

# **LEGAL ISSUES AT THE END OF LIFE**

**Presented by:**

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The hour of her death has come. Pale and weak, Nanna lies peacefully in her hospital bed, or better yet, in the four-poster bed at the old homestead, surrounded by tearful children and grandchildren who have gathered to say goodbye. She has put her affairs in order, planned her own funeral, and designated who gets the good china and the collection of crystal vases. After tearful goodbyes, Nanna sighs, closes her eyes, and slips away into eternity. Most of us would rather avoid death entirely, our own and that of our loved ones. But if we have to think about it, we'd prefer that it be like the scene I just described. It almost never is. It is heartbreaking, messy, and incredibly stressful for everyone. More than likely it involves quarreling relatives, difficult financial issues, and medical decisions no one should have to make. My remarks today are for those who find themselves having to deal with the imminent death of a loved one, and are based on my experiences serving as a guardian and agent under a medical power of attorney ("POA") and also on my experiences as a human being who has lost someone close to him.

### **WHO'S IN CHARGE?**

Once Nanna has been diagnosed with a terminal illness or is otherwise not expected to live much longer, according to her doctor(s), the first thing to be determined is who is in charge of her health care. Can Nanna communicate her wishes regarding her treatment and care? What happens if she loses this ability to communicate later on or is incapacitated to begin with? Assuming she cannot communicate her wishes or is mentally incapacitated, you must first determine if she executed a Medical Power of Attorney or Designation of Guardian. One of the key differences between these two documents is that in a properly-executed Designation of Guardian, Nanna can specifically *exclude* someone from serving as her guardian. Texas Health & Safety Code §§1101.201 and 1101.202. Additionally, a properly-executed Designation of Guardian is *prima facie* evidence that Nanna was competent at the time of execution and that the named guardian in the Designation would serve her best interests. Health and Safety Code §1104.209. If she hasn't executed a Medical POA or Designation of Guardian and she is mentally incapacitated or cannot communicate her wishes, we look to the family for decision-making.

Health and Safety Code §166.038. Specifically, the attending physician and **one** person from one of the following categories, in order of priority, may make a treatment decision on Nanna's behalf that includes the decision to withhold or withdraw life-sustaining treatment: her (1) spouse; (2) reasonably available adult children; (3) parents; (4) nearest living relative. This is roughly the same pecking order of persons who can consent to medical treatment on behalf of Nanna that is found in section 313.004 of the Health and Safety Code. Of course, if there is no one in any of these categories available or willing or able to step up to the plate and make these decisions or, worse yet, these folks cannot agree on the course of action with respect to her care and treatment, a guardianship is likely, whether initiated by the healthcare provider or by a family member. If this guardianship application is contested or if a cross-application is filed, the court will most likely appoint a third-party temporary guardian pending the contest, along with an attorney ad litem to represent her. The appointment of a third party guardian can be costly for Nanna because the Estates Code allows for the temporary guardian and the attorney ad litem's fees and expenses to be paid out of the proposed ward's estate. So this is obviously a situation to be avoided if possible.

### **YOU'RE IT. NOW WHAT?**

No matter how you got this role, you now find yourself as Nanna's decision maker, her "decider." What do you do first? What should you expect? If you haven't done so already, have a meeting with her treatment team immediately. Find out what their "plan" is and what her prognosis is; talk openly with them. And ask lots of questions because physicians like to talk succinctly and (many times but not all the time) speak as if you, too, have a medical background. So slow them down and make them spell out clearly and in detail what their treatment goals are for her and what her prognosis is...in terms you understand. Identify the point-person (usually the attending physician) and make sure he/she, as well as the social worker, has your contact information (read: cell number) and vice versa (read: cell number or pager number). Make sure a copy of the Medical POA, Guardianship Letters, etc are in Nanna's chart, and make sure your contact information is in her chart. I say this because the healthcare providers will, depending on her circumstances, be contacting you repeatedly, at all hours of the day and night, asking for your consent to perform various medical procedures.

