *Id.*
334. *Id.*
335. *Id.*
336. *Id.* at 919.
337. *Id.*
338. *Id.* at 919-20.
339. *Id.*
340. *Id.* at 920.
341. *See id*.

Many clients are more comfortable seeking the assistance of an attorney, accountant, or financial advisor than seeking the assistance of a therapist.[342] Attorneys need to be cognizant that a client may need more than an attorney is capable of providing.[343] Most clients are serving as executors for the first time; therefore, it is unreasonable to expect them to understand these complex legal and financial environments.[344] Often the attorneys draw up the documents and appear in court, but they do not get involved in the day-to-day administration of the estate.[345] Attorneys may think a first-time fiduciary should know how to fulfill an executor's requirements, understand written instructions, or fill out and return forms; however, this is normally not the case.[346] For example, evaluating assets may seem like foreign terminology to a fiduciary.[347] This is where an attorney's legal staff may be able to assist without an extraordinary expense being charged to the estate.[348]

Grieving clients may need a check-up call from their attorneys to see how they are progressing, but this also gives the attorneys a good way to show support for their clients.[349]

F. Sharing Grief

When a husband loses a wife, chances are a parent has lost a daughter and a child has lost a mother.[350] When a wife loses a husband, chances are that a parent has lost a son and a child has lost a father.[351] Sharing of the fear, anger, and sadness with others reaffirms relationships with those similarly affected.[352] When sharing occurs there is no need to pretend with those involved, and this alone brings relief.[353] Sharing shows young children that it is okay to grieve and also allows for growth.[354]

G. The Role of Legal Advisor

Competent advice can keep a grieving person on a productive path and minimize the mistakes that frequently plague someone embroiled in stress.[355] Sensitivity to the process that your client is struggling through can allow the

342. *Id.*
343. *See id*. at 920-21.
344. *Id*. at 920.
345. *Id.*
346. *Id*. at 920-21.
347. *Id*. at 921.
348. *See id*. at 921, 923.
349. *See id*.
350. *Id*. at 921.
351. *See id*.
352. *Id.*
353. *Id.*
354. *Id.*
355. *Id*. at 912.

attorney to serve him efficiently and appropriately.[356] Grief can color the assessments and evaluations a person makes with estate administration.[357] The estate attorney should be familiar with "the symptoms of grief to urge the client to seek medical advice."[358] If the attorney is not aware of the help available, then the phone book listings under "Social Service Organizations" or a local pastor can give guidance.[359]

The grieving process is necessary for the person to become healthy again.[360] Attorneys must recognize the client's emotional needs as well as legal, financial, physical, and spiritual needs.[361] Attorneys should prepare for the moments when the client recycles through emotions, thoughts, and concerns.[362]

As probate attorneys, we face grief in clients routinely.[363] Each client will follow a unique grief timetable.[364] Friends, family, and advisors must allow the client to follow the most pressing need at all times rather than steering the client into a regimen.[365] The best guideline for attorneys is to listen, encourage, reassure, and accept rather than tell, order, remind, and argue.[366] No one advisor will meet all the client's needs, but one person can stay constant with knowledge and refer the client to competent assistance when necessary.[367]

Attorneys who are aware of the symptoms of grief will communicate with the client more effectively.[368] They will understand the client's questions and be alert to the issues with which the client is coping.[369] They will recognize the symptoms of grief, including the client's decreased ability to concentrate, confusion, anger, shock, and depression.[370] Attorneys aware of the symptoms of grief will be patient with the client.[371]

H. The Role of the Guardian

From the following, section 166.039 of the Texas Health and Safety Code lays out the procedure to use when a person has not executed or issued a directive and is incompetent or incapable of communication:

---

356. *Id.* at 913.
357. *Id.*
358. *Id.*
359. *See id*. at 913-14.
360. *See id*. at 919, 922.
361. *See id*. at 916.
362. *Id.* at 920.
363. *Id.* at 922.
364. *Id.* at 923.
365. *Id.*
366. *Id.*
367. *Id.*
368. *Id.* at 924.
369. *Id.*
370. *Id.*
371. *Id.*

> (a) If an adult qualified patient has not executed or issued a directive and is incompetent or otherwise mentally or physically incapable of communication, the attending physician and the patient's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient.
>
> (b) If the patient does not have a legal guardian or an agent under a medical power of attorney, the attending physician and one person, if available, from one of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment:
>
> (1) the patient's spouse;
> (2) the patient's reasonably available adult children;
> (3) the patient's parents; or
> (4) the patient's nearest living relative.
>
> (c) A treatment decision made under Subsection (a) or (b) must be based on knowledge of what the patient would desire, if known.
>
> (d) A treatment decision made under Subsection (b) must be documented in the patient's medical record and signed by the attending physician.
>
> (e) If the patient does not have a legal guardian and a person listed in Subsection (b) is not available, a treatment decision made under Subsection (b) must be concurred in by another physician who is not involved in the treatment of the patient or who is a representative of an ethics or medical committee of the health care facility in which the person is a patient.
>
> (f) The fact that an adult qualified patient has not executed or issued a directive does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining treatment.
>
> (g) A person listed in Subsection (b) who wishes to challenge a treatment decision made under this section must apply for temporary guardianship under Section 875, Texas Probate Code. The court may waive applicable fees in that proceeding.[372]

A qualified patient is defined as "a patient with a terminal or irreversible condition."[373] The attending physician must certify the patient's condition in writing.[374] The guardian's decision must be based on the knowledge of what the ward would desire if known.[375] The guardian has the duty to make every effort to determine those wishes.[376]

372. TEX. HEALTH & SAFETY CODE ANN. § 166.039 (Vernon 2001).
373. *Id.* § 166.031(2).
374. *Id.*
375. § 166.039(c).
376. *See id.*

In situations in which the ward previously executed a directive, the directive should serve to guide the guardian's treatment choices.[377] If no directive exists, then the guardian must investigate to try to determine the ward's wishes.[378] The investigation may include researching old medical records or hospital stays, speaking with family members, and interviewing neighbors, friends, or former work colleagues.[379]

If none of the above is available, then the guardian must develop evidence as to what course of treatment is best for the ward. This would encompass consultation with the treating physician, experts, and second opinions.

The National Guardianship Association (NGA) has the same requirements as Texas, which are as follows:

> NGA Standard 14 — Decision-Making About Medical Treatment
>
> I. The guardian shall promote, monitor, and maintain the ward's health and well-being.
> II. The guardian shall ensure that all medical care necessary for the ward is appropriately provided.
> III. The guardian shall determine whether the ward, before the appointment of a guardian, executed any advance directives, such as a living will, a durable power of attorney, or any other specific written or oral declaration of intent. On finding such documents, the guardian shall consider the ward's wishes in the decision-making process. The guardian shall inform the court and other interested parties of the existing documents.
> IV. Absent an emergency or the execution of a living will, durable power of attorney for health care, or other advance directive declaration of intent that clearly indicates the ward's wishes with respect to medical intervention, a guardian who has proper authority may not grant or deny authorization for medical intervention until he or she has given careful consideration to the criteria listed in Standard 6 — Informed Consent and Standard 7 — Standards for Decision-Making.
> V. In the event of an emergency, a guardian who has proper authority shall grant or deny authorization of emergency medical treatment based on a reasonable assessment of the criteria listed in Standards 6 and 7, within the time allotted by the emergency.
> VI. The guardian shall seek a second opinion for any medical treatment or intervention that would cause a reasonable person to do so or in circumstances where any medical intervention

377. *See id.* § 166.038(b) (Vernon Supp. 2008).

378. *See* § 166.039(c) (suggesting, but not mandating, that the guardian investigate the ward's wishes).

