# HCPOA & Living Wills in Action

## Issues during COVID and beyond…

## CMBA Estate Planning, Probate & Trust Law Section CLE

**Panel discussion moderated by Paul R. Shugar, Esq., Reminger Co., LPA**

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# Meet the Panel

**90%** of people say that talking with their loved ones about end-of-life care is important.

**27%** have actually done so.

*Source: The Conversation Project National Survey (2013)*

**60%** of people say that making sure their family is not burdened by tough decisions is extremely important.

**56%** have not communicated their end-of life wishes.

**80%** of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

**7%** report having had this conversation with their doctor.

**82%** of people say it's important to put their wishes in writing.

**23%** have actually done it.

*Source: The Conversation Project National Survey (2013)*

# Competence and capacity

- Competence is a **legal** judgment made by judge.
- Capacity is the **functional** ability to make a decision in a given situation
  - Fluid
  - A patient can have capacity to make one decision and not another
  - A patient can have capacity at one time and not another
  - Decisional relativity
- I don’t see any great harm is using the terms capacity and competence relatively interchangeably

# Competence and capacity

## Capacity requires that the patient has*:

1. The ability to understand information about one's condition generally
2. The ability to appreciate how that information applies to one's own situation specifically
3. The ability to reason with that information, weighing the benefits and burdens of treatment options in order to make a choice
4. The ability to express that choice clearly once made

- Freedom from coercion is often added
  - A patient can voluntarily waive their autonomy

*Grisso and Applebaum 1998

# Competence and capacity

- Delirium and Dementia
  - Delirium is a waxing and waning syndrome that has an acute onset and is marked by inattention
  - Dementia is the acquired, chronic loss of a cognitive function
- Inability to communicate
  - Intubation
  - CVA
- Intoxication
- Stable medical condition

# Competence and capacity

- MoCA, SLUMS, MMSE have very little to do with capacity
- Toronto ACE (Assessing Capacity in the Elderly) is well authenticated
- Needs assessment of attention, level of consciousness and cooperation
- Recent anesthesia or psychoactive medications
- (Anticholinergic) medications
- Linguistic barriers
  - Medicare rule: conversation at 8$^{th}$ grade or less

# Competence and capacity (Bayes theorem)

**Table 1.** Prevalence of Incapacity in Select Populations

| Disease or Patient Care Setting | No. of Studies | No. of Patients | Patients With Incapacity | | |
|---|---|---|---|---|---|
| | | | No. | % (95% CI) | Standard Deviation |
| Healthy elderly controls | 16 | 1817 | 51 | 2.8 (1.7-3.9) | 0.005 |
| Mild cognitive impairment | 1 | 147 | 29 | 20 (14-26) | 0.03 |
| Glioma patients | 1 | 26 | 6 | 23 (6.9-39) | 0.08 |
| Medicine inpatients | 8 | 816 | 212 | 26 (18-35) | 0.11 |
| Parkinson disease | 4 | 148 | 62 | 42 (23-60) | 0.13 |
| Nursing home | 5 | 346 | 152 | 44 (28-60) | 0.08 |
| Alzheimer disease | 10 | 1425 | 770 | 54 (28-79) | 0.13 |
| Learning disabled | 4 | 208 | 141 | 68 (41-97) | 0.14 |

Abbreviation: CI, confidence interval.

Sessums et al, 2011

# Competence and capacity

- Frequency of incapacity in geriatric inpatient has a confidence interval from one out of five to one out of three patients
- Patients with mild cognitive impairment have incapacity between one out of seven and one out of four patients
- Patients with Alzheimer's disease have incapacity between one out of three and four out of five patients
- Physician assessment is highly specific and poorly sensitive
  - Sensitivity was 41% (CI 30%-53%)

# ACE tool

1. Able to understand medical problem?
2. Able to understand proposed treatment?
3. Able to understand alternative treatments?
4. Understands ability to refuse?
5. Able to understand likely consequences of treatment?
6. Able to understand likely consequences of refusing treatment?
7. Decision unaffected by depression, delusion, or psychosis?

# MED-SAIL tool

Pick two of the scenarios-

- The door to your home is locked and you do not have the key
- You run out of a medication that you take regularly
- You are at home and suddenly there is a fire in the kitchen
- You notice that a cut on your foot is not getting better and looks infected
- Someone calls you and tells you that you have one $100,000 and all you have to do is give them your social security number to verify your identity
- You are driving to the grocery store and get a flat tire
- Your heater/air conditioner breaks down when it is very cold/hot outside

# MED-SAIL tool (continued)

1. Please tell me what I said in your own words
2. What would you do in this situation?
3. What would you do if that didn’t work?
4. What is good and bad about these two options?
5. How could you prevent this situation from happening?