### **Did Nanna execute any Advanced Directives?**

If so, locate them and make sure both documents are in her chart. If she executed a Directive to Physicians, determine if the Directive was done properly (*see* Health and Safety Code §166.001, *et seq* for the specific requirements, as well as Appendix “A” for an example) and is the most recent in time (Health & Safety Code §166.008). If you believe you have in your possession her most recent properly-executed Directive then you are required to notify her physicians of its existence, and her physicians are required to place it in her chart. (Health & Safety Code §166.042). If she does not have a Directive and she is incompetent or cannot communicate her wishes, then Health & Safety Code section 166.039 controls. Section 166.039 provides that her guardian or agent under her Medical POA and her attending physician “may” make a treatment decision that can include withholding or withdrawing life-sustaining treatment. If Nanna does not have a guardian or Medical POA agent, then 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) Nanna's spouse;
- (2) Nanna’s reasonably available adult children;
- (3) Nanna's parents; or
- (4) Nanna's nearest living relative.

If she has no guardian, no Medical POA agent, and no one is available from the above list, then any treatment decision her attending physician makes must be concurred with by another physician who is not involved in her care OR by a member of the health care facility’s ethics/medical committee. NOTE: A treatment decision made under section 166.039, regardless of who makes it, must be based on knowledge of what she would desire, if her desires are known, and anyone challenging a treatment decision made under these circumstances (e.g. there is no Directive) must apply for temporary guardianship.

Also worth noting is that Nanna can revoke her Directive at any time, even if she’s incompetent! A person’s *current communicated* wishes control over any previously-executed Directive. Health & Safety Code §166.037 (emphasis added). If she’s pregnant no one can withhold or withdraw life-sustaining treatment from her, regardless of what her Directive states. Health and Safety Code §166.049.

**Out-of-Hospital DNR.** These are governed by Health and Safety Code sections 166.081 and 166.088. An Out-of Hospital DNR (hereinafter “DNR” for our purposes) is an order directing health care professionals acting in an out-of-hospital setting (long-term care facilities, in-patient hospice facilities, private homes, hospital outpatient or emergency departments, physician's offices, and vehicles during transport) to withhold CPR and certain other life-sustaining treatment (advanced airway management, artificial ventilation, and defibrillation, for example). NOTE: a DNR does not and cannot give authorization to withhold treatment or therapies considered necessary to provide comfort care, to alleviate pain, or to provide water or nutrition.

Requirements: A DNR must be (a) in the form and contain the language specified in Health and Safety Code section 166.083; (b) signed in the presence of two (2) witnesses or notarized; (c) signed by her attending physician; (d) placed in her chart. *See* Appendix “B.” Her guardian or her agent under her Medical POA can execute a DNR on her behalf, and a DNR can be expressed in non-written terms (and put in writing by the physician). If Nanna does not have a guardian or Medical POA agent, then the attending physician and one person, if available, from one of the following categories, in the following priority, may execute a DNR:

- (1) Nanna’s spouse;
- (2) Nanna’s reasonably available adult children;
- (3) Nanna’s parents; or
- (4) Nanna's nearest living relative.

If she has no guardian, no Medical POA agent, and no one is available from the above list, then another physician who is not involved in her care OR a member of the health care facility’s ethics/medical committee must concur with the DNR. Worth noting: A DNR order made under these circumstances must be based on knowledge of what Nanna would desire, if known, and anyone challenging a DNR order issued under these circumstances (e.g. not given by Nanna) must apply for temporary guardianship.

**Declaration for Mental Health Treatment.**

This document allows Nanna to make decisions in advance about mental health treatment, specifically (a) psychoactive medication; (b) convulsive (“electro shock”) therapy; and (c) emergency mental health treatment. Tex. Civ. Prac. & Rem. Code §137.001 *et seq.* *See* Appendix “C” for an example. It is effective for only three (3) years from the date of execution unless she becomes incapacitated during that three year period, at which point the Declaration

continues in effect until Nanna is no longer incapacitated.