379. *See* NATIONAL GUARDIANSHIP ASSOCIATION, STANDARDS OF PRACTICE 9-11 (3d ed. 2007), *available at* http://www.guardianship.org/pdf/standards.pdf.

poses a significant risk to the ward. The guardian shall obtain a second opinion from an independent physician.

VII. Under extraordinary medical circumstances, in addition to assessing the criteria and using the resources outlined in Standards 6 and 7, the guardian shall enlist ethical, legal, and medical advice, with particular attention to the advice of ethics committees in hospitals and elsewhere.

VIII. The guardian may speak directly with the treating or attending physician before authorizing or denying any medical treatment.

IX. The guardian shall not authorize extraordinary procedures without prior authorization from the court unless the ward has executed a living will or durable power of attorney that clearly indicates the ward's desire with respect to that action. Extraordinary procedures may include, but are not limited to, the following medical interventions:

A. Psychosurgery
B. Experimental treatment
C. Sterilization
D. Abortion
E. Electroshock therapy

NGA Standard 15 — Decision-Making About Withholding and Withdrawal of Medical Treatment

I. The NGA recognizes that there are circumstances in which, with the approval of the court if necessary, it is legally and ethically justifiable to consent to the withholding or withdrawal of medical treatment, including artificially provided nutrition and hydration, on behalf of the ward. In making this determination there shall in all cases be a presumption in favor of the continued treatment of the ward.

II. If the ward had expressed or currently expresses a preference regarding the withholding or withdrawal of medical treatment, the guardian shall follow the wishes of the ward. If the ward's current wishes are in conflict with wishes previously expressed when competent, the guardian shall have this ethical dilemma reviewed by an ethics committee and if necessary, submit the issue to the court for direction.

III. When making this decision on behalf of the ward, the guardian shall gather and document information as outlined in Standard 6 — Informed Consent and shall follow the Standards for Decision Making, Standard 7.[380]

380. *See id*.

If the guardian has an extremely ill or terminally ill ward, then the guardian may want to compile a special notebook which should be readily available for caretakers of the ward. This notebook is called "Mindy's Book" and is discussed in Appendix H.[381]

I. Differing Opinions: Medical Personnel vs. Surrogate Decision Maker

What happens when the guardian and the ward's attending physician disagree? Texas anticipated this potential conflict when, in 1999, the Advance Directives Act was amended to include procedures that are to be followed by physicians when disagreements arise between the medical team and the surrogate decision makers.[382] The Advance Directives Act states the following:

> (a) [Ethics Committee] If an attending physician refuses to honor a patient's advance directive or treatment decision, the physician's refusal shall be reviewed by an ethics or medical committee. The attending physician may not be a member of the committee. [Interim Care] The patient shall be given life-sustaining treatment during the review.
> (b) [Notice] The patient or the person responsible for the health care decisions of the individual who has made the decision regarding the directive or treatment decision:
> (1) may be given a written description of the ethics or medical committee review process and any other policies and procedures related to this section adopted by the health care facility;
> (2) shall be informed of the committee review process not less than 48 hours before the meeting called to discuss the patient's directive, unless the time period is waived by mutual agreement;
> (3) at the time of being so informed, shall be provided:
> (A) a copy of the appropriate statement set forth in Section 166.052; and
> (B) a copy of the registry list of health care providers and referral groups that have volunteered their readiness to consider accepting transfer or to assist in locating a provider willing to accept transfer that is posted on the website maintained by the Texas Health Care Information Council under Section 166.053; and

381. *See infra* App. H.
382. TEX. HEALTH & SAFETY CODE ANN. § 166.046.

(4) is entitled to:
(A) attend the meeting; and
(B) receive a written explanation of the decision reached during the review process.

(c) The written explanation required by Subsection (b)(2)(B) must be included in the patient's medical record.