Please score each answer as either:

0: Neither logical nor complete
1: Logical but not complete
2: Logical and compete

# My questions:

- Why are you in the hospital?
- What intervention is being offered?
- Why it is being offered?
- What are the risks and benefits of agreeing?
- What are the risks and benefits of refusing?
- Is the patient in their right mind?

# Competence and capacity

Formal interview

- Patient in stable medical condition
- Quiet
- Document level of consciousness, cooperation, attentiveness
- Document discussion of proposed interventions with patient understanding of interventions, alternatives, and consequences using quotes from patient where possible
- Scores on formal assessment tools (i.e. ACE tool or MED-SAIL)
- Conclusion

# Special cases

## Uncooperative patient

- Patient cooperation and appropriate effort should be routinely documented as part of the note
- Refusal to cooperate is a sign of poor judgement
- Patient can be asked if they would prefer a different interviewer
- For me, the refusal to take part in a medical examination shows a patient’s lack of capacity to make judgements in their best interests

# Special cases

Patient without capacity and without representation

- Named patients without proxies at UH* also known as unbefriended patients and unrepresented patients
- If no legal surrogate decision maker can be found, the ethics committee has  a volunteer group that are not medical professionals and not hospital employees.  Several members of this group meet with the patient and the medical care group.  Friends and associates of the patient are contacted as well.
- “PWP committee members synthesize this information, discuss and make a recommendation that is in the patients best interest and consistent with his or her values (if known).”

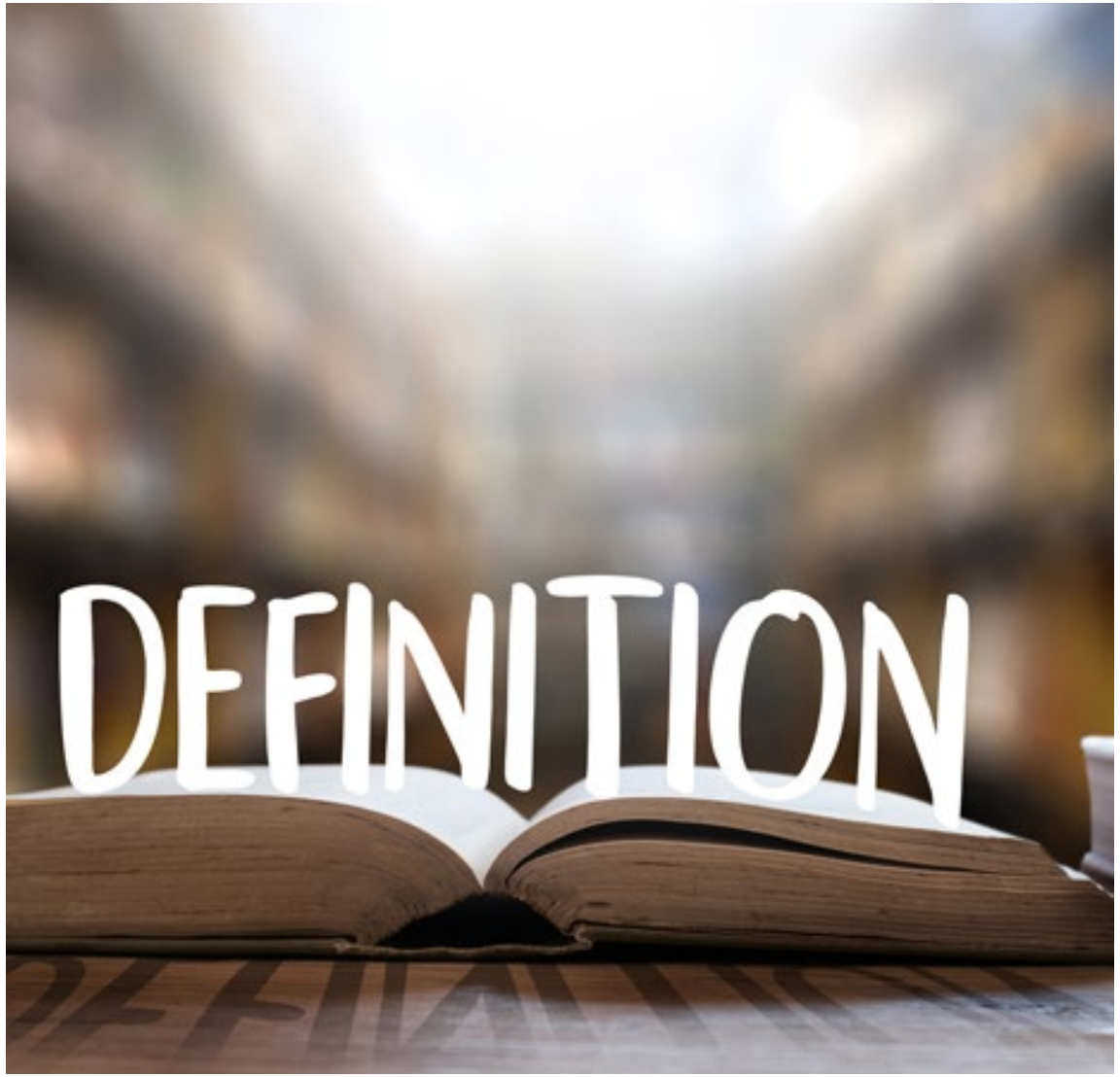
*Blackstone et al, HEC Forum 2020 32:47-62