### **WHAT IF THE DOCTOR AND THE DECIDER DON'T AGREE?**

If the attending physician refuses to honor Nanna's Directive, the physician's refusal is reviewed by an ethics committee (of which the attending physician cannot be a member). During this time Nanna is given life-sustaining treatment. She (or her decider) must be informed of the committee review process at least forty-eight (48) hours before the ethics committee meeting takes place and must be given a list of referral groups or health care providers who have indicated their readiness to accept her as a patient or to assist in locating a facility to accept her as a transfer patient if the committee concludes that the facility should no longer accept her as a patient. She (or her decider) is entitled to attend the meeting and receive a written explanation of the committee's decision. *See* Appendix "D" and "E."

If Nanna, the physician, or the decider does not agree with the committee's decision, the physician/facility must make a reasonable effort to transfer her to a physician/facility that is willing to comply with her Directive. If she or the decider is requesting life-sustaining treatment that her physician and the committee conclude is inappropriate, she must receive life-sustaining treatment pending any transfer (the facility is not obligated to provide such treatment beyond the 10<sup>th</sup> day from the day the committee's decision was provided to her), and she is responsible for all costs associated with her transfer. If she is re-admitted to the same facility within six (6) months from the date of the committee's decision, none of these procedures are required to be followed if her attending physician and another physician on the ethics committee document in her chart that her condition is the same or worse than when the committee previously conducted its review process.

In certain situations in an abundance of caution the guardian or agent will ask the probate court for direction by filing a "Motion for Instructions." This is usually filed either (a) when the decider, at the urging of the attending physician, wants to change Nanna's code status (e.g. "full code" to DNR status); or (b) in situations where the decider is dealing with a (often times litigious) family with differing views on what she wanted or what is best for her. *See* Appendix "F." Once a Motion for Instructions is filed, the court will appoint (or re-appoint, as the case may be) an attorney ad litem to represent Nanna for purposes of the motion. A full evidentiary hearing will

take place on the motion on the record and, in some of the more contentious cases, the attending physician will testify at the hearing, as will family members and other care-givers. Often times the court will order a “partial” change in the code status; for example, that chest compressions not be used in the event of a code but that artificial ventilation be performed. Sometimes a physician or facility will seek a Temporary Restraining Order and Temporary Guardianship in situations where the decider is not honoring a patient’s Directive and/or otherwise preventing the facility from administering the appropriate care. In these situations the court will appoint the patient an attorney ad litem and guardian ad litem.

## **OTHER MATTERS**

You should determine, if possible, what her wishes are with respect to the disposition of her remains. Does Nanna want to be cremated? Buried? Where? What are her religious beliefs? Is she a veteran? You should strongly consider a pre-paid funeral and, depending on the circumstances, make arrangements with a funeral home to pick up her body when she passes. If she is a veteran you will need to secure her Form DD 214 from the VA as soon as possible because you will need that form to secure not only VA benefits while she is alive but also to have a ceremony and burial at a veterans’ cemetery, if desired, upon her passing. To the extent possible, you should obtain her login and passwords to her online accounts, locate her Last Will and Testament, and other important documents (life insurance, IRA, 401k papers). Determine if her house and other applicable property are properly insured. Change the locks on her house if you don’t trust someone in her life or if the family is fighting you or each other. Upon her death, if you are her court-appointed guardian, you will need to file your Final Accounting, turn over the estate to the duly-appointed representative of her estate, and file an Application to Close the Guardianship.

While death in reality will never be like an idyllic scene from a Hallmark Channel movie, as “deciders”, we can make the experience less painful and fraught for the family and at the same time help Nanna die with dignity and peace.