(d) [Transferring the Patient] If the attending physician, the patient, or the person responsible for the health care decisions of the individual does not agree with the decision reached during the review process under Subsection (b), the physician shall make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive. If the patient is a patient in a health care facility, the facility's personnel shall assist the physician in arranging the patient's transfer to:
(1) another physician;
(2) an alternative care setting within that facility; or
(3) another facility.

(e) If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer under Subsection (d). The patient is responsible for any costs incurred in transferring the patient to another facility. The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the written decision required under Subsection (b) is provided to the patient or the person responsible for the health care decisions of the patient unless ordered to do so under subsection (g).

(g) [The Court's Role] At the request of the patient or the person responsible for the health care decisions of the patient, the appropriate district or county court shall extend the time period provided under Subsection (e) only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted.[383]

383. §§ 166.046 (a)-(e), (g).

In *Hudson v. Texas Children's Hospital*, a mother sought an injunction under section 166.046(g) of the Texas Health and Safety Code ordering a hospital to continue life-sustaining treatment for her severely disabled infant while she attempted to find a facility willing to admit the infant.[384] In a pre-trial hearing, the court set a date to hear the section 166.046 question and dismissed other claims under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) and section 311.002 of the Texas Health and Safety Code.[385] During this hearing, the judge made a comment suggesting that he believed the child was in pain despite the fact no evidence to that effect had been submitted.[386] The plaintiff then submitted a motion to recuse the trial judge, but the judge denied the motion.[387] On appeal, the court held that the judge was required either to recuse himself or to refer the request to another judge.[388]

J. Other Considerations

Definition of Life-Sustaining Treatment:

> (10) "Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.[389]

For minor patients younger than 18 years old, a directive may be executed on their behalf by the following persons: (1) the minor patient's spouse, so long as the spouse is an adult; (2) the minor patient's parents; or (3) the minor patient's legal guardian.[390] For pregnant patients, no person is permitted to withdraw or withhold any life-sustaining treatment.[391]

Additionally, a directive may be revoked by a declarant at any time no matter what the declarant's mental state or competency is determined to be at the time the revocation is made.[392] A directive may be revoked orally, in

---

384. Hudson v. Tex. Children's Hosp., 177 S.W.3d 232, 233 (Tex. App.—Houston [1st Dist.] 2005, no pet.).

385. *See id*. at 234.

386. *Id.*

387. *Id.* at 235.

388. *Id.* at 238.

389. TEX. HEALTH & SAFETY CODE ANN. § 166.002(10) (Vernon 2001 & Supp. 2008).

390. *Id.* § 166.035 (Vernon 2001).

391. *Id.* § 166.049.

392. *Id.* § 166.042(a).

writing, or by a physical act—defacing, tearing, or otherwise destroying the directive.[393] However, only competent adults may execute a written directive.[394]

393. *Id.* § 166.042.
394. *Id.* § 166.032.

APPENDIX A
SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE[395]

1. What is the date today (month/day/year)? All three correct to score.
2. What day of the week is it?
3. What is the name of this place? Any correct description.
4. What is your telephone number? If no telephone, what is your street address?
5. How old are you?
6. When were you born (month/day/year)? All three correct to score.
7. Who is the President of the United States now?
8. Who was the President just before him?
9. What was your mother's maiden name?
10. Subtract three from twenty, and continue subtracting three from each result until it can no longer be subtracted from without the result being negative. The client must complete the entire series to score.

Error score (out of 10):

Add one if educated beyond high school; subtract one if not educated beyond grade school:

0 - 2 errors:	normal mental functioning
3 - 4 errors:	mild intellectual impairment
5 - 7 errors:	moderate intellectual impairment
8-10 errors:	severe intellectual impairment

APPENDIX B
DETERMINING MENTAL STATUS[396]

1. Person
   - (A) What is your full name?
   - (B) How old are you?
   - (C) What is your birthdate?
   - (D) What is your maiden name?
   - (E) What is your home telephone number?
2. Family
   - (A) How many children do you have?
   - (B) How many grandchildren do you have?
   - (C) What are the names of your children?
   - (D) What are the names of your grandchildren?
   - (E) Which of your grandchildren are married?

