HEALTH CARE CONCERNS IN HOLISTIC ESTATE PLANNING

Introduction: For many clients and their families, the most taxing aspect of their declining years is not the Internal Revenue Service – it’s the torn fabric of family relationships when bitter conflicts arise over "what dad (or mom) would have wanted."

Why should estate planners and financial planners care about advance directives? They may sound esoteric or distantly removed from "mainstream" tax issues, but they can play a crucial role in the contexts of estate planning and financial planning. Here are some noteworthy effects of advance directives:

1) They set limits and provide direction about the type of treatment a client wants, and hence the type of treatment that the client's trustee or fiscal agent should expect to pay for. Hundreds of thousands of dollars in hospital and nursing home bills can easily be incurred for medical procedures that the client never wanted; and the emotional damage often costs more than money can measure – or fix.

2) They name the client's health care "spokesman" who will interface for financial agents, attorneys-in-fact, trust officers, and planners whose advice or services are also involved during periods of incapacity;

3) They provide a means of informing a trustee's discretion regarding "health, support and maintenance;"

4) To the extent that they include instructions about home health care, intermediate or long-term residential arrangements, they can effect a change in domicile or residence;

5) To the extent that they authorize experimental therapies, out-of-state treatment, or temporary re-location for purposes of convalescence or "being close to the children," they can trigger a sudden need for mobilizing significant resources;

6) They can literally affect the time (and location) of death.
"The estate planning context is often most appropriate for generating discussion about the delegation of health care decision-making powers." [Grice KL, "Advance Health Care Planning: Filling the Void" 4(4) Prob and Property 40 (July-August, 1996).]

I. Legal Foundations for Advance Care Planning

A. Common law recognizes the essential role of "informed consent" for any medical treatment, including life-saving procedures.

1. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Socy. of New York Hospital, 105 N.E. 92 (1914).

2. "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Union Pacific Railway Co. v. Botsford, 141 U.S. 250 (U.S. Supreme Court, __________).


   a. CAVEAT: Thus far, damages for battery in these cases have been limited to direct, actual harm from the "battery" (e.g., resuscitation) itself, and not from resulting or foreseeable consequences (e.g., costs of nursing home or later surgeries).

   b. CAVEAT: Thus far, other theories of
liability (e.g., "wrongful living" or "interference with the right to die") have not been judicially accepted.

B. U.S. Constitutional "Liberty Interest":

1. Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 110 S.Ct. 2841 (U.S. Supreme Court, 1990). Patients have a constitutionally protected liberty interest in the choice of accepting or refusing any form of medical treatment, including artificial nourishment.

2. "Informed Refusal": "The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is to refuse treatment." Cruzan v. Director, Missouri Department of Health, supra.

3. A state may require "clear and convincing evidence" of the patient's own wishes regarding consent or refusal of life-sustaining treatment. Cruzan.

C. Federal Statute: "The Patient Self-Determination Act" 42 USC 1396a(w)

1. Requires all health care provider organizations receiving federal medicare or medicaid funds to take the following steps:

a. Inform incoming patients about their rights to give informed consent or informed refusal: (Facilities must "provide written information" to patients at the time of admission concerning "an individual's right under state law (whether statutory or as recognized by the courts of the State) to make decisions concerning...medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives");

b. Maintain written policies and procedures
regarding advance directives;

C. Document in the patient's advance directive in the medical record;

D. Ensure compliance with the requirements of state law," and

E. "Provide (individually or with others) for education for staff and the community on issues concerning advance directives."

2. Preserves "conscientious objection" rights, as recognized under state law, for institutional or individual health care providers who refuse to honor advance directives. However, a facility must provide advance notice to patients about its conscientious objection policy.

3. The Act was passed in 1990. Compliance became required on December 1, 1991.

II. Colorado Law and Advance Directives


Essential elements of Colorado living wills.

1. Limited to "qualified" patients, i.e., in a "terminal" condition certified by two doctors.

2. Applies only to decisions concerning withdrawal/withholding of artificial life support.

3. Allows option to continue/terminate artificial nourishment and hydration ("tube feeding") in living wills executed after March, 1989.

4. Execution requirements: Two witnesses, neither of whom may be a health care provider or employee thereof; anyone who will acquire a share or claim
in the declarant's estate; or a fellow patient in the same facility where the declarant is receiving treatment.

5. A waiting period of seven days is included in the "optional" statutory living will form, but is not required by statutory text.