## **APPENDIX “A”**

**COMBINATION DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES  
AND  
MEDICAL POWER OF ATTORNEY  
(AND HIPAA RELEASE AUTHORIZATION)**

**PART I. DIRECTIVE TO PHYSICIANS**

I, NANNA, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

**Terminal Condition.** If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

- A.     \_\_\_\_\_     I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
  
- B.     \_\_\_\_\_     I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

**Irreversible Condition.** If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

- C.     \_\_\_\_\_     I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
  
- D.     \_\_\_\_\_     I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

After signing this document, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided, and I would not be given available life-sustaining treatments.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain

my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

**Additional Requests.** (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

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**Instructions For Completing This Document.** This is an important legal document. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill. You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing this document. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of this document to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences. In addition to this document, Texas law provides for another type of directive that can be important during a serious illness called an Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss this document with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

## **PART II. MEDICAL POWER OF ATTORNEY**

I, NANNA, designate:

Name:                                   The Decider  
Address:  
Phone:

as my agent (hereinafter referred to as "agent") to make any and all health care decisions for me. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

## **DESIGNATION OF ALTERNATE AGENT**

If The Decider is unable or unwilling to make health care decisions for me, I designate the following person as my agent to make health care decisions for me as authorized by this document:

Name:                               The Alternate Decider  
Phone:

## **LIMITATIONS**

Limitations on the decision-making authority of my agent are as follows:

I hereby require my agent to direct my physician to comply with any valid Directive to Physicians (or similar document) which I may have heretofore executed or which I may hereafter execute. My agent is not authorized to direct my physician in a manner which would contradict any such valid Directive to Physicians (or similar document).

## **HIPAA RELEASE AUTHORITY**

I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. This release authority is effective immediately.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose and release to my agent who is named herein, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, my agent shall have the ability to ask questions and discuss my protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information to my agent. Such information may also be released to any person designated as a primary or successor agent or attorney-in-fact in a durable power of attorney which I have executed, whether or not such person is presently serving as such, and to any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as settlor.

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to the person who is nominated as my agent hereunder, including any written opinion relating to my incapacity that the person nominated as my agent may have requested. This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my agent.

This authority given to my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to re-disclosure by my agent and may no longer be protected by HIPAA. I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this release authority. No covered entity may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies. Further, in order to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records. Any information disclosed to my agent may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is subsequently disclosed by my agent. The authority given to my agent herein has no expiration date and shall expire only in the event that I revoke this Combination Directive to Physicians and Family or Surrogates and Medical Power of Attorney in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this Combination Directive to Physicians and Family or Surrogates and Medical Power of Attorney.

#### **ORIGINAL**

The original of this document is kept at: Nanna's residence.

#### **COPIES**

The following individuals or institutions have copies of the signed originals:

Name: The Decider

Name: The Alternate Decider

Name: Dewey Cheatham and Howe, LLP

#### **DURATION**

I understand that my designation of an agent exists indefinitely from the date I execute this document unless I establish a shorter time or revoke such designation. If I establish a shorter time and if I am unable to make health care decisions for myself when such time period does expire, the authority I have granted my agent shall, nevertheless, continue to exist until the time I become able to make health care decisions for myself. I do not wish to have my designation of

an agent end on a specified date.

**PRIOR DESIGNATIONS REVOKED**

I revoke any prior durable power of attorney for health care and any prior medical power of attorney.

**ACKNOWLEDGMENT OF DISCLOSURE STATEMENT**

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

Houston, Harris County, Texas

Signed on the \_\_\_\_ day of \_\_\_\_\_, 2014.

\_\_\_\_\_  
Nanna, Declarant and Principal

THE STATE OF TEXAS           §  
  §  
COUNTY OF HARRIS           §

This instrument was acknowledged before me on the \_\_\_\_ day of \_\_\_\_\_, 2014, by Nanna.

\_\_\_\_\_  
Notary Public, State of Texas

Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

- (1) that may be treated, but is never cured or eliminated;
- (2) that leaves a person unable to care for or make decisions for the person's own self; and
- (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"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 hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"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.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

## **MEDICAL POWER OF ATTORNEY DISCLOSURE STATEMENT**

THIS IS AN IMPORTANT LEGAL DOCUMENT REGARDING YOUR MEDICAL POWER OF ATTORNEY. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician. Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions. Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have copies of the signed originals. Your agent is not liable for health care decisions made in good faith on your behalf. Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent medical power of attorney. This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one. You may wish to designate an alternate agent in the event that your agent is unwilling,

unable or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

- (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
- (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

I have read and understand the contents of this disclosure statement, and I certify that I signed this disclosure statement prior to signing my Combination Directive to Physicians and Family or Surrogates and Medical Power of Attorney.