# How do lawyers evaluate testamentary capacity?

- Testamentary capacity exists when the testator has sufficient mind to (1) understand the nature of the business in which he is engaged; (2) comprehend generally the nature and extent of the property which constitutes his estate; (3) hold in his mind the names and identity of those who have natural claims on his bounty; and (4) appreciates his relation to the members of his family. *Niemes v. Niemes*, 97 Ohio St. 145 (1917), paragraph 4 of the syllabus.
- The general rule is that the testator's mental condition at the time of making the will determines the testator's testamentary capacity. This test is similar to the same test used to evaluate a person's capacity to contract (i.e., execute a beneficiary designation).

# What does incompetent mean?

- R.C. 2111.02(D) defines incompetent as “any person is so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substances abuse, that the person is incapable of taking proper care of the person’s self or property or fails to provide for the person’s family.”
- The purposes of guardianship is to protect the rights of one unable to manage his or her own affairs. (R.C. 2111.01(A).)



# Who determines competency?

- R.C. 2111.02(A) provides that the probate court, on its own motion or on application by any ***interested party***, shall appoint a guardian of the ***person***, the ***estate***, or ***both*** as long as the person for whom the guardian is to be appointed is a resident of the county and has had the opportunity to have assistance of counsel.

# Advance Care Planning

- Advance care planning is a process of discussion that enables competent adults to express their wishes about periods of decisional incapacity and end of life care.

- Social workers are often the key professionals who interface with patients and families during life transitions because of their skills of communication, negotiation, support, and advocacy.

# Social Worker Role

- Social workers are responsible for initiating advance directive discussion, educating patients on how to formalize wishes, identifying a decision maker, completion of forms, and documenting and scanning into medical record.
- Initiate discussion
  - This is where an individual's decision-making capacity might come into question.
- Educate on how to formalize wishes
- Identify a decision maker
  - Clear
  - Not clear
  - None
- Complete forms and notarize
- Scan into medical record

# In practice in the outpatient setting

- Information sharing: We can share information with patient and POA-HC. This results in improved care coordination and care for person with complex medical needs.

- In situations requiring adult protective services, a statement of expert evaluation might be requested if an individual declines services.

# How can I best help my clients?

- Start with introducing the conversation during life events such as support with divorce, death of a loved one, when a child turns 18 years of age, or at least every 5 years.  Being proactive in supporting this conversation can help clients during a time without crisis when considerations can be most deliberate.

- Advise clients to share documents with loved ones and keep updated in a location that can be easily accessed if needed during an emergency.

# How can I best help my clients?

- Clients can have conversations with doctors during appointments and even bring with them.  For instance, at CCF, AD documents can be scanned into the medical record at any outpatient appointment.

- Offer clients resources on how to have the conversation with their family. Consider “The Conversation Project”

# Conversation Project

## How to start

### Here are some ways you could break the ice:

"I need your help with something."

"Remember how someone in the family died—was it a 'good' death or a 'hard' death? How will yours be different?"

"I was thinking about what happened to _____, and it made me realize..."

"Even though I'm okay right now, I'm worried that _____, and I want to be prepared."

"I need to think about the future. Will you help me?"

"I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

### What to talk about:

- ☐ When you think about the last phase of your life, what's most important to you? How would you like this phase to be?
- ☐ Do you have any particular concerns about your health? About the last phase of your life?
- ☐ What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*
- ☐ Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? *(This person is your health care proxy.)*
- ☐ Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?
- ☐ Are there any disagreements or family tensions that you're concerned about?
- ☐ Are there important milestones you'd like to be there for, if possible? *(The birth of your grandchild, your 80th birthday.)*
- ☐ Where do you want (or not want) to receive care? *(Home, nursing facility, hospital)*
- ☐ Are there kinds of treatment you would want (or not want)? *(Resuscitation if your heart stops, breathing machine, feeding tube)*
- ☐ When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

***This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your doctor or nurse if you'd like them to suggest more questions to talk about.***

**REMEMBER:**

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances change.
- Every attempt at the conversation is valuable.
- This is the first of many conversations—you don't have to cover everyone or everything right now.