---

395. E. Pfeiffer, A Short Portable Mental Status Questionnaire for the Assessment of Organic Brain Deficit in Elderly Patients, 25 J. OF AM. GERIATRICS SOC'Y 433, 433-41 (1975).

396. *See* Jane L. Pearson, et al., The Mini-Mental State Exam and the Mental Status Questionnaire: Depression in Azheimer's Patients, 8(4) Clinical Gerontologist 31, 34 (1989).

(F) Are you now married? What is your spouse's name?

3. Assets
   (A) Do you own a home? How much do you think you might get for your home if you sold it?
   (B) How much are your assets worth in total?
   (C) Do you have any debts?
4. Time
   (A) What is today's date?
   (B) What day of the week is it?
   (C) What time is it?
   (D) What season is it?
   (E) How long have you been in this hospital/nursing home?
   (F) How long have we been talking?
5. Place
   (A) Where are we right now? What is the name of this place? What kind of place are we in now?
   (B) What is your home address?
   (C) What city or town are you in now?
   (D) Where do your children live?
6. Events
   (A) Who is the President?
   (B) Who was the previous President?
   (C) Who is the Governor?
   (D) What is the medical reason that you are in the hospital/nursing home?
   (E) What year did you pay off your mortgage?
   (F) What was the date of your marriage?
7. Miscellaneous
   (A) What is 30 minus 3? Can you continue to subtract 3 from your answer?
   (B) Can you hear this question and repeat it a few moments later?
   (C) Can you name what I am writing with?
   (D) Can you spell your first name backwards?

APPENDIX C
SELECTED ELEMENTS OF GRIEF[397]

1. Separation Anxiety/Fear
2. Anger
3. Depression
4. Anxiety
5. Personal Issues
6. Shock/Emptiness
7. Sadness/Loneliness
8. Guilt
9. Avoidance
10. Denial
11. Loss of Identity
12. Acceptance vs. Resignation

APPENDIX D
QUESTIONNAIRE FOR ATTORNEYS: RECOGNIZING GRIEF[398]

1. What situation has brought them to your office?
2. What other important situations are affecting their life?
3. Do they have a hidden agenda?
4. Are they clear about their wishes in this matter?
5. Are they insistent about controlling every phase of their work or do they refuse to make decisions or take responsibility?
6. Do they often forget important details, or are they unable to concentrate?
7. Do they seem to consistently mis-remember your advice or argue that a decision was made in a different way than the file indicates?
8. Are they "at war" with family members, etc., often over insignificant details?
9. Is their emotional response often disproportionate to the situation?
10. Are they "up" one time and "down" the next?
11. Do they make disadvantageous decisions to simply avoid conflict?
12. Are they unreasonably overprotective of their own interests or do they seem to feel that all other parties are aligned against them?
13. Are they unreasonably overprotective of other people and even work against their own best interests?
14. Do they have an unusually high number of physical complaints?
15. Do they have difficulty expressing their wishes, opinions, or intentions?

---

397. Nan L. Baker, *Increasing Your Effectiveness Through Griefwork*, WILLS AND PROBATE INSTITUTE 907, 916-17 (State Bar of Tex., Prof'l Dev. 1997).

398. *Id.* at 930 app. E.

16. Do they have an unusually short attention span?
17. Are they flippant or facetious about serious matters?
18. Do they have no "sense of humor"?
19. Do they insist on a disproportionate amount of your attention beyond what is necessary for you to complete their legal work?
20. Do they avoid serious discussions?
21. Do they smile or giggle inappropriately?
22. Do they seem lethargic, bored, hyperactive, jittery, nervous, or upset?
23. Are they "depressed"?
24. Are they vindictive or inappropriately angry?
25. Do they cry easily?
26. Do they often speak in terms of guilt, fear, sadness, loneliness, hopelessness, or helplessness?
27. Are they overly talkative or too reticent?
28. Are their goals, decisions, or actions unrealistic as if they were living in a fantasy world?
29. Are they unreasonably impatient?
30. Can they not see the forest for the trees, or vice versa?
31. Are they depending on alcohol, drugs, or escapist behaviors?