6. Revocation of living wills can be accomplished at any time by oral or physical act.

B. Medical Durable Powers of Attorney (Source: C.R.S. 15-14-503, et seq.): Broad-spectrum delegation of authority for decisions concerning medical treatment and personal care.

1. The scope of the agent's authority, unless otherwise limited in the document, extends to all medical treatment and personal care decisions, not limited to terminal conditions and artificial life support.

2. Health care providers may rely on the agent's instructions/decisions as a source of the patient's substitute "informed consent" or "informed refusal" of treatment.

3. Unless expressly stated, medical durable powers are unlimited in scope and duration.

4. The statute permits revocation of a medical durable power of attorney by unlimited (and unspecified) methods. Dissolution of marriage, annulment, or legal separation automatically revokes the (former) spouse's appointment as agent.

5. There are no explicit provisions for judicial review of an agent's acts: the probable route for challenging an agent's decision would be through a guardianship proceeding.

6. Agents use a "substituted judgment" standard if
the patient's wishes and values are known or can be ascertained. In medical decision-making, substitute decision-making has replaced the "best interests" standard.

7. Medical durable powers of attorney come in many different formats, and in the author's judgment there is no "one-size-fits-all" version.

   a. Fill-in-the-blank form sand checklists are available through the mail and public marketplace.

   b. The "Five Wishes" form is a popular "generic" version, and practitioners should be aware of its features. The form can be purchased on-line for a nominal fee, and is distributed at no charge by some hospitals as "service" for patients at the time of admission.

   In brief, the form includes: blank lines for the name(s) of an agent and alternate agents; a list of optional comfort measures that can be checked off if desired ("I want someone to wipe my forehead with a warm cloth / I want someone to hold my hand and say prayers with me."), and four end-of-life scenarios in which the reader is given three choices: to use artificial life support, to decline to use it, or to use it "if my doctor thinks it will help me, and if my doctor doesn't think it will help me, I want it to be stopped." The final option invites the reader to describe "other conditions in which I do not wish to be kept alive" and provides several blank lines.

   It is not uncommon to encounter prospective clients who assert "We have
the Five Wishes, so that takes care of everything we need." To the contrary, there are many important issues that Five Wishes does **not** cover.

C. **CPR (Cardiopulmonary Resuscitation) Directive** (Source: C.R.S. 15-18.6-101, et seq.): Essentially, a CPR Directive is an outpatient "Do Not Resuscitate" instruction. It is a "Stop sign" for paramedics and "911" personnel, instructing them to avoid attempting resuscitation. (Other types of medical treatment or procedures are permitted, such as pain relief.)

1. Any adult (over 18) may execute a CPR directive signifying that CPR should **not** be attempted in the event of respiratory failure. **There is no requirement of a terminal condition.** However, the form must be counter-signed by a physician.

2. CPR directive forms have been issued by the Colorado Board of Health to all licensed health providers and health facilities. Other forms of CPR directives are legal.

3. Persons who refrain from administering CPR on the basis of a CPR directive are immune from civil and criminal liability. There are no explicit sanctions for failing to honor a CPR directive, but presumably ordinary tort law, e.g., battery and intentional infliction of emotional distress, would apply.

4. In the absence of a CPR directive, informed consent to CPR is presumed.

5. CPR directives may be revoked by the declarant or, if the directive was signed originally by the patient's guardian, agent, or proxy, that person may revoke it.

6. CPR directives are applicable to minor patients whose parents consent and whose physician has previously entered a "Do Not Resuscitate" order.
D. **Medical Proxies:** (C.R.S. 15-18.5-101, et seq.): Substitute decision-making when there is no advance directive or guardian with medical decision-making authority.

1. The common law "next of kin" presumption has been replaced by consensus appointment of a surrogate, selected by "interested persons."

2. If a physician determines that the patient lacks decisional capacity, the patient's spouse, adult child(ren), parent(s), sibling(s), grandchild(ren) and, if appropriate, good friend arrive at a consensus among themselves concerning selection of a proxy to provide informed consent or refusal. The proxy should be someone who has a close relationship to the patient and who knows the patient's medical treatment wishes.

3. There is no hierarchy or preference given to any particular "interested person." The **patient's spouse is NOT the "automatic" proxy.**

4. In the event of disagreement concerning a proxy, any of the "interested persons" may initiate guardianship proceedings.