# How can I best help my clients?

- Offer insight into Ohio law in absence of AD:

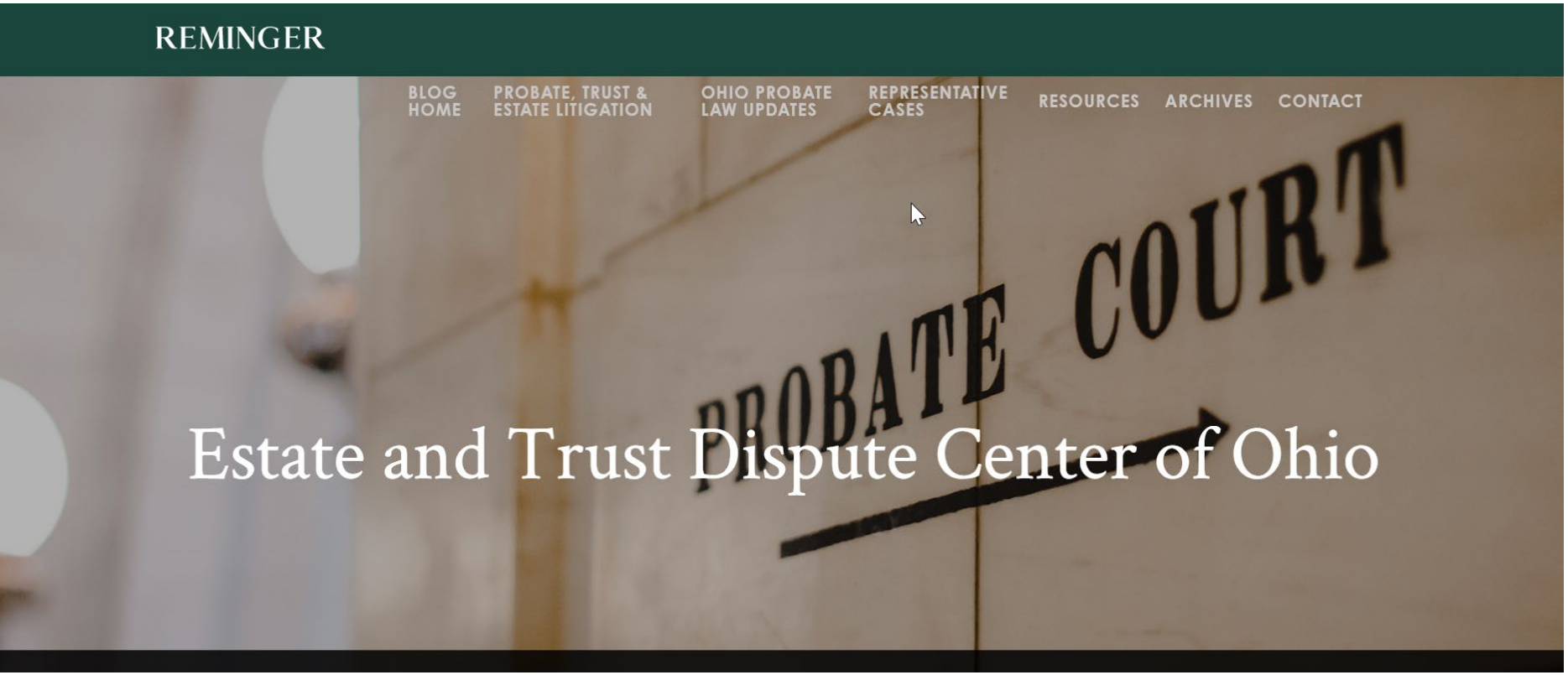
  The law recognizes an Order of Decision Makers if you are unable to make healthcare decisions for yourself and you do not have a Health Care Power of Attorney document. If the state has appointed a guardian, this person is the first decision maker. If not, the Order of Decision Makers for Ohio, according to the law, are:

  - Spouse
  - Adult children (majority of)
  - Parents
  - Adult siblings (majority of)
  - Or other nearest relative

- OH Law – 2 physician unilateral DNR

# COVID-19:
# LESSONS LEARNED

# More Questions?

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# Thank you for attending!

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