APPENDIX E
"THE SELF-DESTRUCTIVE CHOICES OF AVOIDANCE & DENIAL OF GRIEF AVOIDANCE:"[399]

AVOIDANCE:

> [T]he self-destructive attempt to delay emotional or other pain by attempting to ignore situations, feelings, or challenges; to put off active engagement of our emotional work.

DENIAL:

> [T]he self-destructive attempt to escape emotional or other pain by refusing to admit the existence of situations, feelings, or challenges; to choose to edit reality rather than to actively engage in emotional work.

SELECTED MOTIVATIONS FOR AVOIDANCE AND DENIAL:

1. the simple desire to escape or minimize pain
2. lack of confidence in ability to cope
3. revenge
4. self-degradation
5. martyrdom
6. desperation
7. depression

399. *Id.* at 929 app. D.

8. confirmation of closely held beliefs about ourselves, others, or the nature of life
9. pursuit of conflicting agenda
10. concern for our own well-being
11. self-protection
12. concern for others
13. attempt to adhere to moral, ethical, or religious beliefs

APPENDIX F
"FACETS OF GRIEF TO WHICH WE TEND TO ASSIGN AFFECTIVE VALUE"[400]

Facets of grief we may experience as "negative," "bad," or "uncomfortable":

Confusion	Depression
Unreasonableness	Self-defeating behaviors
Paralysis	Rage
Loneliness	Guilt
Fear/panic	Isolation/withdrawal
Strife/conflict/estrangement	Self-hate
Hopelessness	Helplessness
Anxiety	Dependency
Separation anxiety	Shock/numbness/emptiness
Meaninglessness	Resignation

Facets of grief we may experience as "positive," "good," or "fulfilling":

Motivation	Balance of perspective
Seriousness/commitment	Self-discovery
Confidence	Growth
Independence	Liberation
Trust/faith	Pioneering spirit
Character-building	Love
Inner peace	Self-reliance
Experience/knowledge	Discovery of meaning
Acceptance	

400. *Id.* at 927 app. B.

APPENDIX G

§ 409.31 Level of care requirement.

(a) Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that:
  (1) Are ordered by a physician;
  (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
  (3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements.
  (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
  (2) Those services must be furnished for a condition—
    (i) For which the beneficiary received inpatient hospital or inpatient CAH services; or
    (ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or
    (iii) For which, for an M+C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.
  (3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.[401]

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non skilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or habilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the

401. 42 C.F.R. § 409.31 (2007).

complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.[402]

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) Services that could qualify as either skilled nursing or skilled rehabilitation services—

(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create[s] a high potential for serious complications, such an understanding is essential to

402. 42 C.F.R. § 409.32 (2007).

ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition—

(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

(ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.

(3) Patient education services—

(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions.

(b) Services that qualify as skilled nursing services.

(1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(c) Services which would qualify as skilled rehabilitation services.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;
(7) General maintenance care in connection with a plaster cast;
(8) Routine care in connection with braces and similar devices;
(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;
(10) Routine administration of medical gases after a regimen of therapy has been established;
(11) Assistance in dressing, eating, and going to the toilet;
(12) Periodic turning and positioning in bed; and
(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.[403]

§ 409.34 Criteria for "daily basis".