5. Proxies may consent to withdrawal of tube-feeding only if two doctors agree that artificial nourishment will only prolong the dying process and is unlikely to restore independent neurological functions.

III. Ethical Principles: Physician Integrity, Patient Autonomy, Non-maleficence and Justice.

A. "We expect the first line of defense against abuses in withdrawal of treatment to be the ethical guidelines of the medical profession." In re Lawrance 579 N.E.2d 32, 42 (Ind. 1991).

1. Physician integrity:
a. "The moral basis of the physician-patient relationship is the obligation of the physician to attempt to do the patient some good. Actions that do not contribute to this end are not morally required." Source: Tomlinson L. and Brody H. "Futility and the Ethics of Resuscitation", JAMA 1990; 264:1276.

b. "Physicians are not ethically obligated to deliver care that, in their best judgment, will not have a reasonable chance of benefitting their patients. Patients should not be given treatment simply because they demand (it). Denial of treatment should be justified by reliance on openly stated ethical principals and acceptable standards of care...not on the concept of 'futility', which cannot be meaningfully defined." Source: Amer. Med. Assoc., 1994 Code of Medical Ethics, Opinion 2.035.

2. Patient autonomy:

a. "Under the ethical principle of respect for autonomy, competent patients have the right to refuse artificial life-prolonging treatment and to permit a natural and peaceful death to occur. Such action is in accord with the highest ethical standards of medical practice." Source: Report of the Ethics and Humanities Committee of the American Academy of Neurology, Neurology, 1993; 43:222-223.

b. "The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity...A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make
such a decision. A patient may also appoint a surrogate decision-maker in accordance with state law." American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, Sec.2.20, (2006-2007 ed.)

c. "The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment." American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, Sec. 10.01(2), (2006-2007 ed.)

3. Non-maleficence ("Primum non nocere"; "First, do no harm"):  


b. Physicians have "an ethical responsibility to provide only those treatments to their patients which they believe to be beneficial, or at least not harmful or burdensome. To directly harm a patient violates both the Hippocratic oath and the Christian notion of beneficence." Source: Clark P. and Mikus C., "Time for A Formalized Medical Futility Policy," Health Progress, July-August 2000, 24-32.

4. Justice  

a. In Aristotelian terms, justice meant fair or proportionate treatment: "The formal principle of justice or equality attributed to Aristotle is...that equals should be treated equally and unequals unequally, in

b. In contemporary terms, justice applies to the distribution of medical resources. "As a matter of justice, patients/surrogates cannot be given the absolute right to demand any medical treatment they choose. To do so would create a system that...would irrationally allocate health care to socially powerful people with strong preferences for immediate treatment to the disadvantage of those with less power and less immediate needs. If patients/surrogates were given non-beneficial treatments, those treatments would be given at the expense of the poor, the powerless, and the marginalized—would be given, that is, unjustly. In this debate, failure to consider the allocation of scarce resources would itself be a grave injustice."


B. The American Medical Association's Code of Medical Ethics strongly supports a patient's right to make independent, informed decisions to accept or to decline medical treatment, and to use advance directives.

1. "The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment." AMA Code of Medical Ethics, Sec. 10.01(2) (2008-2009 ed.)

2. "A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decision-maker in accordance with state law." AMA Code of
Medical Ethics, Sec. 2.20 (2008-2009 ed.)

3. "More rigorous efforts in advance care planning are required in order to tailor end-of-life care to the preferences of patients so that they can experience a satisfactory last chapter in their lives. There is need for better availability and tracking of advance directives....Patients and physicians should make use of advisory as well as statutory documents..." AMA Code of Medical Ethics, Sec.2.225 (2008-2009 ed.)

IV. Drafting Issues in Advance Directives

A. Generic versions of advance directives, such as "Five Wishes" or other standardized templates, are available at little or no cost.


2. Disadvantages: limited to "end stage" scenarios and black-or-white choices, overlook many practical considerations, do not capture "quality of life" factors, and do not encourage careful consideration.

B. Excerpts from Standardized Advance Directives

1. "If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life support treatment would only postpone the moment of my death, (choose one of the following):

   ____ I want to have life support treatment.
I do not want life support treatment. If it has been started, I want it stopped.

I want to have life support treatment if my doctor believes it could be helpful, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms."