Date: the \_\_\_\_ day of \_\_\_\_\_, 2014.

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Nanna

## **APPENDIX “B”**

# OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

## TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form



This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name \_\_\_\_\_

Date of birth \_\_\_\_\_

Male  
 Female

**A. Declaration of the adult person:** I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Person's signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

**B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:**

I am the:  legal guardian;  agent in a Medical Power of Attorney; OR  proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

**C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication:** I am the above-noted person's:

spouse,  adult child,  parent, OR  nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

**D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person:** I am the above-noted person's attending physician and have:

seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR  observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

Lic# \_\_\_\_\_

**E. Declaration on behalf of the minor person:** I am the minor's:  parent;  legal guardian; OR  managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

**TWO WITNESSES:** (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

Witness 2 signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

**Notary in the State of Texas and County of \_\_\_\_\_.** The above noted person personally appeared before me and signed the above noted declaration on this date: \_\_\_\_\_.

Signature & seal: \_\_\_\_\_

Notary's printed name: \_\_\_\_\_

Notary Seal

[ Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner ]

**PHYSICIAN'S STATEMENT:** I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Physician's signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

License # \_\_\_\_\_

**F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative:** The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

Lic# \_\_\_\_\_

Signature of second physician \_\_\_\_\_

Date \_\_\_\_\_

Printed name \_\_\_\_\_

Lic# \_\_\_\_\_

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

**All persons who have signed above must sign below, acknowledging that this document has been properly completed.**

Person's signature \_\_\_\_\_

Guardian/Agent/Proxy/Relative signature \_\_\_\_\_

Attending physician's signature \_\_\_\_\_

Second physician's signature \_\_\_\_\_

Witness 1 signature \_\_\_\_\_

Witness 2 signature \_\_\_\_\_

Notary's signature \_\_\_\_\_

**This document or a copy thereof must accompany the person during his/her medical transport.**

## INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

**PURPOSE:** The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

**APPLICABILITY:** This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

**IMPLEMENTATION:** A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

**Section A** - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

**Section B** - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.

**Section C** - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

**Section D** - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

**Section E** - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

**Section F** - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.

**In addition**, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

**REVOCACTION:** An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

**AUTOMATIC REVOCACTION:** An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

### DEFINITIONS

**Attending Physician:** A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state. [HSC §166.002(12)].

**Health Care Professional:** Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

**Qualified Relative:** A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

**Qualified Witnesses:** Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

**Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.**

*Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011*

## APPENDIX “C”

# DECLARATION FOR MENTAL HEALTH TREATMENT

I, \_\_\_\_\_, being an adult of sound mind, wilfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

(OPTIONAL PARAGRAPH) I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

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## PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

I consent to the administration of the following medications:

---

I do not consent to the administration of the following medications:

---

I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

---

---

Conditions or limitations: \_\_\_\_\_

---

---

## CONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

I consent to the administration of convulsive treatment.

I do not consent to the administration of convulsive treatment.

Conditions or limitations: \_\_\_\_\_

---

---

## PREFERENCES FOR EMERGENCY TREATMENT

In an emergency, I prefer the following treatment FIRST (circle one):

Restraint                  Seclusion                  Medication

In an emergency, I prefer the following treatment SECOND (circle one):

Restraint                  Seclusion                  Medication

In an emergency, I prefer the following treatment THIRD (circle one):

Restraint                  Seclusion                  Medication

\_\_\_\_\_ I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and/or medications:

---

---

Conditions or limitations: \_\_\_\_\_

---

## ADDITIONAL PREFERENCES OR INSTRUCTIONS

---

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Conditions or limitations: \_\_\_\_\_