(a) To meet the daily basis requirement specified in § 409.31(b)(1), the following frequency is required:
  (1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or
  (2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.
(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.[404]

APPENDIX H
MINDY'S BOOK

I had a family member that compiled a special notebook that was of immense benefit for the care of the terminally ill. I call it "Mindy's Book" after

403. 42 C.F.R. § 409.33 (2007).
404. *Id.* § 409.34.

its maker. Mindy's Book was a two inch, loose leaf notebook purchased at the store. It had dividers with pockets.

Mindy's Book consisted of:

1. Loose-leaf paper for notes.
2. List of family and close friends with phone numbers—these were the friends who had offered to run errands, sit with the patient, et cetera.
3. List of all doctors and contact information including staff names.
4. Medical history with specific date, if possible—this was constantly updated.
5. Information about preferred hospital.
6. List of any drug allergies.
7. List of current and previous medications with dosage, time of administration, type of medication, and how to administer them.
8. Legal information, such as power of attorney, advance directives, and HIPAA authorization.
9. Hospital discharge paperwork.
10. Paperwork from doctor's visits.
11. Any paperwork from home health care and medical equipment rental.
12. Insurance information, such as group/member number, phone and address, list of benefits, and list of in-network providers.
13. Hospice information.
14. Calendar to keep track of doctor appointments and when to start, stop, or change medications.
15. Pre-need burial policy.
16. Funeral service plans, such as who and what the patient wants for the service.
17. Professionals to call upon death (hospice worker, minister, et cetera).
18. Friends' and relatives' phone numbers to be called upon death.
19. Lab reports stating the normal conditions to compare to new lab reports and what symptoms to look for, including temperature, pulse, blood pressure, skin color/texture, etc., so families know when to call the doctor.

Mindy's Book was invaluable when the loved one had to go to the doctor or hospital because it had everything that would be needed to answer questions. If someone other than the primary caretaker was there, then the book would answer any questions he might have. All the information was in one place, so it was easy to grab at a minute's notice and easy to transport.

APPENDIX I
PUBLICATIONS OF INTEREST

One of the best publications that I have found to help families is *Gone from My Sight: The Dying Experience*, by Barbara Karnes.[405] This 14-page booklet is excellent to prepare the family for what to expect. It stresses that death is unique to each person, but it provides some guidelines for what to expect one to three months prior to death, one to two weeks prior to death, one to two days prior to death, just hours prior to death, and minutes prior to death.[406]

Karnes also has two other booklets, and both are available in English and Spanish.[407] The cost is $2.00 each plus shipping, but for a bulk order there is a discount.[408] You can order the booklets at www.bkbooks.com or by mailing Barbara Karnes Books, Inc., at P.O. Box 822139, Vancouver, WA 98682.[409]

For the families who are grieving, *Seven Choices: Finding Daylight After Loss Shatters Your World*, by Elizabeth Harper Neeld, Ph.D., is recommended.[410] It encompasses the author's emotions and trials upon the sudden loss of her husband, and it is a compilation of several persons' experiences.[411] The book is available at major book stores or Amazon.com.[412]

---

405. Barbara Karnes, Gone from My Sight: The Dying Experience (Barbara Karnes Books, Inc. 2005).

406. *Id.*

407. *See* BARBARA KARNES, MY FRIEND, I CARE—THE GIFT EXPERIENCE (Barbara Karnes Books, Inc. 1991) *and* BARBARA KARNES, A TIME TO LIVE—LIVING WITH A LIFE-THREATENING ILLNESS (Barbara Karnes Books, Inc. 1996), *available at* http://www.bkbooks.com/BookletOrderForm.pdf.

408. http://www.bkbooks.com/BookletOrderForm.pdf.

409. *See id*.

410. Elizabeth Harper Neeld, Ph.D., Seven Choices: Finding Daylight After Loss Shatters Your World (reprint ed. 2003).

411. *Id.*

412. http://www.amazon.com/Seven-Choices-Finding-Daylight-Shatters/dp/0446690503/ref=pd_bbs_sr_1?ie=UTF8&s=books&quid=1219525207&sr=8-1.