Source: Five Wishes, revised edition

2. "Imagine that... You are now seriously ill, and doctors are recommending chemotherapy, and this chemotherapy usually has very severe side effects, such as pain, nausea, vomiting, and weakness that could last for 2-3 months. Would you be willing to endure the side effects if the chance of regaining your current health was less than 2 percent?

A. Yes
B. No
C. I am uncertain

Imagine that...You have moderate dementia causing mental confusion. About half the time, you recognize and interact with friends and loved ones on a simple level. You also have circulatory problems, which resulted in one leg being amputated because it developed gangrene. Now the other leg develops gangrene and the doctor recommends amputation because the condition could be fatal. Would you want the operation?

A. Yes.
B. No.
C. I am uncertain.

"Is it more important for you to (A) have your specific treatment preferences followed at the end of life even if family members or friends disagree, or (B) have family and friends all in agreement and comfortable with whatever decision is made?"
A. Have specific preferences followed, even if there is disagreement.
B. Have family and friends all in agreement.
C. I am uncertain

Source: American Bar Association
Lawyer's Tool Kit for Health Care Advance Planning

C. Excerpts from Individualized Advance Directives

1. "I am not a quitter. If given a choice, I believe that a person should make the best out of staying alive as long as there's any chance of recovery....As long as I still know what's going on around me, and I can see my family and watch my grandchildren grow up, then life is worth living... Even if I become paralyzed, bedridden, or dependent on other people for feeding, cleaning and bathing, I would still want to live as long as I could still enjoy life.... As long as there's a chance I can experience quality of life, even if it's something as simple as enjoying an ice-cream cone, I would want to continue living."

2. "After reaching the age of 80, if I have serious problems with my central organ systems I wouldn't want to risk major surgery or take on a lengthy and burdensome course of aggressive treatment such as chemotherapy or long-term dialysis. I believe that at that age, the risks are too great of causing a downward spiral of side effects and compound difficulties...I've seen too many instances where medical technology keeps people alive, but can't keep them healthy, productive or satisfied."

3. "I regard myself as a fit, vigorous and independent man who takes care of my family and enjoys life....I would not have a meaningful quality of life if I become an empty shell with a vacant mind, and I can no longer take care of myself and contribute to, or interact with, my family. It would be unbearable if I
become permanently and totally paralyzed, bedridden, or
totally dependent upon others for my personal hygiene,
feeding, cleaning and bathing, for an extended time."

V. The Attorney's Role in Implementing and Interpreting Advance
Directives After the Documents are Signed.

A. Various Factors including Limits to the Engagement,
Identifying the "client," Maintaining Confidentiality, Off-site
"excursions," and Defining the Fees.

B. Various Models: "Continuing service to the client" vs.
"Mission Accomplished" when the papers are signed.

As a matter of personal opinion, I favor the "continuing
service" model at the request or the agent, because that is when
our client is the most vulnerable and dependent on the document
we drafted. "An enforcer must now be found and, at least for the
present, that role must be accepted by the estate planning
attorney." [Bush J "Who Will Ensure That a Patient's Living Will
is Enforced?" 24(5) Estate Planning 195, 199 (June, 1997).]

The attorney-client relationship can be inclusively defined,
so that the attorney can serve as "on call" advisor for the
agent, upon the agent's request. "Coaching" or supportive
consultations with the agent, appearing at doctor's office
visits, or participating alongside the agent in care planning
conferences can be part of the attorney's role, if those services
are discussed ahead of time and authorized in the document. The
agent should be given explicit permission in the document to seek
legal advice and assistance, if needed. If the directive is
carefully drafted, the cost of such legal services can be
assigned to the principal or his estate in the same fashion as
the cost of medical services. Language containing a limited
waiver or modification of the confidentiality privilege should
also be included in the advance directive, so that the drafting
attorney can selectively share pertinent information with the
client's agent and health care team.

C. Various Tasks. To put it bluntly, it's not all about the paperwork.
"Effective health care advance planning requires two things: meaningful conversation and more meaningful conversation. Having a written and executed health care advance directive is not the goal of legal planning for health care. Instead, the goal is to define and communicate the client's values and wishes about treatment to caregivers and surrogate decision-makers...Lawyers must remember that the document is just one part of the process of end-of-life planning. The lawyer's most important role is to stimulate conversation and give guidance to the process." Morgan RC and Sabatino CP, "Advance Planning and Drafting for Health Care Decisions" 15 Probate and Property 35 (July-Aug. 2001).