---

Signature of Principal: \_\_\_\_\_

Date: \_\_\_\_\_

## STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

## **APPENDIX “D”**

## **Institutional Ethics Committee (IEC)**

### **Formal Consult**

**Date:** 5/27/14

**Patient:** xxxxx

**DOB:** xxxxxx

**DOA:** 4/18/14

#### **Background:**

The patient is an 83-year-old Caucasian male with an extensive medical history including end-stage renal disease requiring regular dialysis, dementia, heart failure, thyroid disease, pneumonia, deep venous thrombosis and pulmonary embolism and inability to swallow resulting in subsequent feeding tube placement. He is also badly deconditioned and has a rapid heart beat. He was hospitalized for an acute kidney injury on March 3 and was discharged on March 11, 2014. He was readmitted on April 18 from his nursing home with deteriorating mental status and sepsis secondary to an E-coli infection. His improvement was limited and he was transferred out of the ICU unit temporarily, but returned again to the Unit and is now also suffering from advanced dementia, anemia, respiratory failure, septic shock, severe malnutrition.

The patient has four children, but a guardian has been appointed to make healthcare decisions for the patient. At the recommendation of the attending MICU physician, the guardian obtained judicial approval for a DNR order, which is in place. Some members of his family insist on aggressive treatment of all of his conditions. However, the patient executed a Directive to Physicians requesting that if he is in a terminal or irreversible condition, he wants only those treatments necessary to keep him comfortable. The healthcare team has determined that his condition meets that criteria and, at this time, any other treatment is contrary to current medical standards and is not in accordance with the patient's wishes.

**Issue:** What treatment is in the best interests of this patient?

**Healthcare Team Members:** Dr. Doshi, Attending Physician

**IEC Members:** Dr. Boisaubin, Dr. Guerrero, Ann Sparker, Kim Vu, Arline Worsham

**Others:** Geoffrey Sansom (Guardian), Star Caesar (Pt Liaison), Laurie Schuler (Chaplain), Peggy Reed (SWK)

**Advisory Opinion:** The above IEC Members and others listed met this afternoon for this consultation. After extensive review of the patient's medical situation, the IEC Members concurred with the treating team that the patient indeed is suffering from a terminal and irreversible medical condition with death foreseeable in the very near future and that he fully meets the criteria for his Directive to Physicians to be enacted. All further medical care should be only palliative in nature as all other forms would be non-beneficial, against the patient's stated wishes, and contrary to the current standards of medical practice.

Written by Eugene V. Boisaubin, MD  
Chairman, IEC Subcommittee  
Staff Member, Memorial Hermann Hospital

## **APPENDIX “E”**



01/Jan. 31. 2013 11:55AM BACC  
Jan. 8. 2013 2:55PM

No. 1828 P. 3/8/008  
NO. 2740 SandstormPlan 31.2013 11.58



January 4, 2013

Re:

To Whom It May Concern:

was admitted to our hospital on 12/21/2012. He was diagnosed with sepsis. The patient has multiple wounds, including a stage 4 wound to the sacrum, left heel blister, and a right leg lesion. He has a history of wounds, dementia, paranoid schizophrenia, anemia, hyperthyroidism, and hypotension. The patient has a feeding tube. He is non-verbal. He is bed bound.

During the course of his treatment here, he has required cardio-pulmonary resuscitation over four times and has been placed on the ventilator for respiratory failure; he continues to be ventilated. is also life-sustaining medication including a vasopressin drip.

I believe that this patient's quality of life is extremely poor and that, over time, it will continue to deteriorate. His prognosis is poor. I ask that he be made DNR (do not resuscitate) and that he be allowed to die naturally.

Sincerely,

Dr. Adeeba Akhtar

A handwritten signature in black ink that reads "Adeeba Akhtar".



Houston West  
9430 Old Katy Road  
Houston, TX 77055

Houston Heights  
1917 Ashland Street  
Houston, TX 77008

Houston Medical Center  
Life Science Plaza  
2130 W. Holcombe Boulevard  
Houston, TX 77030

[www.selectmedicalcorp.com](http://www.selectmedicalcorp.com)

01/Jan. 31. 2013: 11:56AM BASE  
Jan. 8. 2013 2:55PM

No. 1828 P. 4/8/008  
SansomGrplan.31.2013.11.58  
No. 2940 P. 2/3



4 January 2013

Re:

To Whom It May Concern:

Mr. [redacted] is currently being treated at our hospital by Dr. Adeeba Aklar. His primary diagnosis is sepsis. He also has multiple wounds, including a stage 4 wound to the sacrum, left heel blister, and a right leg lesion. He has a feeding tube, is bed bound, and is unable to communicate his needs. He has a history of wounds, dementia, paranoid schizophrenia, anemia, hyperthyroidism, and hypotension.

Mr. [redacted] has required CPR on several occasions and has been placed on a ventilator (artificial breathing machine) for respiratory failure and requires life sustaining medication including, but not limited to, vasopressin drip. The patient's prognosis and quality of life are extremely poor and will continue to deteriorate over time. I am, therefore, recommending that Mr. [redacted] be made a DNR (do not resuscitate) and that he be allowed to die naturally.

  
Respectfully, Quima Ratchford MD



Houston West  
9430 Old Katy Road  
Houston, TX 77055

Houston Heights  
1917 Ashland Street  
Houston, TX 77008

Houston Medical Center  
Life Science Plaza  
2130 W. Holcombe Boulevard  
Houston, TX 77030

## **APPENDIX “F”**

**COPY**

NO.

GUARDIANSHIP OF

§  
§  
§  
§  
§

IN PROBATE COURT

NUMBER TWO OF

AN INCAPACITATED PERSON

HARRIS COUNTY, TEXAS

MOTION FOR INSTRUCTIONS

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES HARRIS COUNTY GUARDIANSHIP PROGRAM, Movant, and says:

1. Movant was appointed Guardian of the person and estate of \_\_\_\_\_ and qualified in that capacity on June 10, 2008.
2. Ward's physicians have recommended a "Do Not Resuscitate" order as indicated in correspondence from Adeeba Akhtar, M.D., dated January 4, 2013 and Daima Ratcliff, M.D., dated January 4, 2013, copies of which are attached hereto.

WHEREFORE, Movant requests this Court for instructions as to whether it would be in the best interest of \_\_\_\_\_ to consent to a "Do Not Resuscitate" order and, if so, further requests the Court to grant Movant the authority to consent to such an order.

Respectfully submitted,

HARRIS COUNTY GUARDIANSHIP PROGRAM,  
by its Attorney

VINCE RYAN, SPN 99999939  
HARRIS COUNTY ATTORNEY

By Cecilia J. Longoria  
Cecilia J. Longoria, SPN 12543520  
Assistant County Attorney  
2525 Murworth, Ste. 103  
Houston, Texas 77054  
(713) 578-2181  
FAX NO. (713) 578-2195

	NO.	
GUARDIANSHIP OF	§	IN PROBATE COURT
	§	
	§	NUMER TWO OF
	§	
AN INCAPACITATED PERSON	§	HARRIS COUNTY, TEXAS

ORDER INSTRUCTING GUARDIAN

On this date came on to be considered the Motion for Instructions and the Court finds that it is in the ward's best interest to have his guardian consent to a "Do Not Resuscitate" order.

It is therefore ORDERED, that the Harris County Guardianship Program is hereby granted the authority to consent to a treatment plan that would withhold and/or withdraw the following interventions:

1. cardiopulmonary resuscitation;
2. advanced airway management;
3. artificial ventilation;
4. defibrillation;
5. transcutaneous cardiac pacing;
6. Code Blue Drug Protocol; and
7. renal dialysis

It is further ORDERED, that, in the event \_\_\_\_\_ is out of the hospital, Harris County Guardianship Program is hereby authorized to execute a Texas Department of Health Standard Out-of-Hospital DO-NOT-RESUSCITATE Order.

SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 2013.

\_\_\_\_\_  
JUDGE MIKE WOOD